Technical Assistance Consultant's Report

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Cambodia, Lao People's Democratic Republic, Myanmar, Viet Nam: Greater Mekong Subregion Health Security Project (Part 3/4)

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Asian Development Bank

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Cambodia	Project Title:	**GMS HEALTH SECURITY PROJECT (RRP REG 48118)**
Lending/Financing Modality:	Project	Department/ Division:	South-east Asia Regional Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY[i]

Poverty targeting: targeted poverty intervention – MDG6.

A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy:

The Rectangular Strategy-Phase III (RSIII) of the Royal Government of Cambodia (RGC), implemented during the fifth Legislature (2013-2018), reaffirms the RGC's strong commitment to sustainable development and poverty reduction that respond to the people's will and emerging contexts of national and international developments.[1] The RSIII aims at promoting economic growth, creating jobs, equitable distribution of the fruits of growth, and ensuring effectiveness of public institutions and management of resources. The Strategy will be implemented through a comprehensive National Strategic Development Plan (2014-2018), with clearly defined indicators and timeframe for implementation, and consistent with sectoral policies. One national target is to reduce poverty by one percentage point per year. The Government's earlier focus on agriculture, infrastructure, private sector development and employment is now shifting towards human resources development. While there is no explicit poverty reduction strategy, two multisector strategies have poverty reduction at their core: the 2011 National Social Protection Strategy for the Poor and Vulnerable, and the 2014 National Strategy for Food Security and Nutrition.

The Cambodia Country Partnership Strategy (2014-2018)[2] of the Asian Development Bank (ADB) aims to support the Government's RSIII to reduce poverty and vulnerability based on three strategic areas: (i) inclusive economic growth, (ii) environmentally sustainable growth; and (iii) regional cooperation and integration. It focuses on five sectors (agriculture, natural resources, and rural development; water and other urban infrastructure and services; transport; education; and finance) and one cross-cutting sector (public sector management). It aims to reduce poverty and to promote inclusive growth by focusing on rural areas and rural-urban links, targeting the areas where poorest people live, and promoting connectivity for isolated areas through all-weather rural roads and tourism infrastructure. These developments also carry health risks. ADB is committed to regional cooperation in the Greater Mekong Subregion, including for communicable diseases control (CDC), as confirmed in the Regional Partnership Strategy, including mitigation of negative impacts of development as one of the pillars of Strategy 2020.[3]

B. Results from the Poverty and Social Analysis during PPTA or Due Diligence

1. **Key poverty and social issues**.

In 2013, Cambodia had a population of 14.7 million, with 21.4% living in urban areas, most of whom live in a more industrialized and urbanized band along the south-east to north-west axes.[4] Cambodia is a success story in poverty reduction among the GMS Project countries. From 2004 through 2011, household consumption increased by nearly 40% due to rapid economic growth. This growth was pro-poor, not only reducing inequality but proportionally boosting poor people's consumption further and faster than the non-poor. The share of total consumption of the poorest 20% of households increased from 7.5% in 2007 to 9.3% in 2012. Official poverty lines introduced in 2013 show that the poverty rate fell sharply from 47.8% in 2007 to 18.9% in 2012. There are now about 3 million poor people and 8 million near-poor, about 80% of which live in rural areas, with slightly higher poverty rates, 20.0% in 2012 compared to 16.3% in Phnom Penh and 14.5% in other urban areas.

Extreme poverty measured by the international poverty line of $1.25 per person per day also shows a sharp reduction. In 2011, 10% of the population lived on less than $1.25 per day, down from 31% in 2007. However, in 2011, 41% of the population still lived on less than $2 per day, and 72% lived on less than $3 per day. Demonstrating the growing vulnerability in Cambodia, 31.2% of the population, or about 4 million people live between the $1.25 and $2.00 per day poverty lines. The total $2 per day poverty rate increased from 40.7% in 2009 to 41.2% in 2011. Based on using various references, Kampong Chhnang, Kampong Thom, Kratie, Preah Vihear, Pursat, Siem Reap, and Stung Treng appear to be among the poorest provinces.

World Bank analysis has suggested that poverty reduction is mainly as a result of increased agricultural productivity and related rural development. Indebtedness, including for farming, employment, and medical services, is a major cause of new poverty. About 70% of employed women and 59% of employed men are in vulnerable employment. Poverty tends to be higher in less educated, larger households. Households headed by women are likely to be more

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[1] Government of Cambodia, Fifth Legislature of the National Assembly. *Rectangular Strategy for Growth, Employment, Equity and Efficiency.* Phase III. Phnom Penh. September 2013.

[2] ADB. *Country Partnership Strategy* (2014-2018). November 2008. Manila

[3] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila

[4] ADB. *Country Poverty Analysis*. 2014. Manila

vulnerable. The Ministry of Planning has identified poor households to improve targeting of investments
While Cambodia has achieved most of its Millennium Development Goals, particularly reducing income poverty, expanding primary enrollment, and combating HIV and tuberculosis, progress is less in gender equity, reducing child malnutrition and infant and child mortality, and providing basic sanitation. Due to lack of access to basic services, Cambodia's multidimensional poverty rate is estimated at twice the income poverty rate, at 46% in 2010.[5]
The linkages between burden of disease and poverty and development are well known. The project does not primarily target the poor, but contributes to poverty reduction by averting morbidity and mortality from communicable diseases of regional relevance. The poor are at greatest risk because of their living conditions, occupational exposure, and lower access to health care. Migrant labor, especially to Thailand, makes a significant economic contribution to Cambodia but migration is weakly controlled, and migrant lack access to prevention and care.
The project is expected to contribute to MDG 6 – halt and reverse the spread of communicable diseases, including emerging infectious diseases, HIV/AIDS, tuberculosis malaria, and dengue. The Project will contribute to poverty reduction primarily by preventing the spread of communicable diseases and improving access to diagnostics and treatment, thus reducing medical expenses, morbidity, mortality and related household impact. Preventing or containing a major epidemic will have major poverty reduction impact. The proposed regional goal is that outbreaks have less than 100 case fatalities and less than 0.5% impact on GDP in any quarter. Any reduction in GDP will have major impact on the poor.
Selected provinces are primarily targeted because these are at increased risk of communicable diseases, not because these are mostly poor provinces. Targeting economic corridors will help safeguard gains in connectivity by reducing possibilities for disease outbreaks along these routes. The project targets 13 mostly poor border provinces out of a total of 25, in the north-east, the south-east, and the north-west of Cambodia. Those in the north-east have significant ethnic minority populations. The other two clusters are along the main east-west corridor, among others a major avenue for the movement of migrants to and from industrial zones and related services.
2. **Beneficiaries**. The larger part of investment of the project will benefit the general public, while a small part of the project is targeting high risk groups, often but not always poor, with communicable diseases control. A small part of the project will specifically help improve coverage of migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs). These MEVs are more likely to be exposed to and spread different types of diseases and drug resistance, depending on their location and occupations, and in general have less access to health services. **3. Impact channels**. The majority of resources will be allocated to timely disease outbreak reporting and response, which will contain the spread of outbreaks of infectious diseases and thus reduce disease impact on the poor; and by strengthening health care in border areas, thereby improving prevention and access to services, in particular for the poor including MEVs.
4. Other social and poverty issues. The percentage of the poor seeking health care when ill increased from 62% in 2004 to 92% in 2011, with a steady increase in the percentage of the poor seeking care in the public sector. There are no specific data for internal and external migrants. Health spending declined from 3.3% of total income in 2007 to 2.5% in 2011 for all groups and from 2% to 1.5% for the poor, and remains a significant burden, with 18% of the poor incurring debt because of health expenses, and higher for rural people.
5. Design features. The project addresses key poverty and social issues by strengthening surveillance and outbreak response up to village level; by strengthening regional control strategies, by improving prevention and care for MEVs, and by improving laboratory diagnostics and hospital infection control. This will be monitored through the annual evaluation of the regional disease control strategy, national surveillance and response monitoring system, laboratory and hospital quality control systems, and provincial health services and outreach statistics in targeted provinces.

II. PARTICIPATION AND EMPOWERING THE POOR

1. **Participatory approaches and project activities**. Each province will propose, through need assessment, consultations, and detailed preparation, project investment as part of its regular annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability.
2. Role of civil society. Civil society has a legal obligation to report outbreaks. Civil society representatives in this project will usually be members of the village health group, and will be engaged in community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use mobile phone for reporting. In addition, MOH is considering to engage NGOs to provide mentoring for provincial laboratories..
3. Civil society organizations. The project will ensure MOH endorsement of village health group participation, conduct mobilization and assessment of target groups, conduct participatory planning, and use various experts, including for gender and social safeguards to prepare and monitor implementation plans.
4. Types of participation. The following forms of civil society organization participation are envisaged during project

[5] ADB, United Nations Economic and Social Commission for Asia and the Pacific, United Nations Development Programme. 2013. *Asia-Pacific Aspirations: Perspectives for a Post-2015 Development Agenda*. Asia-Pacific Regional MDG Report 2012/13. Manila.

implementation, rated as high (H), medium (M), low (L), or not applicable (NA):
☒ M Information gathering and sharing ☒ M Consultation ☒ M Collaboration ☐ Partnership
5. Participation plan. ☐ Yes. ☒ No Participation of village health groups is well established within the health sector program of MOH.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: effective gender mainstreaming

A. Key issues. The Project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve access of women to health services. The patterns of infectious diseases differ substantially among women and men, because of differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's' access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.
The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas. Sufficient gender legislation is in place. MOH has a central focal point for gender, but this may be lacking at provincial level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level.

B. Key actions.
The Ministry of Women's Affairs Government of Cambodia launched a new five-year strategic plan (2014 – 2018) for Gender Equality and the Empowerment of Women in Cambodia called "Neary Rattanak IV". The plan articulates the long awaited move from project-based gender activities to a program-based approach to deal with fragmentation of gender efforts in projects. It is also to enhance capacity for gender analysis, advocacy and policy advice across the entire Government. Accordingly, the project's gender action plan (GAP) needs to follow the overall GAP or equivalent for the health sector which is still being prepared.
In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), the Poverty and Social Analysis (PSA), covenants, and the GAP.[6] The Project, based on general good practice for gender endorsed by MOH, will enhance participation of women in all its activities:

(i) The executing and implementing agencies have active gender focal points for project activities;
(ii) The project engages a gender and social development expert with a focus on community activities;
(iii) Project implementation plans and annual operational plans (AOPs) will address gender dimensions;
(iv) The project will collect, analyze and report gender-disaggregated data;
(v) All project reports report on gender issues;
(vi) The project will proactively target youth and women at increased risk of infectious diseases;
(vii) Education materials and care procedures will be gender-sensitive;
(viii) Outbreak response and outreach services will ensure female participation;
(ix) Participation of female and male staff in training programs and scholarship will be equitable;
(x) Refurbishment of laboratories and isolation wards will be gender sensitive;
(xi) All regional, cross-border and inter-sectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

☒ Gender action plan ☐ Other actions or measures ☐ No action or measure

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI
1. Key impacts. No resettlement is involved in this project.
2. Strategy to address the impacts. No strategy required
3. Plan or other Actions. A resettlement framework has been prepared in the event that there is a chance of scope during implementation involving hospital rehabilitation (but no resettlement is expected).
☐ Resettlement plan
☒ Resettlement framework
☐ Environmental and social management system arrangement
☐ No action
☐ Combined resettlement and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Social impact matrix

B. Indigenous Peoples **Safeguard Category:** ☐ A ☒ B ☐ C ☐ FI

[6] ADB. *Policy on Gender and Development*. June 1998. Manila; and Operations Manual Bank Policies Section C2/BP issued in December 2010.

1. Key impacts. Ethnic minorities excluding more recent migrant from Viet Nam and other countries only constitute about 4% of the population and are mainly located in the north-east of the country. They mainly belong to the Mon-Khmer group which has many subgroups and languages. However, malaria control, the development of rural access roads and migration of Khmer settlers to these provinces is rapidly changing the physical, social and economic environment of these indigenous groups, with mixed results depending on the coping capacity of groups.
The project is expected to have positive impact on ethnic minorities in the proposed project areas given the type of project activities, including identification of major infections still highly prevalent in ethnic minority communities such as tuberculosis and zoonotic infections, and linking them with health services. An indigenous people's plan has been prepared to help ensure that benefits for ethnic groups are realized. Proposed interventions are not considered sensitive for ethnic minority groups. Promotion of child immunization will require obtaining support of tribal leaders. Parents will be able to make more informed choices, but participation remains voluntary.
Is broad community support triggered? ☐ Yes ☒ No

2. Strategy to address the impacts. There are no mitigating measures required within any given State.

3. Plan or other actions.
☒ Indigenous peoples plan
☐ Indigenous peoples planning framework
☐ Environmental and social management system arrangement
☐ Social impact matrix
☐ No action
☐ Combined resettlement plan and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Indigenous peoples plan elements integrated in project with a summary

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. Relevance of the project for the country's or region's or sector's labor market, indicated as high (H), medium (M), and low or not significant (L).
☐ unemployment ☒ L underemployment ☐ retrenchment ☒ L core labor standards

2. Labor market impact. There will be no substantial impact on the local labor market. There will be short term employment benefits from avoiding and containing epidemics, such in factories, schools and tourism. There will be long term health and labor standards benefits from improving education and health care of migrants.

B. Affordability The project will not increase the price of health services but increased availability of services may increase health spending by the poor. However, health interventions provided under current arrangements are usually free for public goods, and subsidized for the poor through the health equity funds. No payments are required for diagnosis and treatment associated with major communicable diseases. Increasing diagnostic facilities will also reduce travel time and costs. Subsidizing supplies will further reduce out of pocket spending. Selecting the most cost-effective diagnosis and treatment strategies will help ensure financial sustainability.

C. Communicable Diseases and Other Social Risks
1. The impact of the following **risks** are rated as high (H), medium (M), low (L), or not applicable (NA):
☐ NA Communicable diseases ☐ NA Human trafficking ☐ NA Others (please specify) ______________
2. Risks to people in project area: NA. The purpose of this project is to reduce the risks of communicable diseases.

VI. MONITORING AND EVALUATION

1. Targets and indicators. Poverty and Social targets and indicators overlap with overall targets and indicators, as described in the DMF. Baselines and targets will vary considerably by province and are yet to be established through the provincial planning process. The following gender and social development areas will be monitored:
a) Prevention and control of communicable diseases in MEVs, monitored by measuring the use of services by MEVs in the health facilities, based on facility statistics by gender and, in relevant provinces, also by ethnic group;
b) Surveillance and response for communicable diseases, monitored through the national surveillance system;
c) Laboratories and hospitals quality and biosafety standards, monitored through annual assessments;
d) Female and male participation in workshops, training and other events, monitored through event reports.
2. Required human resources. Village health group, hospital and health center staff, MOH and provincial health staff, gender and social safeguards experts, laboratory and biosafety experts, other experts.
3. Information in the project administration manual (PAM). The PAM describes the project performance management system including DMF, quarterly and annual reports, mid-term review, project completion report, and independent evaluation and audit.
4. Monitoring tools. Similar to overall project monitoring, including health services statistics and project reports.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Lao PDR	Project Title:	**GMS HEALTH SECURITY PROJECT (RRP REG 48118)**
Lending/Financing Modality:	Project	Department/ Division:	South-east Asia Regional Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Poverty targeting: targeted poverty intervention – MDG6.

A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy:

The National Growth and Poverty Eradication Strategy of the Government of the Lao People's Democratic Republic (Lao PDR) was approved in 2003 as the framework to develop and implement initiatives to end poverty and sustain national growth.[1] It aimed at eradicating poverty in Lao PDR by 2020, particularly by focusing on the poorest districts. Since then, the country has been moving towards a market-oriented economy and is one of the fasted growing economies. The Lao PDR has achieved remarkable economic growth at about 7% of GDP annually and quickly increased its annual per capita income to about $1600 in 2014. It has set a target of 7.5% growth up to 2020 to graduate from least developed country status. Growth contributed to lowering the number of poor people to an estimated 23.2 percent of the population in 2012/13 from 33.5 percent a decade ago.

However, this rapid growth has been less equitable and comes at a cost. The country has done less well on poverty reduction compared to the region because development was largely urban based and driven by foreign investment in small industries, also resulting in major migration. While Lao is a resource-rich country, exploitation of natural resources contributed only one third to economic growth. The key strategies used by the Government for poverty reduction are human resource development, rural development and people's participation. These are long term strategies and the Lao PDR has done less well in these areas, due to lack of investment in rural access roads and competent institutions, and a reluctance of the Government to allow civil society participation in development. Based on the upcoming 8th National Socio-economic Development Plan (NSEDP), 2016-2020, the Government adopted a more modest target of reducing the poverty rate to 15% by 2020.

The Lao PDR achieved several of its Millennium Development Goals (MDGs) in 2015, including halving poverty, reducing hunger and improving education and health outcomes. However, malnutrition remains high with about one quarter of children being underweight, and maternal mortality is also high as this depends on access to hospital services. Based on the 8th NSEDP, priorities in the health sector up to 2020 include strengthening and improving the quality of health care at the grassroots level, particularly in under-served areas. Safe drinking water, sanitation systems and improved nutritional standards are also prioritized. Child mortality among infants aged less than one year is set to fall to 30 deaths per 1,000 live births, while the goal for the maternal mortality rate is set at 200 deaths per 100,000 live births, which is still high compared to other countries in the region.[2]

ADB's Lao PDR Country Partnership Strategy (CPS) 2012–2016[3] is aligned with the government's 7th NSEDP 2011-2015,[4] which aimed to support sustainable economic growth and reduce poverty and inequality, and promoted inclusion of women, ethnic groups, those living in remote areas, the private sector, NGOs, and development partners. The CPS 2012-2016 sought to gain efficiency and sustainability through larger operations implemented over a longer period; maximize synergies with the Greater Mekong Subregion (GMS) program; and increase responsiveness to emerging issues in a rapidly changing economy. It aimed to reduce poverty and to promote inclusive growth by focusing on rural areas and rural-urban links, targeting the areas where poorest people live, and promoting connectivity for isolated areas through rural roads. Industrialization and connectivity, with associated migration and changing behavior, carries health risks. The CPS includes support for public sector management in the health sector.

ADB is committed to regional cooperation as one of the pillars of Strategy 2020.[5] The regional partnership strategy for the Greater Mekong Subregion prioritizes communicable diseases control (CDC), among others to mitigate risks and negative impacts of connectivity and development.

B. Results from the Poverty and Social Analysis during PPTA or Due Diligence

1. **Key poverty and social issues**.

About 70% of the population of Lao PDR lives in rural areas and depends on agriculture and natural resources for

[1] The Government of the Lao PDR. *National Growth and Poverty Eradication Strategy. 2003*. Vientiane. Prime Minister's Instruction on the eradication of poverty provides an operational definition: "*Poverty is the lack of ability to fulfil basic human needs such as not having enough food, lacking adequate clothing, not having permanent housing and lacking access to health, education and transportation services"* (Instruction No 010/PM, June 25, 2001).

[2] Speech of the Minister of Planning and Investment at the National Assembly, December 2015.

[3] ADB. *Lao PDR Country Partnership Strategy 2012-2016*. 2012. Manila.

[4] The Government of the Lao PDR. *7th National Socio-economic Development Plan 2011-2015*. 2010. Vientiane.

[5] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila

survival. Farming is largely at the subsistence level and productive conditions are generally poor. Poverty and extreme poverty are most common in mountain villages where the majority of the country's ethnic minority peoples live, in particular in the eastern districts bordering Viet Nam. In upland areas, the poverty rate is as high as 43 percent. During the rainy seasons as many as half of all Lao villages become unreachable. Rural communities have very limited access to government and financial services, roads, markets, basic education and health services. Lack of education prevents them from gaining access to information that would help them improve their living standards. Rural people especially suffer from many communicable diseases that are easily treated or prevented, but even where services are available many people in Laos avoid using them because of the relatively high user fees. The poorest groups are not explicitly targeted, but most beneficiaries are likely to be low-income agricultural and forest workers, migrants, and ethnic groups more likely to suffer from the targeted communicable diseases. The project targets 12 border provinces out of a total of 18 provinces and 36 border districts.

2. Beneficiaries. The Project will benefit the general public, as most project resources will be allocated to strengthening disease control and hospital services. A small part of the project is targeting high risk groups, often but not always poor, with communicable diseases control. Due to high prices and perceived poor quality of public health services, they often resort to traditional medicine and self-medication. The project will specifically help improve coverage of migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs). These MEVs are more likely to be exposed to and spread different types of diseases and drug resistance, depending on their location and occupations, and in general have less access to health services

3. Impact channels. The majority of resources will be allocated to timely disease outbreak reporting and response, which will contain the spread of outbreaks of infectious diseases and thus reduce disease impact on the poor; and by strengthening health care in border areas, thereby improving prevention and access to services, in particular for the poor including MEVs. Public health services are well planned but under resourced with limited staff capacity, in particular in rural areas. Poor and vulnerable groups will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

4. Other social and poverty issues. Use of health services often results in financial hardship for patients and their relatives. A 2004 household survey found that 34% of the poorest quintile had sold assets while 29% had borrowed cash from relatives to pay for hospital bills.[6]

5. Design features. The linkages between burden of disease and poverty and development are well known. The project addresses key poverty and social issues by strengthening surveillance and outbreak response up to village level; by strengthening regional control strategies, by improving prevention and care for MEVs, and by improving laboratory diagnostics and hospital infection control. This will be monitored through the annual evaluation of the regional disease control strategy, national surveillance and response monitoring system, laboratory and hospital quality control systems, and provincial health services and outreach statistics in targeted provinces. The project design responds to a favorable legal framework, the commitment to regional cooperation, the need for universal health coverage, human resource constraints, and seeks complementarity and integration with past and current investments. The CPS is supported by safeguarding advances in connectivity by preventing epidemics transmitted across transport routes. For concentrating poverty eradication schemes, the government identified 72 districts as poor, and 47 very poor districts for priority investments. All such identified districts are located in remote and mostly forest areas. There is substantial overlap between these and the selected provinces for the Project.

II. PARTICIPATION AND EMPOWERING THE POOR

1. **Participatory approaches and project activities.** Each province will propose, through need assessment, consultations, and detailed preparation, project investment as part of its regular annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability.

2. Role of civil society. Civil society is required to report outbreaks. Civil society representatives in this project will usually be village health volunteers, and will be engaged in community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use mobile phone for reporting. In addition, MOH is considering to engage NGOs to provide services for forest dwellers and other remote MEVs.

3. Civil society organizations. The project will ensure MOH endorsement of village health volunteer participation, conduct mobilization and assessment of target groups, conduct participatory planning, and use various experts, including for gender and social safeguards to prepare and monitor implementation plans.

4. Types of participation. The following forms of civil society organization participation are envisaged during project implementation, rated as high (H), medium (M), low (L), or not applicable (NA):

☒ M Information gathering and sharing ☒ M Consultation ☒ M Collaboration ☐ Partnership

5. Participation plan. ☐ Yes. ☒ No Participation of village health volunteers is well established within MOH.

III. GENDER AND DEVELOPMENT

[6] MOH. *Health Sector Development Program Health Services Survey*. 2004. Vientiane

Gender mainstreaming category: effective gender mainstreaming

A. Key issues. The Project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve access of women to health services. The patterns of infectious diseases differ substantially among women and men, because of differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's' access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.

As reported in the ADB World Bank Country Gender Assessment of 2012, [7] it notes that increased economic links with neighboring countries present a number of opportunities and risks. Both cross-border and domestic migration are more often done by women. Those who go to work in Thailand are mostly young people from border areas aged 15-25 years old. Women from Mon-Khmer and Tibeto-Burman ethnic groups are disproportionately among migrants. Precise figures are unavailable because the majority of persons migrate through irregular channels. Reports indicate that young women and girls who are trafficked often end up in forced prostitution and domestic labor. The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas.

Sufficient gender legislation is in place. MOH has a central focal point for gender, but this may be lacking at provincial level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level.

B. Key actions.

The Lao Women's Union (LWU) is mandated to represent women of all ethnic groups and to "protect women's rights and interests". It is a grassroots organization with representation in all villages and has substantial local powers. The National Commission for the Advancement of Women (NCAW) was established in 2003 as the national focal agency for gender mainstreaming in development policies and programs. The Lao PDR has no Ministry of Women's Affairs. Gender equality is an important national goal, which is reflected in the Constitution, in major international commitments and in the establishment of the NCAW. One major concern is the fragmentation of gender efforts in projects. Unlike in Cambodia, there has not been a movement to articulate comprehensive sector gender programs. Accordingly, the project's gender action plan (GAP) may need to be adjusted based on later developments.

In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), the Poverty and Social Analysis (PSA), covenants, and the GAP.[8] The Project, based on general good practice for gender endorsed by MOH, will enhance participation of women in all its activities:

- (i) The executing and implementing agencies have active gender focal points for project activities;
- (ii) The project engages a gender and social development expert with a focus on community activities;
- (iii) Project implementation plans and annual operational plans (AOPs) will address gender dimensions;
- (iv) The project will collect, analyze and report gender-disaggregated data;
- (v) All project reports report on gender issues;
- (vi) The project will proactively target youth and women at increased risk of infectious diseases;
- (vii) Education materials and care procedures will be gender-sensitive;
- (viii) Outbreak response and outreach services will ensure female participation;
- (ix) Participation of female and male staff in training programs and scholarship will be equitable;
- (x) Refurbishment of laboratories and isolation wards will be gender sensitive;
- (xi) All regional, cross-border and inter-sectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

☒ Gender action plan ☐ Other actions or measures ☐ No action or measure

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. No resettlement is involved in this project.

[7] ADB and World Bank. *Country Gender Assessment for Lao PDR – Reducing Vulnerability and Increasing Opportunity*. 2012. Vientiane.

[8] ADB. *Policy on Gender and Development*. June 1998. Manila; and Operations Manual Bank Policies Section C2/BP issued in December 2010.

2. Strategy to address the impacts. No strategy required
3. Plan or other Actions. A resettlement framework has been prepared in the event that there is a chance of scope during implementation involving hospital rehabilitation (but no resettlement is expected).

☐ Resettlement plan
☒ Resettlement framework
☐ Environmental and social management system arrangement
☐ No action
☐ Combined resettlement and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Social impact matrix

B. Indigenous Peoples **Safeguard Category:** ☐ A ☒ B ☐ C ☐ FI

1. Key impacts. Ethnic minorities excluding more recent migrant from Viet Nam and other countries constitute about 35% of the population and are mainly located in the hills and mountains of the country. They mainly belong to the Mon-Khmer, Hmong, and Tibeto-Burman language groups with a total of 43 officially recognized subgroups and 257 clans. They are increasingly participating in the national economy through migrant labor or business, and sometimes through resettlement. Studies report increased rates of infections among these communities associated with changing behavior and environment. Even so, there remain remote ethnic minorities with a disproportionate burden of infectious diseases due to lack of awareness, poor living conditions, and malnutrition.
The project is expected to have positive impact on ethnic minorities in the proposed project areas given the type of project activities, including identification of disease outbreaks and major infections in ethnic minority communities, and linking them with better diagnostic health services. An indigenous people's plan has been prepared to help ensure that benefits for ethnic groups are realized. Proposed interventions are not considered sensitive for ethnic minority groups. Promotion of child immunization has been a problem and requires obtaining support of tribal leaders.
Is broad community support triggered? ☐ Yes ☒ No

2. Strategy to address the impacts. There are no mitigating measures required within any given State.

3. Plan or other actions.

☒ Indigenous peoples plan
☐ Indigenous peoples planning framework
☐ Environmental and social management system arrangement
☐ Social impact matrix
☐ No action
☐ Combined resettlement plan and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Indigenous peoples plan elements integrated in project with a summary

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. Relevance of the project for the country's or region's or sector's labor market, indicated as high (H), medium (M), and low or not significant (L).
☐ unemployment ☒ L underemployment ☐ retrenchment ☒ L core labor standards

2. Labor market impact. There will be no substantial impact on the local labor market. There will be short term employment benefits from avoiding and containing epidemics, such in factories, schools and tourism. There will be long term health and labor standards benefits from improving education and health care of migrants.

B. Affordability The project will not increase the price of health services but increased availability of services may increase health spending by the poor. However, health interventions provided under current arrangements are usually free for public goods, and subsidized for the poor through the health equity funds. No payments are required for diagnosis and treatment associated with major communicable diseases. Increasing diagnostic facilities will also reduce travel time and costs. Subsidizing supplies will further reduce out of pocket spending. Selecting the most cost-effective diagnosis and treatment strategies will help ensure financial sustainability.

C. Communicable Diseases and Other Social Risks
1. The impact of the following **risks** are rated as high (H), medium (M), low (L), or not applicable (NA):
☐ NA Communicable diseases ☐ NA Human trafficking ☐ NA Others (please specify) ______________
2. Risks to people in project area: NA. The purpose of this project is to reduce the risks of communicable diseases.

VI. MONITORING AND EVALUATION

1. Targets and indicators. Poverty and Social targets and indicators overlap with overall targets and indicators, as described in the DMF. Baselines and targets will vary considerably by province and are yet to be established through the provincial planning process. The following gender and social development areas will be monitored:
a) Prevention and control of communicable diseases in MEVs, monitored by measuring the use of services by MEVs in the health facilities, based on facility statistics by gender and, in relevant provinces, also by ethnic group;
b) Surveillance and response for communicable diseases, monitored through the national surveillance system;
c) Laboratories and hospitals quality and biosafety standards, monitored through annual assessments;
d) Female and male participation in workshops, training and other events, monitored through event reports.
2. Required human resources. Village health group, hospital and health center staff, MOH and provincial health staff, gender and social safeguards experts, laboratory and biosafety experts, other experts.

3. Information in the project administration manual (PAM). The PAM describes the project performance management system including DMF, quarterly and annual reports, mid-term review, project completion report, and independent evaluation and audit.
4. Monitoring tools. Similar to overall project monitoring, including health services statistics and project reports.

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SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Myanmar	Project Title:	**GMS HEALTH SECURITY PROJECT (RRP REG 48118)**
Lending/Financing Modality:	Project	Department/ Division:	South-east Asia Regional Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Poverty targeting: targeted poverty intervention – MDG6.

A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy:

Myanmar is a resource-rich country with a population of about 55 million people in the Greater Mekong Subregion (GMS). Since 2011, following years of military rule, Myanmar has embarked on a program of political, institutional, economic and social reforms. While parliamentary elections have been held and a new government has been formed, this government is yet to settle down and start addressing multiple challenges. Even so, it has expressed commitment to poverty reduction, and is supportive of a smooth transition.

The previous Government's overall goal was inclusive economic growth and poverty reduction,[1] with a focus on rural employment generation; promotion of economic, social and political reform processes; and reducing vulnerability to natural disasters. The National Medium Term Priority Framework for Socio-Economic Reforms 2011-2014[2] prioritizes to increase agricultural production in order to ensure food security and reduce poverty. Another top priority is to improve rural livelihoods by helping communities harness their physical, natural and human capital. Under the National Strategy for Rural Development and Poverty Reduction,[3] eight priority sectors included agriculture, livestock and fishery, rural productivity and cottage industry, micro-savings and credit enterprises, rural cooperatives, rural socio-economy, rural renewable energy, and rural environmental conservation. Hence, the Government's perception of poverty reduction was focused on the "productive" rural sectors. Education, health and social protection were prioritized only recently, as evidenced in increased budget support. The Government has also made efforts to develop local governance capacity, by establishing planning and implementation committees at all levels; promoting community driven development institution and local governance of social services; and preparing participatory township-led development plan. It appears that the township level has become the focus of development.

The Interim Partnership Strategy (IPS) 2012-2014 of the Asian Development Bank (ADB), extended to 2016 is aligned with the strategic objectives of the current National Development Plan, although this Plan is likely to change. ADB's IPS emphasizes transport, energy, agriculture and natural resources, education, and urban development, including water and sanitation. ADB had not had operations in Myanmar from 1988 to 2012, although the country, as a member of the GMS program, has participated in ADB's GMS activities over the last 20 years, including small activities in communicable diseases control (CDC). The Ministry of Health has expressed its commitment to GMS cooperation in CDC. New highways and rural access roads have brought both economic development opportunities and health risks for underemployed rural people, and has stimulated economic migration, including to neighboring Thailand. Mitigation of negative impacts of development as one of the pillars of Strategy 2020.[4] ADB's Regional Partnership Strategy[5] gives priority to CDC in the GMS, with emphasis on regional health security for emerging infectious diseases, control of major infections of regional importance, and integrating CDC initiatives.

B. Results from the Poverty and Social Analysis during PPTA or Due Diligence

1. **Key poverty and social issues**.

Once a country that commanded the world's largest rice exports in the early 1940s, Myanmar today has a per capita income of $1105 per year, the lowest per capita income in the Association of Southeast Asian Nations (ASEAN). Myanmar is richly endowed with natural resources, and well positioned at the center of major economic powers. Myanmar's GDP grew at 8.5% in 2014/15 but is projected to reduce to 6.5% in 2015/16 due to floods and slowing investments. (World Bank). Myanmar's population of 51.4 million including about 32% ethnic minorities is unevenly distributed across 7 regions and 7 states, with Burmese living predominantly in the valleys, and minorities living in the mountainous border states. Less than one-third of the population has access to the electricity grid, road density remains low, and telecom connections are still underdeveloped, with mobile phone and internet penetration rates at 20% and 10% in 2014, respectively. With two private telecom operators having started operations in late 2014, there should be significant increase in mobile phone and internet penetrations.

Among the 10 member ASEAN countries, Myanmar has the lowest life expectancy (65 years) and the second-highest rate of infant mortality (40 per 1,000 births) and child mortality (51 per 1,000 live births). The United Nations

[1] Government of Myanmar. *National Development Plan for 2011-2020*.
[2] Government of Myanmar. *The National Medium Term Priority Framework for Socio-Economic Reforms 2011-2014*
[3] Government of Myanmar. *National Strategy on Rural Development and Poverty Alleviation*.
[4] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila
[5] ADB *GMS Regional Partnership Strategy*

Development Programme's Human Development Index (HDI), which measures achievements in terms of life expectancy, educational attainment and adjusted real income, ranked Myanmar at 149 out of 187 countries in 2012.
The Myanmar Integrated Household Living Conditions Survey (IHLCS) was conducted in 2005 and 2009–2010[6]. Based on the results of this survey, the union poverty incidence fell from 31% in 2005 to 25% in 2009 2010. Food poverty (measuring the chronic poor) also fell from 10% to 5% over the same period. However, the share of food in total consumption actually increased for the poorest 30% of the population, suggesting that the well-being of the poorest families may not have improved at all during this period. While GDP increased by 7.8% annually, nearly 70% of the population lives close to the US$2/day poverty line and most households are likely to face serious problems accessing even the most basic and critical services. Income gains of poor persons were likely absorbed by increased food prices (the price of rice increased in this period by about 135%). Migrant labor to Thailand and other adjoining countries makes a very significant economic contribution in Myanmar, and their remittances help poor households disproportionately. The income poverty rate is slightly higher in rural areas at 29.2% compared to urban areas at 25.6%. By region, income poverty is the highest in Chin (73%), followed by Rakhine (44%), Tanintharyi (33%), Shan (33%), and Ayeyarwardy (32%). Transitionary poverty is substantial in Myanmar, affecting about one third of the population, as households lack support of services to cope with financial shocks like for medical services.
The linkages between burden of disease and poverty and development are well known. The Project does not specifically target the poor, but will contribute to poverty reduction primarily by preventing the spread of communicable diseases and improving access to diagnostics and treatment, thus reducing medical expenses, morbidity, mortality and related household impact. The poor are at greatest risk because of their living conditions, occupational exposure, and lower access to health care. Migrant labor, both formal and informal, is weakly controlled, and migrants lack access to health prevention and care. The project is expected to contribute to MDG 6 – halt and reverse the spread of communicable diseases, including emerging infectious diseases, HIV/AIDS, tuberculosis malaria, and dengue. Preventing or containing a major epidemic will have major poverty reduction impact. The proposed regional goal is that outbreaks have less than 100 case fatalities and less than 0.5% impact on GDP in any quarter. Any reduction in GDP will have major impact on the poor.
Selected provinces are primarily targeted because these are at increased risk of communicable diseases, not because these are mostly poor provinces. Targeting economic corridors will help safeguard gains in connectivity by reducing possibilities for disease outbreaks along these routes. The project targets 5 states and one region out of a total of 14, in the east part of the country along the borders with Thailand, Lao PDR and PCR. The 5 states, Shan North, Shan East, Kayah, Kayin, and Mon have a majority ethnic minority population, and Tanintharyi has a large migrant labor population.
2. **Beneficiaries**. The larger part of investment of the project will benefit the general public, while a small part of the project is targeting high risk groups, often but not always poor, with communicable diseases control. A small part of the project will specifically help improve coverage of migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs). These MEVs are more likely to be exposed to and spread different types of diseases and drug resistance, depending on their location and occupations, and in general have less access to health services.
3. Impact channels. The majority of resources will be allocated to timely disease outbreak reporting and response, which will contain the spread of outbreaks of infectious diseases and thus reduce disease impact on the poor; and by strengthening health care in border areas, thereby improving prevention and access to services, in particular for the poor including MEVs. Public health services are well planned but under resourced with limited staff capacity, in particular in rural areas. Poor and vulnerable groups will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.
4. Other social and poverty issues. Until very recently social protection interventions in Myanmar were minimal and fragmented, forcing families to provide for themselves in dire and hazardous circumstances. A new national social protection strategy introduces an innovative vision reduction of poverty and vulnerabilities. The challenges include overcoming the past low investment in rural health services and inadequate funding for expansion of universal health coverage. The GMS CDCIII Project will support this strategy by improving access to health services by the eastern border population.
5. Design features. The project addresses key poverty and social issues by strengthening surveillance and outbreak response up to village level; by strengthening regional control strategies, by improving prevention and care for MEVs, and by improving laboratory diagnostics and hospital infection control. This will be monitored through the annual evaluation of the regional disease control strategy, national surveillance and response monitoring system, laboratory and hospital quality control systems, and provincial health services and outreach statistics in targeted provinces.

II. PARTICIPATION AND EMPOWERING THE POOR

1. **Participatory approaches and project activities**. For the planning of this project, stakeholders were consulted at different levels in 3 states. Based on this assessment, it is evident that a state/region based implementation planning is required, not only because of each state/region being unique, but because of anticipated implementation problems and to ensure buy-in from local government and beneficiaries. Each state will propose, through need assessment,

[6] Government of Myanmar. *Integrated Household Living Conditions Survey (IHLCS) 2009–2010.*

consultations, and detailed preparation, project investment as part of its regular annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, security, and sustainability. This being a modest first investment of ADB in health security in Myanmar, the geographical scope is limited to the hospital in the 6 state/region capitals and 6 main border township.

2. Role of civil society. Civil society has a legal obligation to report outbreaks. Civil society representatives in this project will usually be auxiliary nurse midwives or village health workers, and will be engaged in community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use mobile phone for reporting. In addition, MOH is considering to engage NGOs to provide mentoring for state laboratories and provide services for hard to reach MEVs.

3. Civil society organizations. The project will ensure MOH endorsement of village health group participation, conduct mobilization and assessment of target groups, conduct participatory planning, and use various experts, including for gender and social safeguards to prepare and monitor implementation plans.

4. Types of participation. The following forms of civil society organization participation are envisaged during project implementation, rated as high (H), medium (M), low (L), or not applicable (NA):

☒ M Information gathering and sharing ☒ M Consultation ☒ M Collaboration ☐ Partnership

5. Participation plan. ☐ Yes. ☒ No Participation of community, health staff and village health workers is well established within health services. Specific plans will need to be prepared by the local townships.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: effective gender mainstreaming

A. Key issues. The Project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve access of women to health services. The patterns of infectious diseases differ substantially among women and men, because of differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's' access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.

The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas. Sufficient gender legislation is in place. MOH has a central focal point for gender, but this may be lacking at provincial level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level.

B. Key actions.

Active engagement of women's associations is proposed to mobilize communities and reach at risk groups. Describe what measures are included in the project design to promote gender equality and women's empowerment—including access to and use of relevant services, resources, assets, and/or opportunities and

Accordingly, the project's gender action plan (GAP) needs to follow the overall GAP or equivalent for the health sector which is still being prepared.

In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), the Poverty and Social Analysis (PSA), covenants, and the GAP.[7] The Project, based on general good practice for gender endorsed by MOH, will enhance participation of women in all its activities:

- (i) The executing and implementing agencies have active gender focal points for project activities;
- (ii) The project engages a gender and social development expert with a focus on community activities;
- (iii) Project implementation plans and annual operational plans (AOPs) will address gender dimensions;
- (iv) The project will collect, analyze and report gender-disaggregated data;
- (v) All project reports report on gender issues;
- (vi) The project will proactively target youth and women at increased risk of infectious diseases;
- (vii) Education materials and care procedures will be gender-sensitive;
- (viii) Outbreak response and outreach services will ensure female participation;
- (ix) Participation of female and male staff in training programs and scholarship will be equitable;
- (x) Refurbishment of laboratories and isolation wards will be gender sensitive;
- (xi) All regional, cross-border and inter-sectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

☒ Gender action plan ☐ Other actions or measures ☐ No action or measure

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

[7] ADB. *Policy on Gender and Development*. June 1998. Manila; and Operations Manual Bank Policies Section C2/BP issued in December 2010.

1. Key impacts. No resettlement is involved in this project.
2. Strategy to address the impacts. No strategy required
3. Plan or other Actions. A resettlement framework has been prepared in the event that there is a chance of scope during implementation involving hospital rehabilitation (but no resettlement is expected).

☐ Resettlement plan
☒ Resettlement framework
☐ Environmental and social management system arrangement
☐ No action
☐ Combined resettlement and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Social impact matrix

B. Indigenous Peoples **Safeguard Category:** ☐ A ☒ B ☐ C ☐ FI

1. Key impacts. Ethnic minorities constitute about 32% of the population and are mainly located in border states. They belong to several large ethnic groups, including Shan (9%), Kayin (7%), Rakhine (3.5%), Chin (2.5%), Mon (2%), Kachin (1.5%), Indians (1.25%), Kaya (0.75%) and others (4.5%) including Wa, Naga, and 100 other groups. However, with economic development in the form of roads, plantations, irrigation, industries, and services, a major internal migration is taking place broadly from north to south, and from south to Thailand. The rapidly changing the physical, social and economic environment for these migrants create both economic opportunities and health risks.
The project is expected to have positive impact on ethnic minorities in the proposed project areas given the type of project activities, including identification of major infections still highly prevalent in ethnic minority communities such as tuberculosis and zoonotic infections, and linking them with health services. An indigenous people's plan has been prepared to help ensure that benefits for ethnic groups are realized. Proposed interventions are not considered sensitive for ethnic minority groups. Promotion of child immunization will require obtaining support of tribal leaders. Parents will be able to make more informed choices, but participation remains voluntary.
Is broad community support triggered? ☐ Yes ☒ No

2. Strategy to address the impacts. There are no mitigating measures required within any given State.

3. Plan or other actions.

☒ Indigenous peoples plan
☐ Indigenous peoples planning framework
☐ Environmental and social management system arrangement
☐ Social impact matrix
☐ No action
☐ Combined resettlement plan and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Indigenous peoples plan elements integrated in project with a summary

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. Relevance of the project for the country's or region's or sector's labor market, indicated as high (H), medium (M), and low or not significant (L).
☐ unemployment ☒ L underemployment ☐ retrenchment ☒ L core labor standards

2. Labor market impact. There will be no substantial impact on the local labor market. There will be short term employment benefits from avoiding and containing epidemics, such in factories, schools and tourism. There will be long term health and labor standards benefits from improving education and health care of migrants.

B. Affordability

The Government's social protection program covers 3.2% of Myanmar's population and 0.1% of the poorest and most vulnerable, respectively.[8] Families suffer major financial hardship when the main income earner becomes injured or dies. User charges at the point of use for goods and health services are applied in all public facilities, and for purchase of medicines and medical supplies from outside vendors as medicines are often out of stock. Consumers also pay in full for services and goods in the private sector and for traditional healers. A MOH directive exempts indigents from paying, but is not implemented systematically.[9] A study in 2007[10] estimated that 28.6% of sampled households had suffered catastrophic health payments, and other studies in Myanmar have indicated a range of 12–18%. No payments are required for diagnosis and treatment associated with major communicable diseases. This Project should ensure that no payments are required for project interventions in the border areas, including for supplies. Increasing diagnostic facilities will also reduce travel time and costs.

C. Communicable Diseases and Other Social Risks

1. The impact of the following **risks** are rated as high (H), medium (M), low (L), or not applicable (NA):
☐ NA Communicable diseases ☐ NA Human trafficking ☐ NA Others (please specify) ______________
2. Risks to people in project area: NA. The purpose of this project is to reduce the risks of communicable diseases.

[8] Source of social protection program coverage data?
[9] MOH directive?
[10] Myanmar study 2007 on out of pocket payment and catastrophic illness ref?

VI. MONITORING AND EVALUATION
1. Targets and indicators. Poverty and Social targets and indicators overlap with overall targets and indicators, as described in the DMF. Baselines and targets will vary considerably by province and are yet to be established through the township planning process. The following gender and social development areas will be monitored: a) Prevention and control of communicable diseases in MEVs, monitored by measuring the use of services by MEVs in the health facilities, based on facility statistics by gender and, in relevant provinces, also by ethnic group; b) Surveillance and response for communicable diseases, monitored through the national surveillance system; c) Laboratories and hospitals quality and biosafety standards, monitored through annual assessments; d) Female and male participation in workshops, training and other events, monitored through event reports. **2. Required human resources.** Village health workers, hospital and health center staff, MOH, consultants. **3. Information in the project administration manual (PAM).** The PAM describes the project performance management system including DMF, quarterly and annual reports, mid-term review, project completion report, and independent evaluation and audit. **4. Monitoring tools.** Similar to overall project monitoring, including health services statistics and project reports.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

Country:	Vietnam	Project Title:	**GMS HEALTH SECURITY PROJECT (RRP REG 48118)**
Lending/Financing Modality:	Project Grant and Loan	Department/ Division:	South-east Asia Regional Department Human and Social Development Division

I. POVERTY AND SOCIAL ANALYSIS AND STRATEGY

Poverty targeting: targeted poverty intervention – MDG6.

A. Links to the National Poverty Reduction and Inclusive Growth Strategy and Country Partnership Strategy:

Viet Nam has developed rapidly since adopting a socialist-oriented market economy in 1986 (*Doi Moi*). The Comprehensive Poverty Reduction and Growth Strategy,[1] approved in 2003, was a major turning point for Viet Nam to a decentralized, participatory planning process and more attention for the social sectors. It featured, among others, development of community health services, combating diseases that mostly affect the poor, in particular infectious diseases and reproductive health, and improving access and quality of health services for the poor. The current Ten-Year Strategy for Socio-Economic Development 2011-2020 and 10th Five Year Plan (2016-2020)[2] have maintained this pro-poor focus, with also more attention being given to lagging ethnic minorities in borders and remote areas. Viet Nam is committed to universal health coverage as part of the sustainable development goals, and to the international health regulations 2005 and Asia Pacific Strategy for Emerging Diseases 2010 of the World Health Organization, for the control of emerging infectious diseases (EIDs) and other public health events.

ADB's Viet Nam Country Partnership Strategy (CPS) 2012-2015[3] is aligned with the government's 9th Five-Year Socio-Economic Development Plan, 2011-2015,[4] and focuses on Viet Nam's transitional constraints to a modern economy. In the health sector, the CPS supports sector management, improving quality of services, and support for the disadvantaged. ADB is committed to regional cooperation as one of the pillars of Strategy 2020.[5] The regional partnership strategy for the Greater Mekong Subregion (GMS) prioritizes communicable diseases control (CDC), among others to mitigate risks and negative impacts of connectivity and development.

B. Results from the Poverty and Social Analysis during PPTA or Due Diligence

1. **Key poverty and social issues**.

From 2001 to 2008, Viet Nam's economic growth rate was above 7% annually, but slowed down to about 5-6% thereafter,[6] as a result of the global economic crisis and high inflation. From 1993 to 2004, income-based poverty reduced from 58.1% to 19.5%. After 2008, the rate of poverty reduction slowed. Using the new poverty line, poverty further reduced from 14.2 % in 2010 to 9.8 % in 2013. Ethnic minority groups have experienced a much slower pace of poverty reduction in income and other dimensions such as education, health, housing, sanitation and water compared to national averages. In response, the Government of Viet Nam in 2011 issued the Resolution 80/NQ-CP[7], providing new directions for sustainable poverty reduction for 2011-2020, aiming at accelerating poverty reduction in the poorest districts, communes and villages of the country, by setting poverty reduction target of 4% per annum (compared to national target of 2%), and by emphasizing priority to mobilize resources and support to these areas. The National Targeted Programme for Sustainable Poverty Reduction 2012-2015[8] (NTP-SPR) was approved in early October, 2012 to accelerate poverty reduction and improve livelihood in these areas.

The Government provides for a health worker in each village, a clinic with a doctor and midwives in each commune, and a hospital in each district, and step up promotive and preventive health services. To address affordability of health services for the poor and indigent, a social safety net has been rolled out, while the government is in the process of developing social health insurance. The country has achieved health-related MDGs including for maternal and child mortality, but malnutrition remains high. The country also achieved its targets on malaria control and made major progress in the control of tuberculosis and HIV/AIDS. However, the country has experienced several epidemics of EIDs, and is also facing a major burden of accidents and non-communicable diseases. The sector is facing financing and affordability constraints, weak institutional capacity, and human resource challenges in improving the quality of services. The Ministry of Health aims to improve efficiency and quality of service delivery through integration of preventive and curative services at district level.

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[1] Government of Viet Nam. *Comprehensive Poverty Reduction and Growth Strategy*. 2003. Hanoi.
[2] Government of Viet Nam. *Ten-Year Strategy for Socio-Economic Development 2011-2020*.
[3] ADB. Viet Nam *Country Partnership Strategy 2012-2015*. 2012. Manila.
[4] The Government of Viet Nam *9th Socio-Economic Development Plan 2011-2015*. 2010. Hanoi.
[5] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila
[6] Socialist Republic of Viet Nam. *Fifteen Years Achieving the Viet Nam Millennium Development Goals*. 2015. Hanoi.
[7] Government of Viet Nam. *Resolution 80/NQ-CP*. 2011
[8] Government of Viet Nam. *The National Targeted Programme for Sustainable Poverty Reduction 2012-2015*.

2. Beneficiaries. The Project will benefit the general public, as most project resources will be allocated to strengthening disease control and hospital services, and integrating services at district level. A small part of the project is targeting high risk groups, often but not always poor, with communicable diseases control. Due to high prices and perceived poor quality of public health services, they often resort to traditional medicine and self-medication. The project will specifically help improve coverage of migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs). These MEVs are more likely to be exposed to and spread different types of diseases and drug resistance, depending on their location and occupations, and in general have less access to health services.

3. Impact channels. The majority of resources will be allocated to timely disease outbreak reporting and response, which will contain the spread of outbreaks of infectious diseases and thus reduce disease impact on the poor; and by strengthening health care in border areas, thereby improving prevention and access to services, in particular for the poor including MEVs. Public health services are well planned but under resourced with limited staff capacity, in particular in rural areas. Poor and vulnerable groups will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

4. Other social and poverty issues. Use of health services often results in financial hardship for patients and their relatives. Until very recently social protection interventions in Viet Nam were shallow, forcing families to provide for themselves difficult circumstances. The Social Protection Strategy 2011-2020, moong others, aims to achieve universal health coverage by 2020 (from about 65% a present). The GMS CDCIII Project will support this strategy by improving access to health services along Viet Nam's border with Cambodia, Lao PDR and PRC.

5. Design features. The linkages between burden of disease and poverty and development are well known. The project addresses key poverty and social issues by strengthening surveillance and outbreak response up to village level; by strengthening regional control strategies, by improving prevention and care for MEVs, and by improving laboratory diagnostics and hospital infection control. This will be monitored through the annual evaluation of the regional disease control strategy, national surveillance and response monitoring system, laboratory and hospital quality control systems, and provincial health services and outreach statistics in targeted provinces. The project design responds to a favorable legal framework, the commitment to regional cooperation, the need for universal health coverage, human resource constraints, and seeks complementarity and integration with past and current investments. The CPS is supported by safeguarding advances in connectivity by preventing epidemics transmitted across transport routes.

II. PARTICIPATION AND EMPOWERING THE POOR

1. **Participatory approaches and project activities.** Several provinces were visited during project preparation to contribute to the project design. Each province will propose, through needs assessment, consultations, and detailed preparation, project investments as part of its regular annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability.

2. Role of civil society. Civil society is required to report outbreaks. Civil society representatives in this project will usually be village health volunteers, and will be engaged in community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use mobile phone for reporting. In addition, MOH is considering to engage NGOs to provide services for forest dwellers and other remote MEVs.

3. Civil society organizations. The project will ensure MOH endorsement of village health volunteer participation, conduct mobilization and assessment of target groups, conduct participatory planning, and use various experts, including for gender and social safeguards to prepare and monitor implementation plans.

4. Types of participation. The following forms of civil society organization participation are envisaged during project implementation, rated as high (H), medium (M), low (L), or not applicable (NA)

☒ M Information gathering and sharing ☒ M Consultation ☒ M Collaboration ☐ Partnership

5. Participation plan. ☐ Yes. ☒ No Participation of village health volunteers is well established within MOH.

III. GENDER AND DEVELOPMENT

Gender mainstreaming category: effective gender mainstreaming

A. Key issues. The Project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve access of women to health services. The patterns of infectious diseases differ substantially among women and men, because of differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's' access to and affordability of health services

including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members. Increased economic links with neighboring countries present a number of opportunities and risks for women.
The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas.

Sufficient gender legislation is in place. MOH has a central focal and provincial focal point for gender, but this may be lacking or inactive at district level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level.

B. Key actions.

The Viet Nam Women's Union (LWU) is mandated to represent women of all ethnic groups and to protect women's rights and interests. It is a grassroots organization with representation in all villages and has substantial local powers. Instead of a Ministry of women's Affairs, Viet Nam has opted for a crosscutting National Commission for the Advancement of Women (NCAW) for gender mainstreaming in development policies and programs. Its recommendations are implemented through five year plans but often lack funding. Gender equality is reflected in the Constitution and in multiple international commitments. One major concern is the fragmentation of gender efforts in projects. Unlike in Cambodia, there has not been a movement to articulate comprehensive sector gender programs. Accordingly, the project's gender action plan (GAP) may need to be adjusted based on later developments.
In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), the Poverty and Social Analysis (PSA), covenants, and the GAP.[9] The Project, based on general good practice for gender endorsed by MOH, will seek to enhance participation and benefits of women in all its activities:

- (i) The executing and implementing agencies have active gender focal points for project activities;
- (ii) The project engages a gender and social development expert with a focus on community activities;
- (iii) Project implementation plans and annual operational plans (AOPs) will address gender dimensions;
- (iv) The project will collect, analyze and report gender-disaggregated data;
- (v) All project reports report on gender issues;
- (vi) The project will proactively target youth and women at increased risk of infectious diseases;
- (vii) Education materials and care procedures will be gender-sensitive;
- (viii) Outbreak response and outreach services will ensure female participation;
- (ix) Participation of female and male staff in training programs and scholarship will be equitable;
- (x) Refurbishment of laboratories and isolation wards will be gender sensitive;
- (xi) All regional, cross-border and inter-sectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

☒ Gender action plan ☐ Other actions or measures ☐ No action or measure

IV. ADDRESSING SOCIAL SAFEGUARD ISSUES

A. Involuntary Resettlement **Safeguard Category:** ☐ A ☐ B ☒ C ☐ FI

1. Key impacts. No resettlement is involved in this project.
2. Strategy to address the impacts. No strategy required
3. Plan or other Actions. A resettlement framework has been prepared in the event that there is a chance of scope during implementation involving hospital rehabilitation (but no resettlement is expected).

☐ Resettlement plan
☒ Resettlement framework
☐ Environmental and social management system arrangement
☐ No action
☐ Combined resettlement and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Social impact matrix

B. Indigenous Peoples **Safeguard Category:** ☐ A ☒ B ☐ C ☐ FI

1. Key impacts. Ethnic minorities constitute about 14% of the population and are mainly located in the hills and mountains in the north and center of the country. They mainly belong to the Tai-Kadai, Khmer, Hmong-Mien, Cham, Chinese, and Tibeto-Burman language groups with a total of 54 officially recognized subgroups and many languages. They are largely participating in the national economy through migrant labor or business, and sometimes through resettlement. Studies report increased rates of infections among these communities associated with changing behavior and environment, but also among Kinh migrants moving into ethnic minority areas. Even so, there remain remote ethnic minorities with a disproportionate burden of infectious diseases due to lack of awareness, poor living conditions, and malnutrition.

[9] ADB. *Policy on Gender and Development*. June 1998. Manila; and Operations Manual Bank Policies Section C2/BP issued in December 2010.

The project is expected to have positive impact on ethnic minorities in the proposed project areas given the type of project activities, including identification of disease outbreaks and major infections in ethnic minority communities, and linking them with better diagnostic health services. An indigenous people's plan has been prepared to help ensure that benefits for ethnic groups are realized. Proposed interventions are not considered sensitive for ethnic minority groups. Promotion of child immunization has been a problem and requires obtaining support of tribal leaders.
Is broad community support triggered? ☐ Yes ☒ No

2. Strategy to address the impacts. There are no mitigating measures required within any given State.

3. Plan or other actions.

☒ Indigenous peoples plan
☐ Indigenous peoples planning framework
☐ Environmental and social management system arrangement
☐ Social impact matrix
☐ No action
☐ Combined resettlement plan and indigenous peoples plan
☐ Combined resettlement framework and indigenous peoples planning framework
☐ Indigenous peoples plan elements integrated in project with a summary

V. ADDRESSING OTHER SOCIAL RISKS

A. Risks in the Labor Market

1. Relevance of the project for the country's or region's or sector's labor market, indicated as high (H), medium (M), and low or not significant (L).
☐ unemployment ☒ L underemployment ☐ retrenchment ☒ L core labor standards

2. Labor market impact. There will be no substantial impact on the local labor market. There will be short term employment benefits from avoiding and containing epidemics, such in factories, schools and tourism. There will be long term health and labor standards benefits from improving education and health care of migrants.

B. Affordability The project will not increase the price of health services but increased availability of services may increase health spending by the poor. However, health interventions provided under current arrangements are usually free for public goods, and subsidized for the poor through the health equity funds. No payments are required for diagnosis and treatment associated with major communicable diseases. Increasing diagnostic facilities will also reduce travel time and costs. Subsidizing supplies will further reduce out of pocket spending. Selecting the most cost-effective diagnosis and treatment strategies will help ensure financial sustainability.

C. Communicable Diseases and Other Social Risks
1. The impact of the following **risks** are rated as high (H), medium (M), low (L), or not applicable (NA):
☐ NA Communicable diseases ☐ NA Human trafficking ☐ NA Others (please specify) ______________
2. Risks to people in project area: NA. The purpose of this project is to reduce the risks of communicable diseases.

VI. MONITORING AND EVALUATION

1. Targets and indicators. Poverty and Social targets and indicators overlap with overall targets and indicators, as described in the DMF. Baselines and targets will vary considerably by province and are yet to be established through the provincial planning process. The following gender and social development areas will be monitored:
a) Prevention and control of communicable diseases in MEVs, monitored by measuring the use of services by MEVs in the health facilities, based on facility statistics by gender and, in relevant provinces, also by ethnic group;
b) Surveillance and response for communicable diseases, monitored through the national surveillance system;
c) Laboratories and hospitals quality and biosafety standards, monitored through annual assessments;
d) Female and male participation in workshops, training and other events, monitored through event reports.
2. Required human resources. Village health group, hospital and health center staff, MOH and provincial health staff, gender and social safeguards experts, laboratory and biosafety experts, other experts.
3. Information in the project administration manual (PAM). The PAM describes the project performance management system including DMF, quarterly and annual reports, mid-term review, project completion report, and independent evaluation and audit.
4. Monitoring tools. Similar to overall project monitoring, including health services statistics and project reports.

Poverty and Social Analysis, Cambodia

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

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Acronyms

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
AOP	annual operational plan
APSED	Asian-Pacific Strategy for Emerging Diseases
ASEAN	Association of South-East Asian Nations
CDCD	Communicable Diseases Control Department
CPS	country partnership strategy
DHS	Department of Hospital Services
DMF	design and monitoring framework
DPIS	Department of Planning and Health Information Systems
EGM	effective gender mainstreaming
EHF	Ebola hemorrhagic fever
EID	emerging infectious diseases
GAP	gender action plan
GDP	gross domestic product
GMS	Greater Mekong Subregion
HEF	Health Equity Funds
HIV	human immunodeficiency virus
HPAI	highly pathogenic avian influenza
IHR	International Health Regulations
ILO	International Labor Organization
IMF	International Monetary Fund
IOM	International Organization of Migration
IPSA	initial poverty and social analysis
Lao PDR	Lao People's Democratic Republic
MDG	Millennium Development Goal
MERS	middle-east respiratory syndrome
MEV	migrants and mobile people, ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
NGO	nongovernmental organization
NIPH	National Institute of Public Health
NSPS	National Social Protection Strategy
PMU	project management unit
PPMS	project performance management system
PSA	poverty and social analysis
RRP	report and recommendations to the president
QA	quality assurance
SARS	severe acute respiratory distress syndrome
SPRSS	summary poverty reduction and social strategy
UNDP	United Nations Development Program
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Executive Summary

Poverty and Social Analysis (PSA) was carried out for the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project) to be financed with support of the Asian Development Bank (ADB). The project will strengthen national health security systems and GMS cooperation for the prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance.

In 2015, Cambodia had an estimated population of 15.6 million, with 21% living in urban areas. Since 1997, the country has seemed impressive economic growth at about 7% average, which is likely to continue and allow Cambodia to graduate to lower middle income country status. Average per capita gross domestic product was estimated at $1,159 per year in 2015 (the World Bank). Cambodia's rapid economic growth is attributed to increased regional connectivity, a good business environment, and reform readiness, which resulted in major investment in industries, often in industrial zones, increased prices for agricultural products, and demand for expanded services. This resulted in turn in new job, migration, and urbanization.

The country experienced remarkable progress in reducing poverty. Between 2003 to 2012, the share of people living below the national poverty line had declined from 50% to 18%. However, in 2011, as much as 41% of the population still lived on less than $2 per day, and 72% lived on less than $3 per day (causing a low average per capita income compared to other GMS countries). Since 2009, the number of people living below the poverty line has remained constant at about three million. Poverty rates are highest in the north-eastern and north-central provinces of the country, while most of the poor live in large population centers. Cambodia has a small ethnic minority population of about 4% of the total population. Migrants are also a vulnerable group for which insufficient regulations and services are in place.

With increasing regional connectivity and trade and a budding health system, the country is vulnerable to emerging infectious diseases. Since 2000, there were outbreaks of SARS, avian influenza, swine flu, cholera, dengue, and hand, foot and mouth disease. It has a residual malaria problem with emerging drug resistance, a large burden of tuberculosis, and a concentrated HIV epidemic. Common communicable diseases such as diarrheal diseases and respiratory infections remain the major burden of diseases among children and the poor. Nosocomial infections and drug resistance are emerging public health problems. Infectious diseases that can easily spread with high mortality constitute a major public health and economic risks.

An extensive but basic network of public health services is in place, as reflected for example in high immunization coverage. However, some poor communities, migrants, and isolated ethnic groups do not report diseases, access public health services less, or may not get proper care if they do. This leads to gaps in the surveillance, prevention, control, and management of infectious diseases, particularly along border areas; and represents major public health and economic risks.

Cambodia is committed to implementing the International Health Regulations (IHR) and the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), as well as implementing other WHO regional strategies for the control of major diseases such as dengue, malaria, tuberculosis and HIV/AIDS. Despite major political commitments and past investments - including by the Asian Development Bank (ADB) - insufficient effort is made for the control of these diseases, and Cambodia is yet to comply with IHR and APSED standards.

The project will help strengthen national health security systems and GMS cooperation for the prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance, which, according to WHO, remain a major threat in the region. The project will enhance regional cooperation and disease control in border areas, strengthen disease surveillance and outbreak response, and improve laboratory services and infection control in hospitals. Total project costs in Cambodia for 2017 to 2022 are estimated at $22.8 million. The Department of Planning and Health Information Systems (DPHIS) represents the Ministry of Health (MOH) as the Executing Agency. The Communicable Diseases Control Department (CDCD), the Department of Hospital Services (DHS), the National Institute of Public Health (NIPH), and 13 provinces along Cambodia's north-western, north-eastern and south-eastern borders will be responsible for project implementation.

To help maximize project benefits and identify risks for the poor, a Poverty and Social Analysis (PSA) was carried out. In terms of project design, the project will help reduce poverty by contributing to protecting health and securing economic growth through the avoidance of major epidemics and reducing the burden of infectious diseases. The project will have only positive impacts on the poor and vulnerable groups in targeted border areas, in the form of village disease reporting, encouraging the use of health services and improving health screening for migrants, ethnic minorities and other vulnerable groups including women and youth (MEV). By targeting diseases that disproportionally affect the poor, targeting provinces and districts with more poverty, and targeting MEVs within these provinces, the project design helps maximize poverty impact.

However, the main concern is that central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its expected impact on extended millennium development goals (MDGs), in particular ***MDG6: halting or reducing the spread of communicable diseases***. Through the containment of infections, the project will also have indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the design and monitoring framework (DMF) and the project performance management system (PPMS).

I. Introduction

1. The Asian Development Bank (ADB) is planning to support the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project).
A Poverty and Social Analysis (PSA) was carried out to help identify poverty reduction opportunities and risk and incorporate these in the project design to maximize poverty reduction impact. The PSA examines (i) project poverty dimensions, (ii) the links of the project to the national poverty reduction strategy and the country partnership strategy; (iii) the poverty targeting classification and its justification; (iv) key poverty and social issues of the potential beneficiaries, including impact channels and expected systemic changes; (v) opportunities and constraints for clients/beneficiaries - particularly poor and marginalized groups - stemming from project activities; and (vi) preparing design measures to achieve inclusive development outcomes during implementation. The PSA also summarizes gender impacts, scope of participation, social safeguards, and other social risks dimensions. The findings from the PSA will be reflected in the ADB Report and Recommendation from the President to the Board of Directors (RRP), the Design and Monitoring Framework (DMF), the Project Administration Manual (PAM), the Risk Analysis and Mitigation Plan, and the Project Performance Monitoring System (PPMS). The PSA follows the initial PSA (IPSA) prepared for the project concept, and is used to prepare the summary poverty reduction and social strategy (SPRSS) for the RRP.

2. Based on the issues flagged in the IPSA, the thematic areas that are covered in the PSA include (i) poverty and inequality; (ii) poverty and health; (iii) institutions, capacity, stakeholders, and participation; (iv) gender and social diversity; (v) social safeguards; and (vi) management of other social risks and vulnerabilities. The PSA includes (a) project summary, (b) poverty and social strategy and analysis, (c) results from the project PSA or due diligence including key poverty and social issues, beneficiaries, impact channels, other poverty and social issues, and design features, (d) participation and disclosure, (e) gender and social diversity, (f) social safeguards and other social risks, (g) monitoring and evaluation, and (h) risk assessment and mitigation.

II. Project Summary

a. The GMS Health Issue

3. Emerging infectious diseases (EID) are a global risk. The International Health Regulations (IHR),[1] 2005, of the World Health Organization (WHO) mandates all countries to achieve minimum health security standards against EIDs. Southeast Asia, with major population hubs and intensive livestock raising with associated biosafety problems, has been identified as being a likely site for outbreaks of EID - such as middle-east respiratory syndrome (MERS), highly pathogenic avian influenza (HPAI), or Ebola hemorrhagic fever (EHF) - with pandemic potential that may lead to significant mortality and economic meltdown.[2] The Asia Pacific Strategy for Emerging Disease (APSED),[3] 2010, of the WHO regional offices identifies 8 strategic areas for compliance by not later than 2016. At present, compliance has reached approximately 70-80% in the GMS, with specific gaps mainly relating to laboratory services,

[1] World Health Organization. 2005. *International Health Regulations*. Geneva.
[2] ADB. 2005. *Potential Economic Impact of an Avian Flu Pandemic on Asia*. Manila.
[3] WHO Western Pacific Regional Office (WPRO). 2010. *Asia Pacific Strategy for Emerging Diseases 2010-2015*. Manila.

hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.[4]

4. Cambodia, located in Southeast Asia, is vulnerable to emerging and re-emerging infectious diseases and had several outbreaks including SARS, avian influenza, swine flu, cholera, and hand, foot and mouth disease. It also has major outbreaks of dengue, a residual malaria problem with emerging drug resistance, a large burden of tuberculosis, and a concentrated HIV epidemic. Immunization coverage is variable[5] and common communicable diseases such as diarrheal diseases and respiratory infections remain the major burden of diseases among children and the poor. Nosocomial infections and drug resistance is an emerging public health problem. All these constitute major public health and economic risks.

5. While the burden of communicable diseases has declined overall in Cambodia, there are increased risks for the spread of communicable diseases because of (i) improved connectivity, (ii) urbanization, industrialization with associated slum formation and labor camps, (ii) increased drug resistance, particularly for hospital infections, tuberculosis, malaria and HIV, (iii) reduced compliance with preventive measures like vaccination, and (iv) emerging and re-emerging diseases for which control measures are still being developed. The incidence of dengue has increased since 1980, with a major outbreak in 2007, and mainly affects children below 9 years.[6] Outbreaks of diarrheal diseases and other highly infectious conditions are also a major burden. Diseases preventable by immunization remain common due to low immunization coverage among poor rural children. While the burden of infectious diseases may have reduced, this is because of major efforts, and sustained financing will be needed to keep infectious diseases under control.

6. Cambodia is particularly vulnerable to epidemic outbreaks because its health system is still developing. The Government has put basic public health infrastructure in place in rural areas, but poor access, quality issues, and financial constraints affect sector performance and early detection of infectious diseases. In addition to strengthening provincial and district capacities, the Ministry of Health (MOH) is making major efforts to reach out to villages and improve village capacity to address the prevention and control of infectious diseases.

b. The Project

7. Under the GMS economic development program, ADB has been supporting various health projects for communicable diseases control, HIV, malaria, and related regional technical assistance.[7] This project aims to further reduce the burden of certain infectious diseases through a combination of preventive strategies, improved diagnosis and treatment protocols, better regional coordination, and improved health system management. The governments of Cambodia, Lao PDR, Myanmar and Viet Nam and ADB have proposed the project to strengthen national health security systems and regional cooperation for the prevention and control of EID and other diseases of regional importance in the GMS, and to help countries to comply with IHR 2005 and implement APSED of the WHO.[8]

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[4] WHO WPRO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.
[5] Ministry of Health. 2015. *Health Sector Analysis Third Health Strategic Plan (HSP3) 2016-2020*. [Second Revised Report]. Phnom Penh.
[6] Huy, R. et al. in bulletin of the WHO. 2010. *National Dengue Surveillance in Cambodia 1980-2008. Epidemiological and virological trends and in the impact of vector control*. Phnom Penh.
[7] ADB. 2010. *Second GMS Regional Communicable Diseases Control Project*. Manila.
[8] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*.

8. The proposed project goal is **strengthened GMS health security**. Key indicators include (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities, (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year, and (iii) increased use of public health services by migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs) in border areas. The proposed project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED and (ii) increased communicable disease control coverage of MEV in border areas. The proposed project outputs are: (i) improved GMS collaboration and MEV access to communicable disease control in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases. The proposed project focuses on 13 provinces in Cambodia along the borders and economic corridors with Lao PDR, Thailand and Viet Nam.[9]

9. MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. This still needs to be mainstreamed and formalized. In addition, some groups of MEV that are more likely to acquire and spread infectious diseases are not being reached through regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries, (ii) develops regional disease control strategies and evidence-based communicable disease control, and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring, as well as outreach and community mobilization to reach and engage MEV.

10. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong due in large part to investments from the Global Fund to Fight AIDS, Malaria and Tuberculosis with additional investments from the Government. The system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level, (ii) web-based reporting including information technology support, (iii) integration of surveillance systems, (iv) risk analysis, communication, and community preparedness, (v) improving capacity of outbreak response teams including transport, and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

11. District facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial or hospital-acquired infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance, (iii) in-service training, (iv) improving district laboratory services, and (iv) equipment and training for infection control and case management of dangerous diseases.

12. In Cambodia, the project is costed at $22.8 million, and financed by a $21.3 million loan from ADB and $1.5 million in Government counterpart funds. The Ministry of Health (MOH) will

[9] Banteay Meanchey, Battambang, Kampot, Kandal, Kratie, Mondulkiri, Pailin, Preah Vihear, Prey Veng, Ratanakiri, Stung Treng, Svay Rieng, and Tbong Khmum Provinces.

be the executing agency, represented by the Department of Planning and Health Information Systems. The Communicable Disease Control Department (CDCD), the Department of Hospital Services (DHS), the National Institute of Public Health (NIPH) and 13 provinces in the northwest, northeast, and southeast will be the implementing agencies. The project will be implemented over a period of 5-year starting early 2017. The project completion date is 30 June 2022.

III. Poverty and Social Strategy

a. Government Strategy

13. The Constitution of the Kingdom of Cambodia, 1993, provides the framework for the social protection of Cambodian citizens. Important laws are the Labor Law[10] and the Insurance Law.[11] While there is no explicit poverty reduction strategy, two multisector strategies have poverty reduction at their core: the 2011 National Social Protection Strategy (NSPS) for the Poor and Vulnerable,[12] and the 2014 National Strategy for Food Security and Nutrition.[13] The NSPS aims to (i) protect the poorest and most disadvantage who cannot help themselves; (ii) mitigate risks that could lead to negative coping strategies and further impoverishment; and (iii) promote the poor to move out of poverty by building human capital and expanding opportunities. Main NSPS features for the health sector are to develop a nationwide social insurance (including contributable for the employed), and provide social safety nets for the poor and other vulnerable groups.

14. The Rectangular Strategy-Phase III (RSIII) of the Royal Government of Cambodia (RGC) (2013-2018) reaffirms a strong commitment to sustainable development and poverty reduction that respond to the people's will and emerging contexts of national and international developments.[14] The RSIII aims to promote economic growth, create jobs, ensure equitable distribution of the fruits of growth, and ensure the effectiveness of public institutions and management of resources. The Strategy is implemented through a comprehensive National Strategic Development Plan (2014-2018). One national target is to reduce poverty by one percentage point per year. The government's earlier focus on agriculture, infrastructure, private sector development and employment is shifting more towards human resources development.

b. ADB Strategy

15. ADB's overall goal is poverty reduction according to ADB Strategy 2020, and regional cooperation is one of the pillars of this strategy.[15] Under the ADB-assisted GMS economic development program, ADB and GMS countries have prioritized communicable diseases control, among others to mitigate risks and negative impacts of increase in regional connectivity, and associated industrialization, urbanization, and behavioral change, in particular in border areas and along economic corridors.

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[10] ILO. 1997. *Kingdom of Cambodia Labor Code 1997*. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_150856.pdf

[11] ILO 2000. *Kingdom of Cambodia Insurance Law*. http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/86080/96913/F580020967/KHM86080.pdf

[12] 2011. Royal Government of Cambodia. *National Social Protection Strategy for the Poor and Vulnerable.* Phnom Penh.

[13] Council for Agricultural Research and Development. 2014. *National Strategy for Food Security and Nutrition.* Phnom Penh.

[14] Royal Government of Cambodia, Fifth Legislature of the National Assembly. 2013. *Rectangular Strategy for Growth, Employment, Equity and Efficiency.* Phase III. Phnom Penh.

[15] ADB. 2008 Strategy 2020. Manila.

16. ADB's Cambodia Country Partnership Strategy (2014-2018)[16] ADB aims to support the government's RSIII to reduce poverty and vulnerability in the areas of (i) inclusive economic growth, (ii) environmentally sustainable growth; and (iii) regional cooperation and integration. It focuses on five sectors (agriculture, natural resources and rural development, water and other urban infrastructure and services, transport, education, and finance) and one cross-cutting sector, public sector management. It aims to reduce poverty and to promote inclusive growth by focusing on rural areas and rural-urban links, focusing on the areas where poorest people live, and promoting connectivity for isolated areas through all-weather rural roads and tourism infrastructure. These developments are also linked to health risks.[17] ADB is committed to regional cooperation in the Greater Mekong Subregion, including for communicable diseases control, as confirmed in the Regional Partnership Strategy, including mitigation of negative impacts.[18]

IV. General Poverty and Social Analysis

a. Poverty and Economic Growth

17. In 2013, Cambodia had a population of 14.7 million, with 21.4% or about 3 million people living in urban areas, most of whom live in a more industrialized and urbanized band along the southeast/northwest axis. Since 1998, Cambodia has had impressive and sustained economic growth of 7%,[19] except during the economic crisis in 2009. The IMF expects this growth to continue at about 7% and Cambodia to graduate to lower-middle income status.[20]

18. Cambodia's population is primarily employed in agriculture. While floods have frequently affected agricultural outputs, the garments industry, tourism and real estate development have continued to show strong growth.[21] Even so, lacking major national resources (except gems) and with nascent human capital, Cambodia's economic situation is vulnerable. Major domestic concerns are financial sector sustainability due to rapid credit growth, fiscal pressures, rising labor wages, and disasters, while external concerns are the economic slowdown and rising oil prices.

19. Cambodia is a success story in poverty reduction among the GMS project countries. From 2004 through 2011, household consumption increased by nearly 40% due to rapid economic growth. This growth was pro-poor, not only reducing inequality but also proportionally boosting poor people's consumption further and faster than the non-poor.[22] The share of total consumption of the poorest 20% of households increased from 7.5% in 2007 to 9.3% in 2012.

20. While Cambodia has made extraordinary progress in reducing poverty, it is still one of the poorest countries in Southeast Asia. Official poverty lines introduced in 2013 show that the poverty rate fell sharply from 47.8% in 2007 to 18.9% in 2012 (figure 3). According to the Ministry of Planning, the rural poverty rate in 2012 was only slightly higher at 20% compared to 16.3% in Phnom Penh and 14.5% in other urban areas: rural and urban poverty rates appear to

[16] ADB. 2008. *Country Partnership Strategy* (2014-2018). Manila.
[17] WHO. 2013. *Bilateral Meeting on Healthy Borders in the Greater Mekong Subregion, Session 5. Health Situation and Health Systems Analysis: Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam.* Bangkok.
[18] ADB. 2012. GMS Strategic Framework. 2012-2022. Manila.
[19] ADB. 2014. Cambodia Country Partnership Strategy 2014-2018. Manila.
[20] IMF. 2015. *Economic Health Check: Fast-growing Cambodia can reap further benefits from reforms, in IMF Survey Magazine, November 2015*. Washington DC.
[21] World Bank. *Where Have All the Poor Gone? Cambodia Poverty Assessment 2013 Second Ed* April 2014.
[22] ADB. 2014. *Cambodia Country Poverty Analysis.* Manila.

be converging. According to World Bank estimates using Cambodia Socio-Economic Survey data, food poverty has declined from 16.0% in 2004 to 3.8% in 2011.

21. There has been a sharp reduction in extreme poverty, based on the international extreme poverty line of $1.25 per person per day, expressed in 2005 purchasing power parity (as per 2015, $1.90 is used as the international extreme poverty line).[23] In 2011, 10% of the population lived on less than $1.25 per day, down from 31.0% in 2007, a drop of 21 percentage points in 4 years.

22. Demonstrating the growing vulnerability in Cambodia, while 28.5% of the population fell between the $1.25 and $2.00 per day poverty lines in 2007, in 2011 this had grown to 31.2% of the population. The $2 per day poverty rate increased from 40.7% in 2009 to 41.2% in 2011, and 72% lived on less than $3 per day.[24] Accordingly, Cambodia has 1.5 million extreme poor, 1.5 million other poor (totalling three million poor people), three million near poor, and a total of 10 million people out of 15 million people living on less than $3 per day. About 80% of the poor live in rural areas. This constitutes a major challenge for the government with an economy dependent on external forces, and has led to a somewhat short term and opportunistic investment approach in the private sector. Accordingly, not only the poor but also the Cambodian economy as a whole is at risk of losing impressive gains.

b. Poverty and Residence

23. About 79% of the population lives within 1,621 rural communes, and this has changed little over time. Half the urban population lives in Phnom Penh, with the other half living in 25 cities and district towns.[25]

24. The rural-urban poverty gap is growing, but rural poverty reduction has driven most of the overall poverty reduction. Real average per capita daily income of people living in rural areas from agricultural crops more than doubled from 2004 to 2009 and continued to rise by 12% in 2011.[26] The dramatic poverty reduction is largely explained by four factors: (i) the increase in the price of rice, (ii) increased rice production, (iii) growth in agricultural wages, and (iv) higher incomes from self-employment in non-agricultural businesses.[27]

25. While economic growth has led to the development of roads, airports and the infrastructure needed for business, the infrastructure needed to lift millions out of poverty has not enjoyed such generous investment. Only 24% of Cambodians have access to electricity, 64% to clean water and 31% to sanitation.[28] Most hospitals accessible to the poor are understaffed, under-equipped and lacking in quality. Almost half a million Cambodians from rural areas work for minimum wage in factories in Phnom Penh.[29]

26. Small-scale farmers practice agriculture at the subsistence level using traditional methods, and productivity is low. Two thirds of the 1.6 million rural households face seasonal food shortages each year.[30] The poorest people are isolated in remote villages far from basic

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[23] http://www.worldbank.org/en/topic/poverty/brief/global-poverty-line-faq.
[24] ADB. 2014. *Country Poverty Analysis 2014*, Manila.
[25] Idem.
[26] World Bank. 2014. *Where Have All the Poor Gone? Cambodia Poverty Assessment 2013 Second Ed.*
[27] Council for Agricultural Research and Development. 2014. *National Strategy for Food Security and Nutrition.* Phnom Penh 2014.
[28] ADB. 2014. *Cambodia Country Poverty Analysis*.
[29] World Bank. 2014. *Where Have All the Poor Gone? Cambodia Poverty Assessment 2013 Second Ed.*
[30] AD 2014. *Rural Poverty Portal: Rural Poverty in Cambodia*. Rome.

social services and facilities. Many have to travel more than 5 km to reach a health clinic, and still others live more than 5 km from the nearest road. The poorest people live in the districts close to the borders with Thailand and the Lao PDR in the north and northeast, and with Viet Nam in the east. Households in the plateau and mountain areas have higher probability of being poor compared with the rest of the country.[31]

27. Cambodia is highly vulnerable to natural disasters, with regular monsoon flooding in the Mekong and Tonle Sap basin, and localized droughts in the plains region. Cambodia experienced extensive flooding at the end of 2011 and again in 2013, causing severe damage to livelihoods and to rice crops across flood-affected provinces. Rising inequality, landlessness and deterioration of common property resources have eroded the coping capacity of food-insecure people in recent years. Limited access for the poor to education and health services and low levels of investment in public infrastructure perpetuate food insecurity and malnutrition.

28. At least 12% of poor people are landless.[32] In 2013, the Guardian reported that since 2006, more than 100,000 hectares had been cleared from just three provinces to make way for sugar plantations. Evictions have occurred in almost all areas of the country. Much of this land was owned by subsistence farmers and rice-producers, who were either forced off their land by security forces or forced to sell their land at below-market rate.[33]

29. The official poverty measure does not show province-level poverty rates. There are, however, several other sources of subnational poverty data, including Identification of poor households targeting system implemented by the Ministry of Planning and the predictive poverty rates derived from the commune database maintained by the Ministry of Interior. Comparing the poorest provinces according to (i) identification of poor households, (ii) the commune database and (iii) the multidimensional poverty index, the rankings differ for each list but seven provinces appear on all three lists and thus may be considered to be particularly poor: Kampong Chhnang, Kampong Thom, Kratie, Preah Vihear, Pursat, Siem Reap, and Stung Treng.[34] However, other provinces in the northeast of the country, Rattanakiri and Mondulkiri, are also known to be very poor but did not feature in all three lists.

30. A comparison of the poverty and malnutrition maps produced by the World Food Program reveals that most of the country exhibits very high rates of stunting,[35] despite a significant improvement of agricultural productivity. Stunting is chronic malnutrition linked to common infectious diseases, seasonal food insecurity, and child care. As people migrate for labor and urbanize, and food prices go up, child care is expected to be affected.

31. An income-based poverty rate does not capture the multidimensional nature of poverty. The Oxford policy and human development multidimensional poverty index was used to compare provinces. Households in the northeast have the highest levels of multidimensional deprivation. The multidimensional poverty rate fell from 59% in 2005 to 46% in 2010 (twice the poverty rate).[36] When compared with the rapid reduction in income poverty over the same period, this relatively slower decline points to Cambodia's weaker performance in improving people's access to basic social services, which plays an important role in promoting well-being.[37]

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[31] ADB. 2014. *Cambodia Country Poverty Analysis*. Manila.
[32] Idem.
[33] Touch S. A Neef. 2015. *Resistance to Land Grabbing and Displacement in Rural Cambodia*. Rotterdam.
[34] ADB. 2014. *Country Poverty Analysis*. Manila.
[35] https://www.wfp.org/countries/cambodia.
[36] World Bank. 2014. *Where Have All the Poor Gone? Cambodia Poverty Assessment 2013 Second Ed* April 2014.
[37] Idem.

c. Poverty and Health

32. Cambodia was an early achiever in many Millennium Development Goal (MDG) areas, particularly in reducing income poverty, increasing primary enrolment, and halting HIV and tuberculosis, progress was somewhat less in gender equity, reducing child malnutrition and infant and child mortality, and providing basic water supply and sanitation. The MDG Progress Report ranks Cambodia's improvements fifth out of 76 poor countries; the UNDP Human Development Indicator ranks Cambodia as the country with the best improvement in the region from 2000 through 2010, above China, Lao PDR, and Viet Nam.[38]

33. Between 2000 and 2014, Cambodia's child mortality rate fell from 124 to 42.5 per 1,000 live births, and infant mortality rate reduced from 95 to 28 per 1,000 live births. The maternal mortality ratio reduced from 472 to 161 per 100,000 live births between 2005 and 2014. The total fertility rate reduced from 4.0 to 2.9 children per woman of reproductive age between 2000 and 2014. Rates of malnutrition (underweight) reduced from 39% to 24% in this period. HIV prevalence reduced from 1.7% to 0.6% of the adult population between 2000 and 2014.[39]

34. Child mortality is highly correlated with wealth, especially among children 1-12 months old. Reduction in child mortality since 2005 was twice as high in urban areas compared to rural, and higher for the richest income quintiles compared to the poorest. Children in the poorest quintile have a three-fold greater risk of death before their fifth birthday than those in the richest quintile. A large fraction of mortality for children under five years of age can be attributed to insufficient coverage and equity disparities along the continuum of care (for example, antenatal care and quality of birth delivery and post-natal care), and a lack of vaccinations and access to potable water and good sanitation. The fertility rate for women in the poorest quintile is more than double that of the richest quintile. Education of the mother is an independent predictor for under-five mortality.[40]

35. Substantial improvements in nutrition were observed from 2000 through 2005, but progress stalled from 2005 to 2010, which was surprising given the improvements in consumption, including food intake. The solution to malnutrition requires actions focusing on issues beyond the quantity of food consumed, including addressing the quality of food, the environment (open defecation), and hygiene practices. In total 32% (or approximately 0.5 million) of children under five are stunted. Stunting is more than twice as common among children in the poorest quintile than in the richest. In total 82% (12.2 million) Cambodian do not have access to piped water supply and 63% (9.3 million people) do not have access to improved sanitation (2014).[41]

36. Routine vaccination coverage for childhood infections has dramatically increased from 40% to 90% between 1990 and 2010. Despite these significant improvements in immunization, only 65% of the poor are fully immunized,[42] in part simply due to access problems.

37. The percentage of the poor seeking some sort of health care when ill increased from 62% in 2004 to 92% in 2011. The percentage of the poor seeking care in the public sector increased steadily from 2004 to 2009, but subsequently declined from 26% in 2009 to only 16%

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[38] UNDP. 2016. *Human Development Indicators* 2016

[39] ADB. 2014. *Framework of Inclusive Growth Indicators: Key Indicators for Asia and the Pacific Special Supplement 2014 4th Edition.*

[40] WHO. 2002. *Commission on Macroeconomics and Health*.

[41] MOH, WHO 2012. *Health Service Delivery Profile Cambodia 2012*.

[42] MOH, WHO 2012. *Health Service Delivery Profile Cambodia 2012*.

in 2011, with 35% seeking care in the private sector and 48% seeking care through drug shops and the nonmedical sector. In 2011, the most frequent sources of curative care for the poor were unlicensed drug shops and markets (47%), health centers (13%), private pharmacies (13%), and other private medical providers (9%). In addition, the use of provincial and district hospitals by the poor declined by half from 2007 to 2011 (to only 1.4% and 0.6%, respectively). The wealthiest sought care nearly three-quarters of the time in the private sector, but they were also more than twice as likely as the poor to use district, provincial, or national hospitals. Residents of Phnom Penh are the most frequent users of national hospitals, but nearly 70% of Phnom Penh residents purchased medicines directly through private pharmacies when sick.[43]

38. Many health facilities in Cambodia were destroyed during decades of conflict. The government's RSIII prioritizes the construction of referral hospitals and health centers; the provision of free health care for the poor; and the continued prevention and treatment programs for communicable diseases. Other interventions include the promotion of maternal and child health, and the adoption and enforcement of health laws and regulations. The strategy focuses on the development of health systems to improve health outcomes; it has established sector-wide strategies to achieve these goals.[44]

39. Total health expenditure has increased together with consistent economic growth, reaching more than 7% of GDP, according to the 2012 National Health Accounts.[45] Household out-of-pocket expenditure is the main part of this total spending (60%), with government and donor funding taking an equal share (20% each). Health insurance plays a very small part in total health funding.

40. Government spending on primary care and preventive services is pro-poor, since the poor benefit disproportionately from these services. Conversely, the better off are more likely to benefit from government subsidies to national or provincial hospitals. Private health spending as a percentage of income and catastrophic health spending have both declined since 2009, owing to rising incomes and the increased use of low-cost services. As a percentage of total income, health spending declined from 3.3% in 2007 to 2.5% in 2011 for all Cambodians and from 2.0% to 1.5% for the poor.[46] Rural people currently spend 2.8% of their income on health, however, compared to only 1.0% for residents of Phnom Penh. Catastrophic health expenditures (defined as household spending of more than 40% of annual non-food expenditure) averaged almost 5% in 2004, 2007, and 2009. It fell to 3.6% in 2010 and fell again to 2.8% in 2011. An estimated 2% of Cambodians fell into poverty in 2011 because of health costs, only a slight decline from 3% in 2004. Health spending remains a significant burden on the poor, with 18% of the poor incurring debt because of health expense.[47]

41. Health spending is also a significant burden for the 9.4% of Cambodians households that reported at least one family member being ill for over a year in 2011 (owing to chronic illness or injury). Poor families spent 25% of per capita monthly income for long-term illness. But in rural

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[43] MOH. 2015. *Health Sector Analysis Third Health Strategic Plan (HSP3) 2016-2020* [Second Revised Report 09.02.2015] DRAFT. Peter Leslie Annear.

[44] MOH. 2015. *Health Sector Analysis Third Health Strategic Plan (HSP3) 2016-2020* [Second Revised Report 09.02.2015] DRAFT. Peter Leslie Annear.

[45] MOH. Bureau of Health Economics and Financing of the Department of Planning and Information. 2014. *Measuring Health Expenditure in Cambodia: National Health Accounts Report 2012*. Phnom Penh.

[46] WHO 2012. *Health Service Delivery Profile Cambodia 2012*. Collaboration of WHO and MOH.

[47] MOH. 2015. *Health Sector Analysis Third Health Strategic Plan (HSP3) 2016-2020* [Second Revised Report 09.02.2015] DRAFT. Peter Leslie Annear.

areas, the average health spending for chronically ill persons was 125% of per capita income, suggesting a significant burden of debt for the household.[48]

42. While the largest proportion of total health expenditure is with private providers, little is known about the nature or the quality of the services provided. The introduction of licensing of all health providers is aimed at including public and private providers within a more integrated national health system. Private providers are not well regulated, and serious problems in the quality of medications and in the quality of advice are reported every day. The MOH is taking the initial steps towards more consistent regulation of the private sector.

d. Poverty, Gender and Social Diversity

43. Poverty tends to be higher in less educated, larger households. The Ministry of Planning has identified poor households to improve focusing of investments. In 2012, 22% of all households were headed by women. The difference in income poverty rates between households headed by women and those headed by men is very small,[49] but female-headed households with more than two children and no adult males are much more likely to be poor and the girls more likely to be working. Households headed by women are likely to be more vulnerable and experience shocks differently than male-headed households.[50] About 70% of employed women and 59% of employed men are in vulnerable employment. Although women own 65% of all businesses in Cambodia, the large majority of women's businesses are microenterprises: 51% employ only one person, and 96% engage four or fewer persons.[51]

44. Ethnic minority group (EMG) populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.[52]

45. Isolated EMGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel reluctant to access services.[53] Programs for behavior change are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EMG villages.

46. Provision of free health insurances has enabled poor EMGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered under the Government scheme. The Government is exploring how to move to Universal Health Coverage in accordance with the relevant Sustainable Development Goal.[54]

[48] WHO. 2002. *Commission on Macroeconomics and Health*.
[49] World Bank. 2014 *Where Have All the Poor Gone? Cambodia Poverty Assessment 2013 Second Ed* April 2014.
[50] ADB. 2014. *Cambodia Country Poverty Analysis.*
[51] ADB. 2013. *Gender Equality in the Labor Market in Cambodia.*
[52] Gupta, Indrani, and Pradeep Guin. Bulletin of WHO. 2010. *Communicable Diseases in the South-East Asia Region of the World Health Organization, towards a more effective response.*
[53] WHO WPRO. 2014. *The Republic of the Union of Myanmar: Health System Review. Health Systems in Transition Volume 4, no 3 2014*. Manila.
[54] MOH. 2012. *Health System Assessment for Universal Health Coverage.* Nay Pyi Taw.

e. Poverty, Migration, and Resettlement

47. Rural people are constantly looking for work or other income-generating activities, which are mainly temporary and poorly paid. Landlessness is a key driver of the high rates of internal migration in Cambodia that is also driven by the pressures of rapid population growth and recurring flood and drought in lowland areas. In addition to urban-urban and rural-urban migration, people move from densely populated rural areas to the more sparsely populated provinces in the northeast, which include some of the country's poorest districts.[55]

48. Cambodia's rural-to-urban migration boom increased Phnom Penh's population by 70% between 1998 and 2013, from just under 1 million to nearly 1.7 million. The proportion of rural households fell from 80.5% in 2008 to 78.6% in 2013, largely due to migration. Half of rural outmigration is to Phnom Penh and about one-third is international, mostly to Thailand. In 2011, 90% of surveyed villages had lost population. The out-migration of primarily younger adults is resulting in a slowly "greying" rural population.[56]

49. Compared to the growth of other income sources from agricultural crops, wage labor, and non-farm self-employment, the contribution of remittances and transfers to household income is small. Some 40.6% of poor households received remittances in 2011, compared to 43.4% of non-poor households. The average amount received by non-poor households nearly three times that received by poor households.[57] Women earn less than men but send more. Remittances are small, but important since the 2009 rural poverty line was just under $26 per month - the average monthly remittance of only $20 can support a poor family's rice needs for nearly four weeks. Cash and in-kind remittances contribute to increased consumption for many rural households, and play a role in explaining at least some of the poverty reduction.

f. Institutions, Capacity, Stakeholders and Participation

50. Total health expenditure has increased with economic growth, reaching US$ 1033 million or $70 per person in 2012 and remaining at more than 7% of GDP. User fees at government health facilities are a part of facility revenues but play a significant role in reducing unofficial payments, providing financial incentives for staff, and covering non-salary operational costs of health facilities.[58] Patient out-of-pocket payments accounted for 60% of total health expenditure; development aid accounted for 20% ($209 million), and budget expenditure for 19% ($199 million) in 2012.[59]

51. The government share represented 6.5% of the total domestic government budget and 12% of the domestic recurrent budget. Donor funding is in both grant and loans. A large proportion was included under the pooled funding arrangement in support of the second national Health Sector Support Program 2008-2015. Donor harmonization and alignment with government policy as well as administrative and management systems has improved but remains a pressing issue.[60]

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[55] Maltoni B, IOM. 2007. *Migration in Cambodia, Internal versus External Flows*. Phnom Penh.
[56] MOH. 2015. *Health Sector Analysis Third Health Strategic Plan (HSP3) 2016-2020* [Second Revised Report 09.02.2015] DRAFT. Peter Leslie Annear.
[57] World Bank. 2014. *Where Have All the Poor Gone? Cambodia Poverty Assessment 2013.*
[58] MOH. 2013. Annual Health Financing Report 2012. Phnom Penh.
[59] WHO. 2015 *Health Systems in Transition Vol. 5 No. 2 2015 The Kingdom of Cambodia.*
[60] WHO. 2013. *Country Cooperation Strategy*. Phnom Penh.

52. Equity in health financing and access to services has improved, partly through focusing public resources on the provision of primary health care services in rural areas (especially reproductive and maternal health care) and from the expansion of social protection schemes. The Strategic Framework for Health Financing 2008-2015 aims to improve health system financing and facilitate a universal risk pooling and prepayment mechanism necessary for achieving universal health coverage.[61]

53. Health Equity Funds (HEFs) were first established by non-governmental organizations (NGOs) in the late 1990s to pay user fees for inpatient services on behalf of the poor. They have since expanded to 45% of all health centers in 44 of Cambodia's 77 operational districts in 2013. An estimated two-thirds of the poor are covered geographically, and the government committed to achieving national coverage by 2015.[62] These funds have emerged as an important source of flexible income for public facilities, with 60% of revenue used for staff incentives, and the balance for operating costs. The poor are identified by the national ID Poor system, managed by the Ministry of Planning who issues HEF cards. Coverage levels of targeted health programs based on Health Equity Funds (HEF) and ID-poor cards are pro-poor, but coverage remains low. Among the poor seeking health treatment, only 20% reported using free or subsidized treatment. Recent assessments suggest that a large proportion of HEF beneficiaries do not use their entitlement to access public-health services, in particular for primary care, although HEFs have helped to increase demand for secondary care at public facilities; one report quantified the increase in health seeking at public facilities due to HEFs at 34% but found only 46% coverage of the poor.[63]

V. Project Poverty and Social Analysis (Due Diligence)

a. Key Poverty and Social Issues

54. The country experienced remarkable progress in reducing poverty. Between 2003 and 2012, the share of people living below the national poverty line had declined from 50% to 18%. However, in 2011, as much as 41% of the population still lived on less than $2 per day, and 72% lived on less than $3 per day (causing a low average per capita income compared to other GMS countries). Since 2009, the number of people living below the poverty line has remained constant at about three million. Poverty rates are highest in the north-eastern and north-central provinces of the country, while most of the poor live in large population centers. Cambodia has a small ethnic minority population of about 4% of the total population. Migrants are also a vulnerable group for which insufficient regulations and services are in place. The project should ensure that MEVs and the poor in general in targeted border areas receive more project benefits through specific project interventions.

55. However, public health services are used much less by MEVs. On the demand side, services may not be affordable or acceptable, ethnic minorities may lack physical access, and migrant laborers may avoid using services or be prevented from it. On the supply side, provincial and district health officers may give less priority to reaching MEVs, may face transport problems, and may lack funding for treatment of sick MEVs. In general, language problems are not an issue and only few locations have major access problems because of rivers to cross in the rainy season.

[61] MOH. 2008. *The Strategic Framework for Health Financing* 2008-2015.
[62] WHO. 2015. The Kingdom of Cambodia *Health Systems Review, Health Systems in Transition Vol. 5 No. 2 2015.*
[63] World Bank. 2013*. Where have all the poor gone? Cambodia poverty assessment 2013.* (Study ACS4545).

56. In addition to general support for improving diagnostics and management of infectious diseases, MOH will need to address these specific MEV challenges by giving priority to reaching MEVs, and prioritizing outreach and services for MEVs. This requires participatory planning with MEVs, inclusion of plans for MEVs in the provincial annual plans and budgets, staff training, additional transport and operational budget, and monitoring benefits. Use of grassroots organizations and NGOs may also be required. Regional, cross-border and intersectoral cooperation will also need to work on addressing the needs of MEVs in border areas.

b. Beneficiaries

57. The project primarily targets selected provinces because the Government considers these provinces more in need of assistance because of the risk of outbreaks of communicable diseases, and health system constraints, not because these are poor provinces per se. The larger part of investment of the project will benefit the general public, while a small part of the project is targeting high risk groups, often but not always poor, with communicable diseases control. A small part of the project will specifically help improve coverage of MEVs. MEVs are more likely to be exposed to and spread different types of diseases and drug resistance, depending on their location and occupations, and in general have less access to health services. Each province will risk conduct mapping of MEVs to identify priorities for action under this project.

58. Targeting the proposed border provinces, most of these poor, along economic corridors will help safeguard gains in connectivity by reducing possibilities for disease outbreaks along these routes. The project targets 13 mostly poor border provinces out of a total of 25 (Pailin, Battambang and Banteay Meanchey provinces in the northeast; Preah Vihear, Stung Treng, Ratanakiri, Mondulkiri, and Kratie in the north-east; and Kandal, Tbong Khmum, Prey Veng, Svay Rieng, and Kampot Provinces in the south-east). Those in the northeast have significant ethnic minority populations. The other two clusters are along the main east-west corridor, among others a major avenue for the movement of migrants to and from industrial zones and related services.

59. The total population in the targeted provinces is 7.6 million, with a population of 3.6 million in targeted border districts. Total populations in districts with large ethnic minority populations amount to 3.7 million, but the actual number of ethnic minorities in these districts is not known, in part as large groups of ethnic minorities are mainstreamed and call themselves Khmer.[64] The total number of poor people is estimated at 1.5 million. While large numbers of poor people live in central Cambodia, the north-eastern provinces are the poorest provinces within the project scope.

c. Impact Channels

60. A major share of project resources will be used for province-wide improvement of community preparedness, disease surveillance, and outbreak response. This will positively impact those in the project area through timely containment of epidemic outbreaks and the concurrent reduction of disease impact. MEV, who are currently disproportionally negatively impacted by epidemic outbreaks, will likely notice the greatest benefits.

[64] Some ethnic minority group call themselves Khmer because of the lower status of ethnic minorities and because of the prosecution of ethnic minorities during the war. However, if they are predominantly poor and identify themselves as ethnic minorities by culture, customs and language, they will be considered ethnic minorities. This constitutes about 4% of the population in Cambodia (during the Pol Pot regime, this was given as 1%) and excludes the Chinese and Vietnamese who make up 6% of the population of Cambodia.

61. In mostly poor border districts, the project will conduct mapping to identify and prioritize MEV communities at increased risk of communicable diseases and not being assisted otherwise. With participatory planning and project resources, MEV communities will be offered outreach services, campaigns, and referral for free health services to improve recognition and reporting of diseases, community preparedness, hygiene and sanitation, and access to disease control programs and HEFs. By focusing these activities in border areas, the project will ensure impact among MEV, including the poor, and hard to reach populations. Beneficiaries in the project area will have positive health impacts though closer and more immediate contact health services, including more effective diagnosis and treatment through improved laboratory functions. Expenses incurred through travel to health service providers will be used more efficiently.

62. The project further aims to raise awareness among health care providers and communities of the importance of including all members of the population – including those in hard to reach populations – and mobilize public and external resources to this effect to achieve both public health security and universal health coverage. This will be done through meetings, workshops, training, and the annual planning and budgeting cycle and monitoring and supervision systems.

d. Other Poverty and Social Issues

63. Cambodia has achieved most of its MDGs, particularly reducing income poverty, expanding primary enrolment, and combating HIV and tuberculosis. Progress in gender equity, reducing child malnutrition and infant and child mortality, and providing basic sanitation has been slower. Due to lack of access to basic services, Cambodia's multidimensional poverty rate is estimated at twice the income poverty rate, at 46% in 2010.[65] Use of health services often results in financial hardship for patients and their relatives, even though HEFs may be available. The NSPS is expected to improve universal health coverage but progress is slow.

64. Improved connectivity is facilitating the spread of communicable diseases such as EIDs, HIV, tuberculosis, malaria, dengue and neglected tropical diseases.[66] People in border districts and migrants are less informed about the health hazards of connectivity, and have less access to services. Migrants and mobile people, isolated ethnic minorities, and other vulnerable groups (MEV) are often not reached by any health services. MEV in border areas are likely to be exposed to, and spread, different types of diseases and drug resistance depending on their location and occupations. As the general public health status improves, the impact of those not reached by the health system becomes relatively larger. Apart from concerns about universal health coverage, MEV also constitute a public health concern as they usually are under the radar of the public health system, including syndromic reporting by community volunteers at village level.[67]

65. By helping improve regional health security, and reaching out to marginalized groups in border areas, the project will contribute to improving the health, learning and productivity of the poor; help protect the poor against catastrophic epidemic events; and contribute to universal health coverage. The targeted border districts have a higher proportion of families living below or

[65] ADB, United Nations Economic and Social Commission for Asia and the Pacific, United Nations Development Programme. 2013. *Asia-Pacific Aspirations: Perspectives for a Post-2015 Development Agenda*. Asia-Pacific Regional MDG Report 2012/13. Manila.

[66] WHO. 2013. *Bilateral Meeting on Healthy Borders in the Greater Mekong Subregion, Session 5. Health Situation and Health Systems Analysis: Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam.* Bangkok.

[67] UNDP. 2015. *The Right to Health for Low-skilled Migrants in ASEAN countries*. Bangkok.

near the poverty line who depend heavily on the availability of a healthy labor force in the family. As the project makes efforts to mobilize these communities to access services, there will be issues of lack of access to services, including access to diagnostic and treatment services for HIV, tuberculosis and malaria, currently financed largely by the Global Fund. Government funding for the health sector has increased substantially in recent years, and improvements are likely in both financial (through recurrent budget, program funds, and HEF) and high quality human resources. The project will need to monitor these resources and harmonize implementation accordingly.

e. Design Features

66. The linkages between the burden of disease and poverty and development are well known. The project addresses key poverty and social issues by strengthening surveillance and outbreak response down to village level; by strengthening regional control strategies, by improving prevention and care for MEV, and by improving laboratory diagnostics and hospital infection control. This will be monitored through the annual evaluation of the regional disease control strategy, national surveillance and response monitoring system, laboratory and hospital quality control systems, and provincial health services and outreach statistics in focus provinces.

67. In terms of poverty impact, the project will help reduce poverty by contributing to protecting health and securing economic growth through the avoidance of major epidemics and reducing the burden of infectious diseases. The project will have only positive impacts on the poor and vulnerable groups in targeted border areas, in the form of village disease reporting, encouraging the use of health services and improving health screening for migrants, ethnic minorities and other vulnerable groups including women and youth (MEV). By targeting diseases that disproportionally affected the poor, targeting provinces with large numbers of poor people, and targeting MEVs within these provinces, the project will maximize impact.

68. The main concern is that, during implementation, central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

69. The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its expected impact on the extended ***MDG6***: halting or reducing the spread of communicable diseases. Through the containment of infections, the project will also have indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the design and monitoring framework (DMF) and the project performance management system (PPMS).

70. Migrant labor to Thailand and other adjoining countries makes a very significant economic contribution in Cambodia, and their remittances help poor households. If a transmissible disease crosses a border and reaches the epidemic stage in urban areas, the poor are at greatest risk because of their living conditions, occupational exposure, and lower access to healthcare. In terms of benefit uptake from the project, the majority of resources will be

allocated to strengthening the rural health system, which will gain coverage and efficiency, and is well utilized by the poorer income groups in Cambodia. Inclusivity will be a function of (i) geographical targeting and this will be a choice made by the executing agency (MOH) and implementing agencies (provinces) rather than ADB; (ii) type of services provided, (iii) effectiveness of reaching those most in need, and (iv) ensuring affordable access through the use of health equity funds or other-wise free or affordable care.

71. The project will require that provinces prepare annual operational plans (AOP) to receive project funding. Each province will propose, through needs assessment, consultations, and detailed preparation, project investment as part of its regular annual health planning cycle. As part of these AOP, provinces will need to identify focus MEV and propose strategies to reach these populations. Each AOP will also reflect on ethnic minority and gender issues as part of its safeguards requirements. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The project Management Unit (PMU) team will be tasked to check these AOP and assist the provinces with planning as needed. This has taken place for earlier ADB investments, but the practice should be strengthened.

72. Civil society representatives in this project will usually be village leaders, representatives from mass organizations, village health groups, malaria health workers, and peer educators. They will be engaged in event reporting, community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use of mobile phone for reporting. MOH is encouraged to engage NGOs to provide services for hard-to-reach forest dwellers and remote ethnic groups but has not yet decided to do so through this project. Access to migrant labor camps, factories and casinos requires the collaboration of factory owners.

VI. Participation and Disclosure

a. Participation

73. During project preparation, stakeholders were consulted at provincial, district, health center and community levels in Battambang, Prey Veng, and Svey Rieng provinces. Among others, stakeholders noted the commitment of health staff but also delivery constraints for field work. Generally, it was confirmed that MEVs are often marginalized and that there are no specific plans for MEVs. Second, it was observed that MEVs vary considerably by location. Based on this assessment, it is evident that specific project implementation plans need to be prepared for each of the project provinces, as each province has unique challenges and opportunities, as well as to ensure buy-in from local government and beneficiaries.

74. To prepare the project implementation in each province, each provincial health office, with representatives of operational districts, hospitals, laboratories and MEVs, will first conduct a needs assessment with the help of the PMU. This will involve mapping of MEVs, field visits and consultations. The provincial project team including representatives of MEVs will prepare a five year project plan and annual project plans as part of the regular provincial annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The team will also conduct participatory monitoring.

75. Each state/region will propose, through need assessment consultations, and detailed preparation, project investment as part of its regular annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, security, and sustainability. This being a modest first investment of ADB in health security in Myanmar, the geographical scope is limited to the hospital in the six state and region capitals and 13 townships.

76. Civil society has a legal obligation to report outbreaks. Civil society representatives in this project will usually be members of the village health group, and will be engaged in community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use mobile phone for reporting. In addition, MOH is considering engaging NGOs to provide mentoring for provincial laboratories.

77. The development of migrant labor is a more recent phenomenon. Efforts to document and address the specific health priorities of migrants are fewer to date, and tend to be limited to specialized agencies such as IOM and ILO. There is little information on the actual health status and health behavior of migrants. As such, there is a recognized need to enhance exchange of views with migrants to achieve at a better understanding of their health priorities.

78. Consultation of migrants is complicated: they often work in off-bounds plantations, factories and casinos and are not registered or illegal, making them reluctant to report to health services. The government may recognize the value of migrant workers as a major contributor to the economy, but less so as a group with specific needs and vulnerabilities, including labor rights, and specific health risks. Migrants face challenging working and living conditions making it more difficult for them to take part in participatory planning activities, or to engage them in health services. MOH will need to facilitate the project by obtaining clearances and participation from the Ministry of Labor and other concerned agencies.

79. ADB will provide, in addition to the consultant currently attached the ADB resident mission, under a regional technical assistance, a consultant to facilitate this planning process. As part of project implementation, a chief technical adviser and a gender and social development expert will be engaged to assist the project management unit (PMU) to continue this process of support for implementing agencies in participatory planning of project activities, in particular to reach MEVs.

b. Disclosure

80. The project purpose and outline were shared with representatives of beneficiaries at the design stage. As part of the bottom up planning approach, there will be a preparatory planning process in each of the 13 participating provinces to identify MEVs and their health priorities, jointly prepare plans, and jointly conduct interventions. This will ensure that beneficiaries are informed and participate at all project stages, and their views incorporated. The project design and implementation progress will be accessible on the website of the regional coordination unit: gmshealthsecurityprojectrcu@gmail.com and on the ADB website.

VII. Gender and Social Diversity

a. Issues

81. The project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve access of women to health services. The patterns of infectious diseases differ substantially among women and men, due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and childcare. Multiple factors contribute to women's access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.

82. The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas. Sufficient gender legislation is in place and as part of gender mainstreaming, the plan is to make a sector-wide gender action plan for all services, programs, and projects. MOH has a central focal point for gender, but this may be lacking at provincial level. Implementation of gender action plans in previous health projects was initially less satisfactory but has been improving. MOH is also in the process of moving to a computerized gender and ethnic group disaggregated health management information. Substantial capacity for gender-related support is also available with Cambodian non-government agencies and grassroots organizations at community level.

b. Actions

83. Active engagement of women's associations is proposed to mobilize communities and reach at risk groups. Cambodia has developed a sector-wide gender plan. Accordingly, the project's gender action plan (GAP) needs to follow the overall GAP or equivalent for the health sector which is still being prepared.

84. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the RRP, the DMF, the PSA, covenants, and the GAP.[68] The project, based on general good practice for gender endorsed by MOH, will enhance participation of women in all its activities:

- (i) The executing and implementing agencies have active gender focal points for project activities;
- (ii) The project engages a gender and social development expert with a focus on community activities;
- (iii) Project implementation plans and annual operational plans (AOPs) will address gender dimensions;
- (iv) The project will collect, analyze and report gender-disaggregated data;
- (v) All project reports report on gender issues;
- (vi) The project will proactively target youth and women at increased risk of infectious diseases;
- (vii) Education materials and care procedures will be gender-sensitive;

[68] ADB. 1998, *Policy on Gender and Development*. Manila; ADB. 2010. *Operations Manual Bank Policies Section C2/BP*. Manila.

(viii) Outbreak response and outreach services will ensure female participation;
(ix) Participation of female and male staff in training programs and scholarship will be equitable;
(x) Refurbishment of laboratories and isolation wards will be gender sensitive;
(xi) All regional, cross-border and intersectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

VIII. Social Safeguards and Other Social Risks

a. Ethnic Minorities

85. Ethnic minorities and indigenous peoples represent 10% of the population. In Cambodia, ethnic minorities are understood as being those of Chinese, Lao, Thai, Vietnamese, or Cham (predominantly Muslim) origin. Indigenous peoples in Cambodia (roughly 100,000) are described as being the 'most ancient inhabitants of the land', with strong cultural and economic ties to their environment.

86. Indigenous peoples constitute about 4% of the population and are mainly located in the northeast of the country. They mainly belong to the Mon-Khmer group, which has many subgroups and languages. Contact through malaria control, the development of rural access roads and migration of Khmer settlers to these provinces is rapidly changing the physical, social and economic environment of these indigenous groups, with mixed results depending on the coping capacity of groups.

87. The project is expected to have positive impact on ethnic minorities and indigenous peoples in the proposed project areas given the type of project activities, including identification of major infections still highly prevalent in ethnic minority communities such as tuberculosis and zoonotic infections, and linking them with health services. An indigenous people's plan (IPP) has been prepared to help ensure that they are not excluded from the benefits of the project. Proposed interventions are not considered sensitive for ethnic minority groups.[69]

b. Other Social Risks

88. Children in the poorest quintile have a three-fold greater risk of death before their fifth birthday than those in the richest quintile.[70] A large fraction of mortality for children under five years of age can be attributed to insufficient coverage and equity disparities along the continuum of care - such as antenatal care and quality of birth delivery and post-natal care, and a lack of vaccinations and access to potable water and good sanitation. Child mortality is highly correlated with wealth, especially among children 1-12 months old.[71] The reduction in child mortality since 2005 was twice as high in urban areas compared to rural, and higher for the richest income quintiles compared to the poorest. The fertility rate for women in the poorest quintile is more than double that of the richest quintile.[72]

89. Some 32% (or approximately 0.5 million) of children under five are stunted. Stunting is more than twice as common among children in the poorest quintile than in the richest. 82% (12.2

[69] WHO. 2014. *Cambodia Country Cooperation Strategy*. Geneva.
[70] ADB. 2014. *Framework of Inclusive Growth Indicators: Key Indicators for Asia and the Pacific Special Supplement 2014 4th Edition*. Manila.
[71] World Bank. 2013. *Cambodia Poverty Assessment*. Phnom Penh.
[72] MOH. 2015. *Health Sector Analysis Third Health Strategic Plan (HSP3) 2016-2020. 2015.* [Second Revised Report 09.02.2015] DRAFT. Peter Leslie Annea.

million people) of Cambodia's people do not have access to piped water supply and 63% (9.3 million people) do not have access to improved sanitation (2014). Substantial nutrition improvements were observed from 2000 through 2005, but progress stalled from 2005 to 2010, which was surprising given concurrent improvements in consumption, including food intake. The solution to malnutrition should include actions targeting issues beyond the amount of food consumed, including addressing food quality, the environment (open defecation), and hygiene practices.

90. Despite significant improvements in immunization, the poorest have lower coverage rates. Routine child vaccination coverage has dramatically increased from 40% to 90% between 1990 and 2010. These high rates of coverage have contributed to reductions in child illnesses and deaths. However, only 65% of the poor are fully immunized.[73]

91. The percentage of the poor seeking some sort of health care when ill increased from 62% in 2004 to 92% in 2011. The percentage of the poor seeking care in the public sector increased steadily from 2004 to 2009, but subsequently declined from 26% in 2009 to only 16% in 2011, with 35% seeking care in the private sector and 48% seeking care through pharmacies and the nonmedical sector. In 2011, the most frequent sources of curative care for the poor were unlicensed drug shops and markets (47%), health centers (13%), private pharmacies (13%), and other private medical providers (9%). In addition, the use of provincial and district hospitals by the poor declined by half from 2007 to 2011 (to only 1.4% and 0.6%, respectively). The wealthiest sought care nearly three-quarters of the time in the private sector, but they were also more than twice as likely as the poor to use district, provincial, or national hospitals. Residents of Phnom Penh are the most frequent users of national hospitals, but nearly 70% of Phnom Penh residents purchased medicines directly through private pharmacies when sick.[74]

IX. Monitoring and Evaluation

92. Poverty and social indicators overlap with overall DMF indicators. Indicative DMF indicators are in table 1 and an indicative outline of poverty and social indicators is in table 2. These indicators will need to be disaggregated by gender/ethnic minority status, or, if this is not feasible, by location or key beneficiary group including the general public, migrants, ethnic minorities and other vulnerable groups. Project baselines and targets will vary considerably by province and are yet to be established through the provincial planning process.

Table 1: Suggested Project Indicators

Indicators
a) Number of casualties due to any epidemic remains below 100 persons in any one-year period. Source: national communicable diseases control reports
b) Economic impact of any outbreak should remain below 0.5% of GDP in any quarter. Source: economic reports
c) APSED compliance increases from 70% to 85% from 2016 to 2021. Source: WHO/IHR assessment.
d) MEVs accessing health services in targeted areas doubled from 2016 to 2021 Source: health program and health facility statistics by gender and ethnic group;
e) All hospitals doing web-based disease reporting increases from 50% to 100% from 2016 to 2021.

[73] ADB. 2014. *Framework of Inclusive Growth Indicators: Key Indicators for Asia and the Pacific Special Supplement 2014 4th Edition.* Manila.

[74] MOH. 2015. *Health Sector Analysis Third Health Strategic Plan (HSP3) 2016-2020* [Second Revised Report 09.02.2015] DRAFT. Peter Leslie Annea.

Source: Web-based surveillance and reporting system reports.

f) Targeted laboratories and hospitals meeting national quality and biosafety standards increased from 40% to 70% from 2016 to 2021
Source: Baseline and end-of-project assessments.

g) MEV communities contacted reach twice per year from 0% to 100% from 2016 to 2021.
Source: outreach team reports

h) Regional, cross-border and intersectoral events conducted from 30 to 100 from 2016 to 2021.
Event reports

i) Female participation in scholarships, workshops, training and other events doubled from 2016 to 2021.
Source: event reports.

j) Provincial annual operational plans include special activities for MEVs from 0% to 100% from 2016 to 2021. Source: Management assessment

APSED: Asia Pacific Strategy for Emerging Diseases; CDC: communicable diseases control; IHR: GDP: gross domestic product; International Health Regulations; MEV: mobile and migrant people, ethnic minorities, and other vulnerable groups; WHO: World Health Organization.

Table 2: Suggested Indicators for Potential Project Poverty and Social Effects and Risks

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
1.1 Regional Cooperation	Regional meetings and workshops	Benefits poor living in border areas, potential for addressing issues of cross-border migrants including health care financing of migrants	Number of events that substantially address poverty and social issues
1.2 Cross-border cooperation	Provincial and district meetings	Potential for addressing health issues of ethnic groups and cross-border migrants in border areas	Proportion of project provinces that substantially address poverty and social issues in cross-border activities
1.3 Intersectoral cooperation	Provincial meetings	Potential for addressing high risk behavior in youth	Proportion of project provinces that address poverty and social issues in intersectoral meetings
1.4 Outreach	District and health center staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Completion of mapping of MEVs being reached
1.5 communicable disease control in border areas	Provincial campaigns	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Number of MEV beneficiaries being reached
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of focus on vulnerable groups	Number of regional workshops substantially address poverty and social issues
2.1 Surveillance	Provincial staff	Difficult to get reports from hard to reach places	Number of MEV groups reporting
2.2 Risk Analysis	Provincial staff	Lack of information from hard to reach communities including migrants	Information quality received from MEV groups including migrants
2.3 Outbreak Response	Provincial staff	Difficult to access remote places and labor camps	Tracking of MEV groups being reached including migrants
2.4 Community preparedness	District and Health center team	Difficult to access remote places and labor camps	Community preparedness sessions conducted
3.1 Laboratory Planning and Management	NIPH	Insufficient attention to setting up transport system to obtain samples from health centers	Specimens received from other health facilities
3.2 Laboratory Pre-service training	NIPH, laboratories	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Profile of recruits and range of tests
3.3 Laboratory Quality Improvement	NIPH, laboratories	Insufficient competencies peripheral laboratory staff	Training of laboratory staff from district hospitals and health centers
3.4 Laboratory quality audit and assurance	NIPH	Insufficient efforts in audit and QA for smaller laboratories	Pilot audit of smaller laboratories to understand the scale of the problem
3.5 Laboratory Upgrading Services	NIPH	Insufficient effort to include tests that benefit the poor more	Range of tests provided
3.6 Laboratory Studies: causes of fever and immunization efficacy	NIPH	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Survey generates specific data for ethnic minorities and migrants
3.7 Hospital Infection Prevention and Control	DHS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Protocols being followed based on one-day observation (also staff)
3.8 Management of Highly	DHS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Use of services by isolated ethnic minorities

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
Infectious Cases			
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	DPHIS, CDCD, PMU, provinces	Insufficient attention to vulnerable groups for communicable disease control in border areas	Number of AOPs meet standards for addressing poverty and social concerns
4.2 Implement GAP, Safeguards, monitoring and Governance assurances	DPHIS, CDCD, PMU, provinces	Insufficient interest of PMU, provinces and districts in implementing these	Number of provinces implementing gender action plan and social safeguards
4.3 Efficient financial Management and Procurement	DPHIS, CDCD, PMU, provinces	Insufficient capacity	Audit report, timeliness of procurement

AOP: Annual Operational Plan; CDCD: Communicable Diseases Control Department; DHS: Department of Hospital Services; DPHIS: Department of Planning and Health Information Systems: NIPH: National Institute of Public Health; PMU; Project Management Unit; QA: quality assurance.

X. Risk Assessment and Mitigation Plan

93. The project builds on the experiences gained in the first and second GMS communicable diseases control projects,[75] HIV projects, a malaria and dengue control technical assistance, and is considered in general implementation terms low risk for MOH Cambodia, similar to Lao PDR and Viet Nam. MOH Myanmar has limited ADB experience, and is considered moderate to medium risk. As mentioned, the main concern is that MEVs are not being reached, which would reduce poverty impact of the project.

94. The project addresses poverty and social issues through its overall pro-poor and pro-vulnerable group design, and through its implementation arrangements to ensure proper project implementation. The project effects, risks, and enhancing or mitigating actions are in Table 3.

95. The major challenges in this project in terms of addressing the needs of the poor and vulnerable groups are (i) not reaching the poor and vulnerable groups. This requires mobilization and possible support of grass-roots organizations; (ii) lack of, or inappropriate services for the poor and vulnerable groups; and (iii) lack of effort or focus on the needs of the poor and vulnerable groups. These need to be mitigated with proper planning, additional resources, and monitoring and assurances. Regional, cross-border and inter-sectoral cooperation also offers more long term opportunities to address the problems of vulnerable groups in border areas, e.g., through better targeting, reaching migrants and remote ethnic groups, and improving health financing for migrants.

96. Regional technical assistance will be provided to engage international consultants during the first project year to ensure a quick project start-up. The project will provide for international consultants including for chief technical adviser, gender and social safeguards, and other areas. In addition, Myanmar MOH will be assisted with upfront project implementation orientation and training. Several administrative risk and mitigating measures are summarized in the RRP.

[75] ADB. 2004. *Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila; and ADB. 2010. *Second Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila.

Table 3: Project Effects, Risks and Mitigating and Enhancing Actions

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
Output 1			
1.1 Regional Cooperation	Regional meetings and workshops	Insufficient strategic planning for improving access of MEVs to health services in border areas including health care financing of migrants and ethnic minorities and sharing best practices.	Planning for MEVs in border areas should be a permanent feature on any regional workshop agenda, and included in country reports.
1.2 Cross-border cooperation	Provincial and district meetings	Risk of not addressing health issues of ethnic groups and cross-border migrants in border areas.	Include this topic on all agendas and participants to report on progress and plans.
1.3 Intersectoral cooperation	Provincial meetings	Risk of not addressing high risk sexual behavior in youth and other priorities in border MEVs.	Include this topic on all agendas and participants to report on progress and plans
1.4 Outreach	District and health center staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons.	Ensure adequate resources, including motorbike, proper mapping and community consultations, include in AOP, supervise, monitor, covenant.
1.5 Communicable disease control in border areas	Provincial campaigns	Risk of not reaching vulnerable groups due to capacity constraints or other reasons.	Ensure adequate resources, proper mapping and campaign planning, include in AOP, supervise, monitor, covenant.
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of strategic focus on priority areas for CDC in GMS including reaching MEVs.	Ensure that workshops include strategic priority areas including reaching MEVs.
Output 2			
2.1 Surveillance	MOH, provincial staff, district staff	Weak surveillance at village level and in labor camps, factories and casinos and in the private sector, reach hard to reach places.	Provide motorbikes to improve mobility and provide training to improve local staff capacity in surveillance and response.
2.2 Risk Analysis	MOH, provincial staff	Insufficient data and data analysis	Introduce syndromic reporting, and improve mobile phone reporting.
2.3 Outbreak Response	MOH, provincial staff, district staff	Difficult to access remote places and labor camps.	Collaborate with the Ministry of Labor and provinces to pre-arrange legal cover for access of premises, and notify all company directors.
2.4 Community preparedness	MOH, district staff, health center staff	Difficult to access remote places and labor camps	Conduct mapping of all villages, labor camps, and private practices. Improve data collection system including disaggregated indicators and obtain specific information from MEVs including migrants.
Output 3			
3.1 Laboratory Planning and Management	NIPH	Insufficient attention to setting up transport system to obtain samples from health centers	Include transport system in AOP and supply containers
3.2 Laboratory Pre-service training	NIPH, laboratories	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Encourage recruits from remote areas and inclusions of testing affecting the poor more
3.3 Laboratory Quality Improvement	NIPH, laboratories	Insufficient competencies peripheral laboratory staff	Give priority to these staff in training programs
3.4 Laboratory quality audit and assurance	NIPH	Insufficient efforts in audit and QA for smaller laboratories	Include smaller laboratories in audit and QA
3.5 Laboratory Upgrading Services	NIPH	Insufficient effort to include tests that benefit the poor more	Include tests that benefit the poor more as appropriate

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
3.6 Laboratory Studies: causes of fever and immunization efficacy	NIPH	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Stratify and enlarge sample to ensure adequate representation of vulnerable groups
3.7 Hospital Infection Prevention and Control	DHS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper education of patients and visitors
3.8 Management of Highly Infectious Cases	DHS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper information of patients and visitors, e.g., videos in various languages
Project Management			
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	DPHIS, CDCD, PMU, provinces	Insufficient attention to vulnerable groups for communicable disease control in border areas	Ensure mainstreaming of reaching vulnerable groups in AOPs, training, monitoring, covenant
4.2 Implement Gender, Safeguards, monitoring and Governance assurances	DPHIS, CDCD, PMU, provinces	Insufficient interest of PMU, provinces and districts in implementing these safeguards	Provide training, include in central and provincial AOPs, supervise, monitor, report, covenants
4.3 Efficient financial Management and Procurement	DPHIS, CDCD, PMU, provinces	Insufficient capacity in project management	Capacity building, monitoring, field inspection, audit

AOP: Annual Operational Plan; CDCD: Communicable Diseases Control Department; DHS: Department of Hospital Services; DPHIS: Department of Planning and Health Information Systems: NIPH: National Institute of Public Health; PMU; Project Management Unit; QA: quality assurance.

Appendix 1: Cambodia Project Location Details

No Provinces	Provinces	No Districts	Districts	Population	Border district	Large Ethnic Population	Poor (%)
1	**Banteay Meanchey**			**746,771**			**25.5**
		1	Mongkol Borei	247,530		1	
		2	Poipet	206,423	1	2	
		3	Preah Net Preah	156,538		3	
		4	Thma Puok	136,280	2	4	
2	**Battambang**			**1,176,528**			**24.8**
		5	Thmar Koul	231,168		5	
		6	Maung Russei	205,902		6	
		7	Sampov Luon	162,472	3	7	
		8	Battambang	372,440	4	8	
		9	Sangkae	204,546		9	
3	**Kampot**			**629,383**			**20.4**
		10	Angkor Chey	123,253			
		11	Chhouk	187,332			
		12	Kampong Trach	172,433	5		
		13	Kampot	146,365			
4	**Kandal**			**742,477**			**14.6**
		14	Takhmao	209,254			
		15	Saang	175,474			
		16	Koh Thom	177,733	6		
		17	Kien svay	118,457			
		18	Leuk dek	61,559	7		
		19	Muk kampoul	71,053			
		20	Lvea Em	99,465			
		21	Khsach kandal	282,966			
		22	Ponhea leu	98,657			
		23	Ang snoul	170,747			
5	**Kratie**			**370,916**			**32.6**
		24	Chhlong	107,617		10	
		25	Kratie	263,299	8	11	
6	**Mondulkiri**			**73,702**			**32.9**
		26	Sen Monorom	73,702	9	12	
7	**Pailin**			**67,565**			
		27	Pailin	67,565	21		23.9
8	**Preah Vihear**			**208,953**			**37.0**
		28	Tbeng Meanchey	208,953	10	13	
9	**Prey Veng**			**1,181,098**			**21.9**
		29	Kamchay Mear	140,476	11		
		30	Kampong Trabek	146,180	12		
		31	Mesang	122,687			
		32	Neak Loeng	129,378	13		
		33	Pearaing	117,840			
		34	Preah Sdach	119,775	14		
		35	Svay Antor	153,216			
		36	Sithor Kandal	75,150			

No Provinces	Provinces	No Districts	Districts	Population	Border district	Large Ethnic Population	Poor (%)
		37	Krong Prey Veng	81,367			
		38	Baphnom	95,029			
10	**Ratanakiri**			**187,005**			**36.2**
		39	Banlong	129,053		14	
		40	Borkeo	57,952	15	15	
11	**Stung Treng**			**133,408**			**36.8**
		41	Steung Treng	133,408	16	16	
12	**Svay Rieng**			**599,119**			
		42	Chi Phu	103,889	17		17.4
		43	Romeas Hek	142,088	18		
		44	Svay Rieng	221,890	19		
		45	Svay Teap	**131,252**	20		
13	**Tbong Khmum**			**776,970**			20.4*
		46	Kroch Chhmar	91,415		17	
		47	Memut	137,015	22	18	
		48	O Reang Ov	92,186		19	
		49	Ponhea Krek	216,436	23	20	
		50	Tbong Khmum	239,918		21	
	TOTAL			**7,616,783**	**3,582,598**	**3,674,253**	**1,493,509**

Sources: Ministry of Health, Department of Planning and Health Information (DPHI) 2016; Ministry of Planning and United Nations Development Programme, 2012. *Poverty Reduction by Capital, Provinces, Municipalities, Districts, Khans, and Communes and Sangkats Based on Commune Database 2004-2012*, Phnom Penh: Ministry of Planning based on the Commune Database 2004-2012.
*Data from Kampong Cham province. Tbong Khmum province split from Kampong Cham province in January 2014.

Poverty and Social Analysis, Lao People's Democratic Republic

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R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

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ACRONYMS

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
AOP	annual operational plan
APSED	Asian-Pacific Strategy for Emerging Diseases
CDC	communicable diseases control
CPS	country partnership strategy
DCDC	Department of Communicable Diseases
DHS	Department of Health Services
DPIC	Department of Planning and International Cooperation
DMF	design and monitoring framework
EGM	effective gender mainstreaming
EID	emerging infectious diseases
EMP	environmental management plan
GAP	gender action plan
GDP	gross domestic product
GMS	Greater Mekong Subregion
HEF	health equity funds
HIV	human immunodeficiency virus
IHR	International Health Regulations
ILO	International Labor Organization
IEE	initial environmental evaluation
IOM	International Organization of Migration
IPSA	initial poverty and social analysis
MDG	Millennium Development Goal
MEV	migrants and mobile people, ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
MOLSW	Ministry of Labor and Social Welfare
NCAW	National Commission for the Advancement of Women
NCLE	National Center for Laboratory and Epidemiology
NGO	nongovernmental organization
NSEDP	National Socio-economic Development Plan
PAM	project administration manual
PPMS	project performance management system
PSA	poverty and social analysis
RRP	report and recommendations to the president
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Executive Summary

A Poverty and Social Analysis (PSA) was carried out for the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project)) to be financed with support of the Asian Development Bank (ADB). The project will strengthen national health security systems and GMS cooperation for the prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance.

In 2016, the Lao PDR has an estimated population of 7.0 million, with about 38% living in urban areas, and 32% belonging to ethnic minorities. Since 1997, about ten years after major economic reforms, the country became one of the fastest growing economies in the region, with an annual growth in GDP of around 7%.[1] With continuing economic growth expected at 7.5% GDP to 2020, Lao PDR will become a lower middle income country. Per capita income has rapidly increased to $1,600 per year. With rapid improvements in regional connectivity, Lao PDR has attracted major investments in small industries, exploitation of natural resources, and services, resulting in new job, migration, and rapid urbanization.

From 2002 to 2012, Lao's poverty rate reduced from 33.5% to 23.2%.[2] However, the poverty rate in uplands was as high as 43% in 2012. Poverty is most common in mountain villages inhabited by ethnic minorities along the eastern border with Viet Nam. Among the vulnerable groups in the lowlands are migrant laborers and resettled people.[3]

With increasing regional connectivity and trade and a nascent health system, the country, located in the center of the GMS, is particularly vulnerable to emerging infectious diseases. Since 2000, there were outbreaks of severe acute respiratory distress syndrome, highly pathogenic avian influenza, swine flu, cholera, dengue, and hand, foot and mouth disease. It has a residual malaria problem with emerging drug resistance, a large burden of tuberculosis, and a concentrated HIV epidemic. Common communicable diseases such as diarrheal diseases and respiratory infections remain the major burden of diseases among children and the poor. Measles and other childhood infections are also common. Nosocomial infections and drug resistance are emerging public health problems. Infectious diseases that can easily spread with high mortality constitute a major public health and economic risks.

In the past two decades, the Government has built up a basic public health infrastructure which however remains seriously underused due to resource constraints. Many rural people, in particular the poor, migrants and traditional ethnic groups, do not use these services because of poor physical access, social acceptability, quality of care, or affordability. Immunization coverage is low, a reflection of rural access problems. This leads to gaps in the surveillance, prevention, control, and management of infectious diseases, particularly along border areas.

Lao PDR is committed to implementing the International Health Regulations (IHR) and the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), as well as implementing other WHO regional strategies for the control of major diseases such as dengue, malaria, tuberculosis and HIV/AIDS. Despite major political commitments and past investments—including by the Asian Development Bank (ADB)—insufficient effort is made for

[1] ANU College of Asia and the Pacific. *Two Decades of Declining Poverty Despite Rising Inequality in Laos. Peter Warr, Sitthiroth Rasphone and Jayant Menon. Working Paper No.* Crawford School of Public Policy September 2015.

[2] ADB 2016 Asian Development Outlook: *Asia's Potential Growth.*

[3] International Fund for Agriculture (IFAD). 2014. *Rural Poverty Portal. Rural Poverty in Laos*. Rome. http://www.ruralpovertyportal.org/country/home/tags/laos.

the control of these diseases, and Lao PDR is yet to comply with IHR and APSED standards. The project will help strengthen national health security systems and GMS cooperation for the prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance, which, according to WHO, remain a major threat in the region. The project will enhance regional cooperation and disease control in border areas, strengthen disease surveillance and outbreak response, and improve laboratory services and infection control in hospitals. Total project costs in Lao PDR for 2017 to 2022 are estimated at $12.6 million. The Department of Planning and International Cooperation represents the Ministry of Health (MOH) as the executing agency, and will implement the project with the Department of Communicable Diseases Control, the National Center for Laboratory and Epidemiology and 12 provinces along Lao's northern, central and southern borders. MOH will also host the regional coordination unit.

To help maximize project benefits and identify risks for the poor, a Poverty and Social Analysis (PSA) was carried out. In terms of project design, the project will help reduce poverty by contributing to protecting health and securing economic growth through the avoidance of major epidemics and reducing the burden of infectious diseases. The project will have only positive impacts on the poor and vulnerable groups in targeted border areas, in the form of village disease reporting, encouraging the use of health services and improving health screening for migrants and mobile people, ethnic minorities and other vulnerable groups including women and youth (MEV). By targeting diseases that disproportionally affected the poor, targeting provinces and districts with more poverty, and targeting MEVs within these provinces, the project design helps maximize project impact.

However, the main concern is that, during implementation, central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its expected impact on extended millennium development goals (MDGs), in particular ***MDG6***: halting or reducing the spread of communicable diseases. Through the containment of infections, the project will also have some indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the design and monitoring framework and the project performance management system.

I. Introduction

1. The Asian Development Bank (ADB) is planning to support the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project). A Poverty and Social Analysis (PSA) was carried out to help identify poverty reduction opportunities and risk and incorporate these in the project design to maximize poverty reduction impact. The PSA examines (i) project poverty dimensions, (ii) the links of the project to the national poverty reduction strategy and the country partnership strategy (CPS); (iii) the poverty targeting classification and its justification; (iv) key poverty and social issues of the potential beneficiaries, including impact channels and expected systemic changes; (v) opportunities and constraints for clients/beneficiaries—particularly poor and marginalized groups—stemming from project activities; and (vi) preparing design measures to achieve inclusive development outcomes during implementation. The PSA also summarizes examine gender impacts, scope of participation, social safeguards, and other social risks dimensions. The finding from the PSA will be reflected in the Report and Recommendation from the President to the Board of Directors (RRP), the Design and Monitoring Framework (DMF), the Project Administration Manual (PAM), the Risk Analysis and Mitigation Plan, and the Project Performance Monitoring System (PPMS). The PSA follows the initial PSA (IPSA) prepared for the project concept, and is used to prepare the summary poverty reduction and social strategy (SPRSS) for the RRP.

2. Based on the issues flagged in the IPSA, the thematic areas that are covered in the PSA include (i) poverty and inequality; (ii) poverty and health; (iii) institutions, capacity, stakeholders, and participation; (iv) gender and social diversity; (v) social safeguards; and (vi) management of other social risks and vulnerabilities. The PSA includes (a) project summary, (b) poverty and social strategy and analysis, (c) results from the project PSA or due diligence including key poverty and social issues, beneficiaries, impact channels, other poverty and social issues, and design features, (d) participation and disclosure, (e) gender and social diversity, (f) social safeguards and other social risks, (g) monitoring and evaluation, and (h) risk assessment and mitigation.

II. Project Summary

a. The GMS Health Issue

3. Emerging infectious diseases (EID) are a global risk. The International Health Regulations (IHR),[4] 2005, of the World Health Organization (WHO) mandates all countries to achieve minimum health security standards against EIDs. Southeast Asia, with major population hubs and intensive livestock raising with associated biosafety problems, has been identified as being a likely site for outbreaks of EID—such as middle-east respiratory syndrome (MERS), highly pathogenic avian influenza (HPAI), or Ebola hemorrhagic fever (EHF)—with pandemic potential that may lead to significant mortality and economic meltdown.[5] The Asia Pacific Strategy for Emerging Disease (APSED),[6] 2010, of the WHO regional offices identifies 8 strategic areas for compliance by not later than 2016. At present, compliance has reached approximately 70–80% in the GMS, with specific gaps mainly relating to laboratory services,

[4] World Health Organization. 2005. *International Health Regulations*. Geneva.
[5] ADB ERD Policy brief no. 42 Potential Economic Impact of an Avian Flu Pandemic on Asia Erik Bloom, Vincent de Wit, and Mary Jane Carangal-San Jose November 2005.
[6] WHO. Western Pacific Regional Office (WPRO). 2010. *Asia Pacific Strategy for Emerging Diseases 2010–2015*. Manila.

hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.[7]

4. The Lao PDR, located in the center of Southeast Asia, is vulnerable to emerging and re-emerging infectious diseases and had several outbreaks including severe acute respiratory distress syndrome (SARS), highly pathogenic avian influenza (HPAI), swine flu, cholera, and hand, foot and mouth disease (HFMD). It also has major outbreaks of dengue, a residual malaria problem with emerging drug resistance, a large burden of tuberculosis, and a concentrated HIV epidemic. Diseases preventable by immunization remain common due to low immunization coverage. Common communicable diseases such as diarrheal diseases and respiratory infections remain the major burden of diseases among children and the poor. Nosocomial infections and drug resistance is an emerging public health problem. All these constitute major public health and economic risks.

5. While the burden of communicable diseases has declined overall in the Lao PDR, it remains high and there are new risks for the spread of communicable diseases because of (i) improved connectivity; (ii) urbanization, industrialization with associated labor camps, (ii) increased drug resistance, particularly for hospital infections, tuberculosis, malaria and HIV; (iii) reduced compliance with preventive measures like vaccination; and (iv) emerging and re-emerging diseases for which control measures such as vaccines are still being developed. While the burden of communicable diseases may have reduced, this is because of major efforts, and sustained financing will be needed to keep all infectious diseases under control.

6. The Lao PDR is particular vulnerable because its health system is still weak. It has developed basic infrastructure in the past 30 years, but low access, limited rural staff capacity, and financial constraints affect sector performance. In addition to making efforts to strengthen provincial and district capacities, the Government is making major efforts to reach out to villages and improve village capacity to address health problems, including prevention and control of infectious diseases.

b. The Project

7. Under the GMS economic development program, ADB has been supporting various health projects for communicable diseases control, HIV, malaria, and related regional technical assistance.[8] The governments of Cambodia, Lao PDR, Myanmar and Viet Nam, and ADB have prepared the project to strengthen national health security systems and regional cooperation for the prevention and control of EIDs and other diseases of regional importance in the GMS, and help countries to comply with IHR 2005[9] and implement APSED of the WHO.[10]

8. The proposed project goal is **strengthened GMS health security**, as measured by the following indicators (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased use of public health services in border areas by MEV. The proposed project outcomes

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[7] WHO WPRO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.

[8] Including Strengthening Preventive Health System Project; Community Action for HIV Prevention in 2001; GMS Regional Communicable Diseases Control Project in 2004; Second GMS Communicable Diseases Control Project in 2010; GMS Capacity Building for HIV/AIDS Prevention Project in 2012; Japan Fund for Poverty Reduction projects such as for Model Healthy Village; and technical assistance for malaria and dengue control, health education, e-Health, and related areas.

[9] World Health Organization. 2005. *International Health Regulations*. Geneva.

[10] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*. Manila.

are (i) improved coverage of GMS public health security system and compliance with IHR/APSED and (ii) increased communicable disease control coverage of MEV in border areas. The proposed project outputs are: (i) improved GMS collaboration and MEV access to communicable disease control in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases. The proposed project targets 12 provinces in the Lao PDR along the borders and economic corridors with China, Cambodia, Thailand and Viet Nam.

9. MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. These processes, however, still need to be mainstreamed and formalized. In addition, some groups of MEVs who may be at greater risk of infection of some diseases are not using regular health services. Under the first output, the project (i) supports regional, cross-border, and inter-sector information sharing and coordination of outbreak control among GMS countries, (ii) develops regional disease control strategies and evidence-based communicable disease control, and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring; and outreach and community mobilization to reach and engage MEV.

10. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong. However, the system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH also needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level, (ii) web-based reporting including information technology support, (iii) integration of surveillance systems, (iv) risk analysis, communication, and community preparedness, (v) improving capacity of outbreak response teams including transport, and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

11. District facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial or hospital-acquired infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance, (ii) in-service training, (iii) improving district laboratory services, and (iv) equipment and training for infection control and case management of dangerous diseases.

12. In the Lao PDR, the project is estimated to cost $12.6 million including $8.41 million in grant and $3.7 million in loan from ADB; and will be implemented by MOH through the Department of Planning and International Cooperation (DPIC) representing the Executing Agency (EA), the Department of Communicable Diseases Control (DCDC), the National Center for Laboratory and Epidemiology (NCLE) and implementing agencies in the 12 project provinces (Phongsaly, Luangnamtha, Bokeo, Udomxay, Xiengkhuang and Huaphanh; in the center Bolikhamsay and Khammuane, and in the south Champasack, Attapeu, Saravane, and Sekong). The project will be implemented over a 5-year period beginning early 2017. The project completion date is 30 June 2022.

III. Poverty and Social Strategy

a. Government Strategy

13. The National Growth and Poverty Eradication Strategy of the Government of the Lao People's Democratic Republic (Lao PDR) was approved in 2003 as the framework to develop and implement initiatives to end poverty and sustain national growth.[11] It aimed to eradicate poverty in Lao PDR by 2020, particularly by prioritizing investments in the 47 poorest districts. Nearly all border districts are considered poor excepting few bordering China and Thailand.[12] The majority of project districts are poor along the Viet Nam, Cambodia, and Myanmar borders.

14. The Government's 7th National Socio-economic Development Plan (NSEDP), 2011-2015,[13] aimed to support sustainable economic growth and reduce poverty and inequality, and promoted inclusion of women, ethnic groups, those living in remote areas, the private sector, NGOs, and development partners. The health sector was one of the four priority sectors.[14]

15. In the 8th NSEDP, 2016-2020, the Government adopted a more modest target of reducing the poverty rate to 15% by 2020. It prioritizes the health sector up to 2020, and includes strengthening and improving the quality of health care at the grassroots level, particularly in under-served areas. Safe drinking water, sanitation systems and improved nutritional standards are also prioritized. Child mortality among infants aged below one year is set to fall to 30 deaths per 1,000 live births, while the goal for the maternal mortality rate is set at 200 deaths per 100,000 live births, which is still high compared to other countries in the region.[15] The 8th NSEDP also recognizes that the sector needs substantial reforms and more financing.

16. The key strategies used by the Government for poverty reduction are human resource development, rural development and people's participation. These are long-term strategies and the Lao PDR has done less well in these areas, due to lack of investment in rural access roads and competent institutions, and a reluctance of the Government to allow civil society participation in development. The Project will develop health human resources through components that will strengthen the health system, and reduce the economic effects of communicable disease in the border districts.

b. ADB Strategy

17. According to ADB's Strategy 2020, ADB's overall goal is poverty reduction, and regional cooperation is one of the pillars of this strategy stated regional cooperation as one of the pillars.[16] Under the ADB assisted GMS economic development program, ADB and GMS countries have prioritized communicable diseases control, among others to mitigate risks and negative impacts of increase in regional connectivity, and associated industrialization, urbanization, and economic growth in particular in border areas and along economic corridors.

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[11] The Government of the Lao PDR. *National Growth and Poverty Eradication Strategy. 2003*. Vientiane. Prime Minister's Instruction on the eradication of poverty provides an operational definition: "*Poverty is the lack of ability to fulfil basic human needs such as not having enough food, lacking adequate clothing, not having permanent housing and lacking access to health, education and transportation services"* (Instruction No 010/PM, June 25, 2001).

[12] JICA/OPMAC Corporation/UNDP in Lao PDR. *Lao PDR Study for Poverty Profiles of the Asian Region Final Report August 2010* and Ref. 23.

[13] The Government of the Lao PDR. *7th National Socio-economic Development Plan 2011–2015*. 2010. Vientiane.

[14] IMF *Lao PDR National Growth and Poverty Eradication Strategy June 2004 (NGPES) Strategy Paper IMF Country Report No. 04/393* December 2004.

[15] Speech of the Minister of Planning and Investment at the National Assembly, December 2015.

[16] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008–2020*. April 2008. Manila.

18. ADB's Lao PDR Country Partnership Strategy (CPS) 2012-2016[17] is aligned with the seventh NSEDP. The CPS 2012-2016 sought to gain efficiency and sustainability through larger operations implemented over a longer period; maximize synergies with the GMS program; and increase responsiveness to emerging issues in a rapidly changing economy. It aimed to reduce poverty and to promote inclusive growth by focusing on rural areas and rural-urban links, targeting the areas where poorest people live, and promoting connectivity for isolated areas through rural roads. Industrialization and connectivity, with associated migration and changing behavior, carries health risks. The CPS includes support for public sector management in the health sector. A new CPS 2016-2020 is being prepared.

IV. General Poverty and Social Analysis

a. Poverty and Economic Growth

19. Prior to adopting the New Economic Mechanism in 1986, the Lao People's Democratic Republic (Lao PDR) was one of the poorest countries in Asia. The New Economic Mechanism marked the shift towards a market based socialist economy. After a dormant period of about 10 years, the country became one of the fastest growing economies in the region, with an annual growth in GDP of around 7%.[18] Lao PDR rapidly increased its annual per capita income to about $1,600 by 2014. It set a target of 7.5% growth to 2020 in order to graduate from least developed country status. Growth contributed to lowering the number of poor people to an estimated 23.2% of the population in 2012-2013 from 33.5% a decade ago.[19] With rapid improvements in connectivity and geographical proximity to large economies, Lao PDR has attracted major investments resulting in rapid industrialization, exploitation of natural resources, and increase in services.

20. This rapid growth has been less equitable and comes at a cost. The country has done less well on poverty reduction compared to other countries in the region because development is largely urban based and driven by foreign investment in small industries. This has also led to large-scale rural-urban migration, and (mainly) temporary migration to neighboring countries. While Lao PDR is a resource-rich country, exploitation of natural resources contributed to only one third of economic growth. Although the incidence of absolute poverty has halved since 1990, inequality has increased, within both rural and urban areas and within all major ethnic groups. The Lao poor have become better off but in relative and absolute terms, the Lao rich have benefited more.[20]

b. Poverty and Residence

21. Poverty in Laos has a strong geographic dimension. About 62% of the population of Lao PDR lives in rural areas and depends on agriculture and natural resources for survival. Farming is largely at the subsistence level and productive conditions are generally poor.[21] The proportion of poor people in rural areas is more than twice as high as that in urban areas. Poverty and

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[17] ADB. *Lao PDR Country Partnership Strategy 2012–2016*. 2012. Manila.

[18] ANU College of Asia and the Pacific. *Two Decades of Declining Poverty Despite Rising Inequality in Laos. Peter Warr, Sitthiroth Rasphone and Jayant Menon. Working Paper No.* Crawford School of Public Policy, September 2015.

[19] ADB 2016 Asian Development Outlook: *Asia's Potential Growth.*

[20] ADB. 2015. Economics Working Papers Series *Two Decades of Rising Inequality and Declining Poverty in the Lao PDR*. Manila.

[21] Inst. for Development Economics. *Infrastructure (Rural Road) Development and Poverty Alleviation in Lao PDR. S. Oraboune IDE Discussion Paper No. 151* April 2008.

extreme poverty are most common in mountain villages where the majority of the country's ethnic minority peoples live, in particular in the eastern districts bordering Viet Nam. In upland areas, the poverty rate is as high as 43%. Most of the poor are concentrated in seven provinces: Bokeo, Udomxay, Huaphanh, Xiengkhuang, Luangprabang, Saravane, and Sekong. About half of the poor live in villages with little or no infrastructure. The poorest group in the lowlands is those that have been resettled from mountain regions.[22]

22. During the rainy seasons as many as half of all Lao villages become unreachable. The more remote rural communities are still cut off from the national economy due to lack of access to government and financial services, roads, markets, basic education and health services. Lack of access to services and information depresses their living standards. The poor still have limited access to infrastructure, including safe water, sanitation and basic health services. Rural households pursue three ways out of poverty: farming, non-farming labor, and migration. The rural economy in the country has been opening up and benefits from trade with dynamic cross-border markets, including cross-border contract farming and commercial plantations, as well as unrecorded informal trade. The greatest challenges persist in the areas bordering Viet Nam and Cambodia, where a large and increasing number of rural poor live. The main determinants of poverty in these areas are remoteness and inaccessibility on both sides of the border, which hinder the dynamic economic activities found on the borders with Thailand and China.[23]

c. Poverty and Health

23. The Lao PDR achieved several of its Millennium Development Goals (MDGs) in 2015, including halving poverty, reducing hunger and improving education and health outcomes. However, malnutrition remains high with about one quarter of children being underweight. Maternal mortality is also high as this depends on access to hospital services.[24] While most health indicators have improved substantially over the past two decades, they still compare unfavorably by regional standards. Poor access to medical care and poor conditions such as the lack of clean drinking water are major factors affecting health. Life expectancy remains low overall at 59 years, and mortality and morbidity rates are very high in mountainous areas where poverty is severe. Rural people especially suffer from many communicable diseases that are easily treated or prevented, but even where services are available, many people in Laos avoid using them because of the relatively high user fees. There is a lack of data on the impact of poverty on people's health status, but, for example, maternal mortality is clearly associated with access to obstetric surgery, which is lacking in less accessible rural areas with a high proportion of poor people.[25]

24. Laos has very low health spending per capita at $35.5 (FY 2011–2012), or 2.8% of GDP.[26] Total health expenditure per capita has continuously increased in the last decade, due to an increased share of private funding (mostly out of pocket payments), while public funding has decreased over the same period. Use of health-care services often results in financial hardship for patients and their relatives. Medical expenditures cause substantial income erosion and are a

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[22] International Fund for Agriculture (IFAD). 2014. *Rural Poverty Portal. Rural Poverty in Laos*. Rome. http://www.ruralpovertyportal.org/country/home/tags/laos.
[23] Ishida M. *Border Economics in the Greater Mekong Sub-region*. 2013. Chennai.
[24] WHO.*The Lao PDR Health System Review. Health Systems in Transition Vol. 4 No. 1* 2014.
[25] ADB 2013. *Thematic Evaluation Study on ADB's Support for Achieving Millennium Development Goals*. Manila.
[26] MOH. *Lao National Health Accounts Report Fiscal Year 2010-2011 and 2011–2012.* Vientiane 2015.

major cause of households slipping into poverty.[27] A 2004 household survey found that 34% of the poorest quintile had sold assets while 29% had borrowed cash from relatives to pay for hospital bills. Subsidies to public inpatient care are concentrated at provincial and central level hospitals.

25. Prime Ministerial Decree No. 52/PM (1995) introduced user fees at government health services along with exemptions for the poor and other groups including civil servants and their families, monks, and students attending government schools. In practice, few exemptions are granted. The large majority of the population is uninsured and pays directly and in full for services provided at both public and private healthcare facilities. Due to relatively high prices and perceived poor quality of public health services, the uninsured frequently resort to alternatives such as traditional medicine and self-medication. Use of public health services by the poor depends on the cost of services (among other factors such as access).[28] The Government has committed to increase public health spending to 9% of general government spending, but actual spending is much less.[29]

26. Health Equity Funds (HEF) for the poor were initially introduced in 2007 and gradually expanded to five schemes. These schemes are to be integrated in the national health insurance scheme. A recent review[30] found that HEF have increased utilization of services, improved financial protection and improved quality of care. Their financial sustainability, however, depends on MOH and the Government supporting the financing of these schemes until the National Health Insurance takes over. The Government also has introduced fee exemptions for mothers and children less than five years of age with funding support from various sources. ADB and the World Bank have increased budget support to the health sector to help finance these schemes, but MOH is yet to receive funds due to Laos' overall tight fiscal situation. The Government has also placed conditions for its initial commitment to allocate 9% of its budget to the health sector, in view of liquidation problems of MOH and fiscal constraints.[31]

d. Poverty, Gender and Social Diversity

27. Social indicators have shown improvement in the Lao PDR but are still among the lowest in the region: Lao PDR was ranked 139 out of 187 countries in the 2014.[32] Social isolation is a particular problem for upland ethnic peoples, who are marginalized in many ways because of their languages, customs and religious beliefs. Ethnic women and girls, especially those in the highlands, are the most vulnerable members of rural communities. Women of ethnic minorities are less literate, and have less physical, social and financial access to services.[33] They often do not speak the national language and have difficulty communicating with health staff. They often prefer to deliver at home. Women are also more vulnerable to sexually transmitted infections, and pregnant women are more vulnerable to malaria.[34] While the Lao PDR has an extensive women's union, gaps between policy and implementation need to be bridged.

[27] Wagstaff A., M. Lindelow. Are Health Shocks Different? Evidence from a Multi-Shock Survey in Laos. World Bank Policy Research Working Paper No 5335. Washington.
[28] ADB. 2012 *Impact of Out-of-Pocket Expenditures on Families and Barriers to Use of Maternal and Child Health Services in Asia and the Pacific*. Manila.
[29] http://www.wpro.who.int/laos/topics/health_financing/en/.
[30] Communication with Dr. Brad Schwartz, health economist and researcher of the HEF, 2015.
[31] ADB. 2014. Lao Health Governance Technical Assistance Project. Manila.
[32] UNDP. 2014. Human Development Report.
[33] World Bank. King, E. D van de Walle. *Indigenous People, Poverty and Development. Chapter 7: Laos. Ethno-linguistic Diversity and Disadvantage.* Washington.
[34] WHO. *The Lao PDR Health System Review. Health Systems in Transition Vol. 4 No. 1* 2014.

28. The main Lao-Tai group (64% of the population) has consistently enjoyed the highest average level of expenditure per person. Minority ethnic groups such as Mon–Khmer, Tibeto–Burman and Hmong–Mien, have higher rates of poverty. It is estimated that more than 600,000 (50%) of Mon–Khmer and 275,000 (44%) of Tibeto–Burman and Hmong–Mien live in poverty.[35] Villages subsist in relatively stable agro-ecosystems, so the perception of endemic poverty has been created by reliance on a numerical definition of poverty. To most villagers, poverty is an issue of livelihood: if villages are able to meet their consumption needs, they do not consider themselves poor. Poverty is mainly due to a lack of access to certain factors of production and surrounding environmental factors, notably agricultural technology and infrastructure. When agro-systems are disrupted or other upheavals occur, poverty often follows. Once ethnic minority households have access to these resources, they are likely as capable of using them for productive activities as lowland dwellers.

e. Poverty, Migration, and Resettlement

29. With improving rural access, men and women are increasingly engaged in migrant labor. Internal migration is much larger than external migration, and is estimated to affect some 10% of the population and a much higher percentage of households.[36] This creates important social and economic shifts that are insufficiently taken into account in government policy. Urbanization and economic growth in Vientiane capital, Savannakhet, Pakse, Thakek and Luangprabang is a driving force for internal migration rural-to-urban and upland-to-lowland migration, rapid formation of economic zones and labor camps that contribute to poverty reduction in the highlands through remittances.

30. In this regard, it may be noted that migrants are not a clearly articulated social safeguards group in terms of ADB projects. Furthermore, migrants are not a well-recognized group for the government, as planning and budgeting of services is done based on the registered population, and until recently, illegal or unregistered migrants had difficulty accessing health services. Poor migrants do not have access to health equity fund support, as this is only made available to registered residents.

31. Cross-border migration, in particular to Thailand, is an important strategy to raise more income. Thai salaries are about double those in Lao PDR, but such migrants are often required to have certain education or skills. Since the populations along the Mekong are more developed and connected to the border economy, households in districts along the Thai border receive nearly three times more remittances than other households. Common language and similar traditions are also strong forces for Lao migration to Thailand.

32. Cross-border migration is common among women, the youth, and the educated, but low levels of formal education and ethnic differences are impediments to rural people considering migration. An estimated 5-10% of migrants are under 18 years of age.[37] Most migrants are not well informed about labor issues and living conditions and health risks as migrant workers. Women are more vulnerable to exploitation, are paid less, and do more work than men.[38] While the World Bank and IOM provide some indicators, good statistics on migrants are lacking.

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[35] SIDA. *Determinants of Poverty in Lao PDR Magnus Andersson et al. Social Indicators Research Volume 126, Issue 2,* March 2016.
[36] IOM. https://www.iom.int/countries/lao-peoples-democratic-republic. 2016
[37] SIDA. *Determinants of Poverty in Lao PDR Magnus Andersson et al. Social Indicators Research Volume 126, Issue 2,* March 2016.
[38] Phetsiriseng I. 2007. *Mapping Migration in Lao PDR*. Presentation at Workshop in London.

33. Ethnic minorities living in resource-rich upland areas are often the target of land purchases by international corporations, and have been relocated without their consent. These resettled villages may suffer much higher mortality rates, also because they are forced to abandon traditional livelihoods and switch to intensive farming.[39] This has contributed to a rural-urban migration, with well-established associated social, health and economic issues, among and within communities.

f. Institutions, Capacity, Stakeholders, and Participation

34. The Prime Minister's office, Lao PDR, is directly concerned with poverty reduction and social inclusion, through various ministries. The Ministry of Health (MOH) is mainly concerned with poverty reduction and social inclusion through the provision of public health services, which are partly subsidized, but also carry a high out of pocket cost. In the Lao PDR, the Lao Women's Union, Lao Youth Union, the Lao Fatherland Front and other state sponsored organizations provide a critical role in advocacy, mobilization and participation. While international non-government organizations (NGOs) play a modest role in the health sector, their role in social mobilization is modest. There are very few local NGOs in the health sector. This presents a major hindrance as local NGOs can play a complementary role to the government. The Government is seeking to explore this further. At village level, a headman/woman and committee, health committees, health volunteers, peer educators, and other health workers are mostly available to provide any assistance for development activities.

35. Government agencies have limited capacity to reach out to hard-to-reach communities due to financing and transport constraints and small travel allowances. Other issues may also play a role, such as concerns about efficiency (focus on low hanging fruits in view of overall financial constraints), staff security, and language problems in addition to a lack of interest of targeted communities. MOH has not extended overall immunization coverage due to access problems during the rainy season and structural and managerial issues. With appropriate incentive, MOH staff have succeeded in reaching most villages with polio and measles vaccination. MOH has also implemented the model healthy village program in remote villages, which further demonstrates their ability to reach out. The overall constraints in which the health sector operates resulting in lack of staff and operational funds in rural areas may, however, encourage provincial and district teams to focus on health services and not on village health care and outreach. This would result in the exclusion of migrants and isolated groups.

V. Project Related Poverty and Social Analysis (Due Diligence)

a. Key Poverty and Social Issues

36. Lao's poverty rate has reduced to 23.2% in 2012, but economic growth has benefitted the rural poor less and the poverty rate was as high as 43% in the uplands in 2012. Poverty is highest in mountain villages inhabited by ethnic minorities along the eastern border with Viet Nam. These ethnic minorities also have a high burden of infectious diseases and less access to health services.

37. In addition to the poor in general, vulnerable groups at increases risk of infectious diseases are migrant laborers and resettled people. Women are also more at risk due to high workload, poor nutrition, and pregnancy, and may have less access to services.

[39] IRIN Foundation. *Laos "Land Grabs" Drive Subsistence Farmers into Deeper Poverty. Dana MacLean* 2015. http://www.irinnews.org/report/100116/laos-land-grabs-drive-subsistence-farmers-into-deeper-poverty.

38. With better regional connectivity, trade, industrialization and urbanization, the country, located in the center of the GMS, is increasingly exposed to EIDs. Since 2000, there were outbreaks of several emerging and re-emerging diseases, cholera, dengue, and hand, foot and mouth disease. Other diseases of regional importance such as malaria, tuberculosis, and HIV/AIDS also need more efforts to bring these under control. Nosocomial infections and drug resistance are on the increase.

39. The public health system is basic and seriously underused due to resource constraints. Many rural people, in particular the poor, migrants and traditional ethnic groups, do not use these services because of poor physical access, social acceptability, quality of care, or affordability. This leads to gaps in the surveillance, prevention, control, and management of infectious diseases, particularly along border areas. People in border districts and migrants are less informed about health hazards, are more at risk, and have less access to services.[40] MEV are often not reached by any qualified health services. As the general public health status improves, those not reached by the health system will continue to pose health security risks to themselves and others.

40. Hard to reach populations, including MEV, are often not covered by national disease surveillance programs, including syndromic reporting by community volunteers at commune level. Hence, an outbreak of EID, dengue or other disease may go unnoticed for a while, thereby making control more difficult and costly. MEVs not access control program also decreases the efficiency of these programs, and leaves these communities vulnerable to undetected slow epidemic outbreaks. Public health services need to strengthen strategy, means and commitment to reach these MEVs.

b. Beneficiaries

41. The project targets 12 provinces out of a total of 18. All of these 12 provinces are border provinces, comprising a total of 36 border districts out of 55 districts.[41] The selected provinces are: Bokeo, Luangnamtha, Udomxay, Phongsaly, Xiengkhuang and Huapanh in the north bordering Thailand, Myanmar, PRC (Yunnan), and Viet Nam; Bolikhamsay and Khammuane in the center bordering Thailand and Viet Nam, and Attapeu, Saravane, Sekong and Champasack in the south bordering Thailand, Cambodia and Viet Nam. With the exception of Champasack, these are among the poorest and least developed provinces of Lao PDR.

42. The total catchment population in these 12 provinces is estimated at 3.0 million (2015), with about 1.4 million living in the 36 border districts including 1.0 ethnic minorities (Appendix 1). By targeting border areas, the project is disproportionally targeting the poor, as was shown in Lao Expenditure and Consumption Survey 2012/2013.[42] This supports an earlier 2004 study, which also reported that poverty is concentrated along the Lao PDR-Viet Nam border, and that focusing on these border areas will more greatly benefit the poor.[43] Within the targeted provinces, the project is not specifically targeting the poor and vulnerable groups except under output 1 for MEVs. Project inputs will be made available to reach these MEVs.

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[40] WHO. 2013. *Bilateral Meeting on Healthy Borders in the Greater Mekong Subregion, Session 5. Health Situation and Health Systems Analysis: Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam.* Bangkok.

[41] The targeted districts are mostly located in remote, forested areas. The selected districts largely overlap with the 72 poor districts and 47 poorest districts identified by the Government for priority investments.

[42] Lao Statistics Bureau. Lao Expenditure and Consumption Survey 2012/13. 2013.

[43] Committee for Planning and Investment National Statistics Center and World Bank. Lao PDR Poverty Trends 1992/93- 2002/2003. 2004.

c. Impact Channels

43. A major share of project resources will be used for province-wide improvement of community preparedness, disease surveillance, and outbreak response. This will positively impact those in the project area through timely containment of epidemic outbreaks and the concurrent reduction of disease impact. MEV, who are currently disproportionally negatively impacted by epidemic outbreaks will likely notice the greatest benefits.

44. In mostly poor border districts, the project will conduct mapping to identify and prioritize MEV communities at increased risk of communicable diseases and not being assisted otherwise. With participatory planning and project resources, MEV communities will be offered outreach services, campaigns, and referral for free health services to improve recognition and reporting of diseases, community preparedness, hygiene and sanitation, and access to disease control programs and HEFs. By focusing these activities in border areas, the project will ensure impact among MEV including the poor, and hard to reach populations. Beneficiaries in the project area will have positive health impacts though closer and more immediate contact health services, including more effective diagnosis and treatment through improved laboratory functions. Expenses incurred through travel to health service providers will be used more efficiently.

45. The project further aims to raise awareness among health care providers and communities of the importance of including all members of the population – including those in hard to reach populations – and mobilize public and external resources to this effect to achieve both public health security and universal health coverage. This will be achieved through meetings, workshops and training, and the annual planning and budgeting cycle and monitoring and supervision systems.

d. Other Poverty and Social Issues

46. By helping improve regional health security, and reaching out to marginalized groups in border areas, the project will contribute to improving the health, learning and productivity of the poor; help protect the poor against catastrophic events; and contribute to universal health coverage. The targeted border districts have a higher proportion of families living below or near the poverty line who depend heavily on the availability of a healthy labor force in the family. Public health services in border areas are under-resourced with limited staff capacity. As the project makes efforts to mobilize these communities to access services, there will be issues of lack of access to services, including access to diagnostic and treatment programs for HIV/AIDS, tuberculosis and malaria (currently largely supported by the Global Fund). Government funding for the health sector has improved substantially in recent years, and efforts should be made to increase resources for rural health services including staff, recurrent budget, program funds, and HEF. The project will need to monitor these resources and harmonize implementation accordingly.

e. Design Features

47. Lao PDR is committed to implementing the International Health Regulations (IHR) and the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), as well as implementing other WHO regional strategies for the control of major diseases such as dengue, malaria, tuberculosis and HIV/AIDS. Despite major political commitments and past investments - including by the Asian Development Bank (ADB) - insufficient effort is made for the control of these diseases, and Lao PDR is yet to comply with IHR and APSED standards.

48. The project will help strengthen national health security systems and GMS cooperation for the prevention and control of EIDs and other diseases of regional importance, which, according to WHO, remain a major threat in the region. The project will enhance regional cooperation and disease control in border areas, strengthen disease surveillance and outbreak response, and improve laboratory services and infection control in hospitals. Total project costs in Lao PDR for 2017 to 2022 are estimated at $12.6 million. The Departments of Planning and International Cooperation, the Department of Communicable Diseases Control, and the National Center for Laboratory and Epidemiology of the Ministry of Health (MOH) will lead project implementation in 12 provinces along Lao's northern, central and southern borders. MOH will also host the regional coordination unit.

49. The GMS Health Security Project helps prevent and control infectious diseases that disproportionally affect the poor. The first output, *enhanced regional cooperation and communicable disease control in border areas*, is specifically targeting cross-border cooperation and outreach for migrants and ethnic minorities in border areas: groups that are also frequently poor. The second output, *strengthened surveillance and response*, is to further build on earlier investment in provincial and district capacity. The project aims to expand these services to health centers and villages. The third output, *improved laboratory and hospital infection prevention and control* will focus on the provincial level. Given that MEV tend to live further away from these facilities than other cohorts, this activity will likely be of more to benefit the general population.

50. Output 1 will actively seek to improve MEV access health services, in particular also accessing control programs for HIV, tuberculosis, and malaria. These programs are co-funded by the Global Fund and the Government and provide counseling, rapid test diagnosis, and follow up care including access to treatment. Many MEV are reluctant to access these services in view of concerns about availability and affordability of services and social stigma. Government health insurance will be extended to MEV so that they can access free health care. Engaging MEV will also provide opportunities to improve community preparedness and public health security against emerging infectious diseases, as well as work with communities for the prevention of other diseases, such as dengue and cholera.

51. In terms of project design, the project will help reduce poverty by contributing to protecting health and securing economic growth through the avoidance of major epidemics and reducing the burden of infectious diseases. The project will have only positive impacts on the poor and vulnerable groups in targeted border areas, in the form of village disease reporting, encouraging the use of health services and improving health screening for migrants, ethnic minorities and other vulnerable groups including women and youth (MEV). By targeting diseases that disproportionally affected the poor, targeting provinces with large numbers of poor people, and targeting MEVs within these provinces, the project will maximize impact.

52. The main concern is that, during implementation, central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

53. The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its potential impact on the extended ***MDG6***: halting or reducing the spread of communicable diseases. Through the containment of infections, the project will also have some indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the DMF and the PPMS.

54. The project will require that provinces prepare annual operational plans (AOP) to receive project funding. Each province will propose, through needs assessment, consultations, and detailed preparation, project investment as part of its regular annual health planning cycle. As part of these AOP, provinces will need to identify focus MEV and propose strategies to reach these populations. Each AOP will also reflect on ethnic minority and gender issues as part of its safeguards requirements. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The project management unit (PMU) team will be tasked to check these AOP and assist the provinces with planning as needed. This has taken place for earlier ADB investments, but the practice should be strengthened.

55. Civil society representatives in this project will usually be village leaders, representatives from the Women's Union and other mass organizations, village health volunteers, malaria health workers, and peer educators. They will be engaged in event reporting, community preparedness and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use of mobile phone for reporting. MOH is encouraged to engage NGOs to provide services for hard-to-reach forest dwellers and remote ethnic groups but has not yet decided to do so through this project. Access to migrant labor camps, factories and casinos also requires the collaboration of factory owners. This will be negotiated with the Ministry of Labor and Social Welfare (MOLSW).

VI. Participation and Disclosure

a. Participation

56. For the past 30 years, extensive exchanges of views have taken place between MOH, provincial and district DOH, health offices and other government agencies, health centers and villages; and beneficiaries. There is quite a good understanding of priorities of the poor and ethnic groups, stemming in part, through implementation of the Model Healthy Village activity under ADB's CDC2 Project,[44] the GMS Strengthening Strategies for Malaria Control Project,[45] and other disease management and infrastructure projects. There is also some experience with resettlement projects, notably through the Nam Thuen 2 hydropower project.[46]

57. The development of migrant labor is a more recent phenomenon. Efforts to document and address the specific health priorities of migrants are fewer to date, and tend to be limited to specialized agencies such as the International Organization of Migration (IOM) and the International Labor Organization (ILO). There is little information on the actual health status and

[44] ADB. Second GMS Regional CDC Project. 2009.
[45] ADB. GMS Strengthening Malaria Control for Ethnic Minorities. 2005.
[46] The World Bank, Lao Nam Theun 2 Power Project PE-P004206-LEN).

health behavior of migrants. As such, there is a recognized need to enhance exchange of views with migrants to achieve at a better understanding of their health priorities.

58. Consultation of migrants is complicated because many are not registered or illegal, making them reluctant to report to health services The Government does not yet fully recognize the value of migrant workers as a major contributor to the economy, and as a group with specific needs and vulnerabilities, including labor rights, and specific health risks. Migrants face challenging working and living conditions making it more difficult for them to take part in participatory planning activities, or to engage them in health services.

59. During the project design phase, representatives of potential beneficiary populations were consulted in bokeo, Luang Namtha, Bolikhamsay and Khammouane provinces. This was easy for officials and the general public, but difficult for small ethnic groups and migrant laborers in factories, casinos, and labor camps. Access to migrant workers often requires authorization from MOLSW and support from ILO or IOM. In addition, certain economic zones, plantations, casinos and factories are practically off-bounds even for government officials. Based on this assessment, it is evident that there are no specific efforts to address the needs of MEVs. MEVs and their needs vary considerably by location. Specific implementation planning is required for each project province to response to these unique challenges and opportunities, as well as to ensure buy-in from local government and beneficiaries. Special arrangements will need to be put in place, not only for laborers in these workplaces, but to ensure that any outbreak of infectious diseases is quickly reported to the authorities.

60. During project implementation, arrangements will need to be made to identify and map the poor and vulnerable groups, continue dialogue, and engage them in a bottom up planning process. The Women's Union, other mass organizations and grassroots/community-based organizations may be engaged to ensure the voice of women and other vulnerable groups. Arrangements will need to be put in place to continue dialogue with communities during implementation, and engage communities in project monitoring.

61. The provincial project team including representatives of MEVs will prepare a five-year project plan and annual project plans as part of the regular provincial annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The team will also conduct participatory monitoring.

62. ADB will provide, in addition to the consultant currently attached the ADB resident mission, under a regional technical assistance, a consultant to facilitate this planning process. As part of project implementation, a chief technical adviser and a gender and social development expert will be engaged to assist the project management unit (PMU) to continue this process of support for implementing agencies in participatory planning of project activities, in particular to reach MEVs.

b. Disclosure

63. The project purpose and outline were shared with representatives of beneficiaries at the design stage. As part of the bottom up planning approach, there will be a preparatory planning process in each of the 12 participating provinces to identify MEVs and their health priorities, jointly prepare a five year and annual plans, and jointly conduct interventions and monitoring. This will ensure that beneficiaries are informed and participate at all project stages, and their

views are incorporated. The project design and implementation progress will be accessible on the website of the regional coordination unit: gmshealthsecurityprojectrcu@gmail.com and on the ADB website.

VII. Gender and Social Diversity

a. Issues

64. The project has been ranked as Category II: **effective gender mainstreaming (EGM)** as it will directly improve access of women to health services. Patterns of infectious diseases differ substantially among women and men, because of differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. In traditional Lao society, women will remain primary caregivers for the prevention, detection and care of infectious diseases amongst family members.

65. As reported in the ADB/World Bank Country Gender Assessment of 2012,[47] increased economic links with neighboring countries present a number of opportunities and risks. Both cross-border and domestic migration are more often undertaken by women. Those who go to work in Thailand are mostly young people from border areas aged 15–25 years old. A disproportionate number of migrants are women from Mon-Khmer and Tibeto-Burman ethnic groups. Precise figures are unavailable as most people migrate through irregular channels. Reports indicate that young women and girls who are victims of trafficking often end up in forced prostitution and domestic labor. The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas.

66. The National Commission for the Advancement of Women (NCAW) was established in 2003 as the national focal agency for gender mainstreaming in development policies and programs. The Lao PDR has no Ministry of Women's Affairs. Gender equality is an important national goal, which is reflected in the constitution, in major international commitments and in the establishment of the NCAW. However, there is insufficient effort to roll out a full-scale gender equality program inclusive of sector-wide gender strategy and action plan and indicators.

67. MOH has a gender focal point, who, until recently, focused on awareness raising within MOH, and further relies on program and project specific gender action plans due to lack of resources. Focal points may be lacking at provincial level. Implementation of gender action plans in previous health projects tended to be fragmented and unsatisfactory. Gender is sometimes not perceived as a major issue by some implementing officers in MOH.

68. The Lao Women's Union (LWU) is mandated to represent women of all ethnic groups and to "protect women's rights and interests." It is a party sponsored socio-political structure with representation in all villages and has substantial central and local powers and capacity. There are also other mass organizations that can be called upon to roll out programs to benefit women.

[47] ADB and World Bank. *Country Gender Assessment for Lao PDR – Reducing Vulnerability and Increasing Opportunity*. 2012. Vientiane.

b. Actions

69. The project has been categorized as effective gender mainstreaming (EGM) as it is not specifically targeting women as beneficiaries, but aims to ensure that women benefit at least equally from project interventions. Gender mainstreaming will directly benefit women, help improve communicable disease control outcomes, and address gender imbalances such as in training and in outreach services. Priority will be given to education of women and girls as they are more vulnerable and are the traditional custodians for the prevention, detection and care of sick family members. Priority will also be given to training female staff.

70. To ensure EGM and gender-related outcomes, a project Gender Action Plan (GAP) has been agreed with MOH that is aligned with sector-wide gender equality commitments. MOH will fully incorporate the gender mainstreaming strategies, included in the project GAP, into government project design documents, and provincial annual operational plans. National gender and social safeguards expert will be engaged. These key features are also mirrored in the project design and monitoring framework, loan assurances, and PAM, including disaggregated monitoring by gender. Unlike in Cambodia, there has not been a movement to articulate comprehensive sector gender programs. Accordingly, the project's gender action plan (GAP) may need to be adjusted based on later developments.

71. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of RRP, DMF, PAM, this PSA, PPMS, and covenants.[48]

72. The project, based on general good practice for gender endorsed by MOH, will enhance participation of women in all its activities:

(i) The executing and implementing agencies have active gender focal points for project activities;
(ii) The project engages a gender and social development expert with a focus on community activities;
(iii) Project implementation plans and annual operational plans (AOPs) will address gender dimensions;
(iv) The project will collect, analyze and report gender-disaggregated data;
(v) All project reports report on gender issues;
(vi) The project will proactively target youth and women at increased risk of infectious diseases;
(vii) Education materials and care procedures will be gender-sensitive;
(viii) Outbreak response and outreach services will ensure female participation;
(ix) Participation of female and male staff in training programs and scholarship will be equitable;
(x) Refurbishment of laboratories and isolation wards will be gender sensitive;
(xi) All regional, cross-border and cross-sector events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

[48] ADB. *Policy on Gender and Development*. June 1998. Manila; and Operations Manual Bank Policies Section C2/BP issued in December 2010.

VIII. Social Safeguards and other Social Risks

a. Ethnic Minorities

73. Ethnic minorities in the Lao PDR, excluding more recent migrants from the PRC, Viet Nam and other countries, constitute about 32% of the population and are mainly located in the hills and mountains of the country. They mainly belong to the Mon–Khmer, Hmong, and Tibeto–Burman language groups with a total of 43 officially recognized subgroups and 257 clans. They are increasingly participating in the national economy through migrant labor or business, and sometimes through resettlement. Studies report increased rates of infections among these communities associated with changing behavior and environment.[49] There remain remote ethnic minorities with a disproportionate burden of infectious diseases due to lack of awareness, poor living conditions, malnutrition, and lack of access to health services and health equity funds.[50]

74. Under output 1—disease control in hotspots in border districts—most of the focus villages around epidemic hotspots are predominantly inhabited by ethnic groups. Along with improving preparedness for emerging diseases, these groups will be assisted to access existing health services for communicable diseases through campaigns, training of village health workers, and mobile clinics. To address a shortfall of health workers in these locations in the long term, the project may also provide scholarships for ethnic students as health workers.

75. The project is expected to bring only positive impacts on ethnic minorities and is **categorized as B** for indigenous people's impact, the risk being that benefits or ethnic minorities are not realized.

76. The project is expected to have a positive impact on ethnic minorities in the proposed project areas through identification of disease outbreaks and major infections in ethnic minority communities, and linking them with better diagnostic health services. An indigenous people's plan has been prepared to help ensure that benefits for ethnic groups are realized.

b. Other Social Risks

77. The project will not entail land acquisition or civil works except for minor repair of laboratories and wards. A resettlement framework has been prepared in the event of a change of project scope. The proposed project is categorized C for involuntary resettlement.

78. The project is categorized as B for environment, as it involves improving laboratory and hospital waste management. Initial Environmental Examination and an Environmental Framework have been prepared. Each province will prepare an Environment Management Plan covering all project activities during implementation.

79. There will be no substantial impact on the local labor market. There will be short-term employment benefits from avoiding and containing epidemics, such in factories, schools and tourism. There will be long term health and labor standards benefits from improving education and health care of migrants.

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[49] WHO. *The Lao PDR Health System Review. Health Systems in Transition Vol. 4 No. 1* 2014.
[50] WHO. *The Lao PDR Health System Review. Health Systems in Transition Vol. 4 No. 1* 2014.

80. The project will not increase the price of health services but increased availability of services may increase health spending among the poor. Health interventions provided under current arrangements are usually free for public goods, and subsidized for the poor through the health equity funds. No payments are required for diagnosis and treatment associated with major communicable diseases. Increasing diagnostic facilities will also reduce travel time and costs. Subsidizing supplies will further reduce out of pocket spending. Selecting the most cost-effective diagnosis and treatment strategies will help ensure financial sustainability.

IX. Monitoring and Evaluation

81. Poverty and social indicators overlap with overall DMF indicators. Indicative DMF indicators are in table 1 and an indicative outline of poverty and social indicators is in table 2. These indicators will need to be disaggregated by gender/ethnic minority status, or, if this is not feasible, by location or key beneficiary group including the general public, migrants, ethnic minorities and other vulnerable groups. Project baselines and targets will vary considerably by province and are yet to be established through the provincial planning process.

Table 1: Suggested Project Indicators

a) Number of casualties due to any epidemic remains below 100 persons in any one-year period. Source: national communicable diseases control reports
b) Economic impact of any outbreak should remain below 0.5% of GDP in any quarter. Source: economic reports
c) APSED compliance increases from 70% to 85% from 2016 to 2021. Source: WHO/IHR assessment.
d) MEVs accessing health services in targeted areas doubled from 2016 to 2021 Source: health program and health facility statistics by gender and ethnic group;
e) All hospitals doing web-based disease reporting increases from 50% to 100% from 2016 to 2021. Source: Web-based surveillance and reporting system reports.
f) Targeted laboratories and hospitals meeting national quality and biosafety standards increased from 40% to 70% from 2016 to 2021 Source: Baseline and end-of-project assessments.
g) MEV communities contacted reach twice per year from 0% to 100% from 2016 to 2021. Source: outreach team reports
h) Regional, cross-border and intersectoral events conducted from 30 to 100 from 2016 to 2021. Event reports
i) Female participation in scholarships, workshops, training and other events doubled from 2016 to 2021. Source: event reports.
j) Provincial annual operational plans include special activities for MEVs from 0% to 100% from 2016 to 2021. Source: Management assessment

APSED: Asia Pacific Strategy for Emerging Diseases; CDC: communicable diseases control; IHR: GDP: gross domestic product; International Health Regulations; MEV: mobile and migrant people, ethnic minorities, and other vulnerable groups; WHO: World Health Organization.

Table 2: Suggested Indicators for Potential Project Poverty and Social Effects and Risks

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
1.1 Regional Cooperation	Regional meetings and workshops	Benefits poor living in border areas, potential for addressing issues of cross-border migrants including health care financing of migrants	Number of events that substantially address poverty and social issues
1.2 Cross-border cooperation	Provincial and district meetings	Potential for addressing health issues of ethnic groups and cross-border migrants in border areas	Proportion of project provinces that include poverty and social issues in cross-border activities
1.3 Intersectoral cooperation	Provincial meetings	Potential for addressing high risk behavior in youth	Proportion of project provinces include poverty and social issues in intersectoral meetings
1.4 Outreach	District and health center staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Tracking of number of vulnerable groups being reached based on mapping
1.5 communicable disease control in border areas	Provincial campaigns	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Number of beneficiaries being reached with various campaigns
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of focus on vulnerable groups	Number of regional workshops, presentations and reports address poverty and social issues
2.1 Surveillance	Provincial staff	Difficult to get reports from hard to reach places	Tracking of vulnerable groups being reached
2.2 Risk Analysis	Provincial staff	Lack of information from hard to reach communities including migrants	Information received from vulnerable groups including migrants
2.3 Outbreak Response	Provincial staff	Difficult to access remote places and labor camps	Tracking of vulnerable groups being reached including migrants
2.4 Community preparedness	District and Health center team	Difficult to access remote places and labor camps	Community preparedness sessions conducted by grassroots organizations
3.1 Laboratory Planning and Management	CDCD, NCLE	Insufficient attention to setting up transport system to obtain samples from health centers	Specimens received from other health facilities
3.2 Laboratory Pre-service training	DHS, Schools	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Profile of recruits and range of tests
3.3 Laboratory Quality Improvement	NCLE, hospitals	Insufficient competencies peripheral laboratory staff	Training of laboratory staff from district hospitals and health centers
3.4 Laboratory quality audit and assurance	CDCD, NCLE	Insufficient efforts in audit and QA for smaller laboratories	Pilot audit of smaller laboratories to understand the scale of the problem

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
3.5 Laboratory Upgrading Services	CDCD, NCLE	Insufficient effort to include tests that benefit the poor more	Range of tests provided
3.6 Laboratory Studies: causes of fever and immunization efficacy	NCLE	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Survey generates specific data for ethnic minorities and migrants
3.7 Hospital Infection Prevention and Control	DHS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Protocols being followed based on one-day observation (also staff)
3.8 Management of Highly Infectious Cases	DHS, hospitals	Cultural and language barriers to behavior of patient and visitors	Information dissemination for patients and visitors
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	DPIC, PMU, provinces	Insufficient attention to vulnerable groups for communicable disease control in border areas	Number of AOPs meet standards for addressing poverty and social concerns
4.2 Implement GAP, Safeguards, monitoring and Governance assurances	DPIC, PMU, provinces	Insufficient interest of PMU, provinces and districts in implementing these	Track implementation of gender action plan and social safeguards
4.3 Efficient financial Management and Procurement	DPIC, DOF, PMU, provinces	Insufficient capacity	Audit report, timeliness of procurement

AOP: annual operational plan; CDCD: Communicable Diseases Control Department; DHS: Department of Health Services; DOF: Department of Finance; DPIC: Department of Planning and International Cooperation; GAP: gender action plan; NCLE: National Center for Laboratory and Epidemiology; PMU: project management unit; QA: quality assurance.

X. Risk Assessment and Mitigation Plan

82. The project builds on the experiences gained in the GMS Communicable Disease Control (CDC) Projects[51] and HIV projects and is considered in general implementation terms low risk for MOH Lao PDR, similar to Cambodia, and Viet Nam. MOH Myanmar has limited ADB experience, and is considered moderate to high risk.

83. The project addresses poverty and social issues through its overall pro-poor and pro-vulnerable group design, and through its implementation arrangements to ensure proper project implementation. The project effects, risks, and enhancing or mitigating actions are in Table 3.

[51] ADB. 2013. *Completion Report. GMS Regional Communicable Diseases Control Project*. Manila.

84. The major challenges in this project in terms of addressing the needs of the poor and vulnerable groups are (i) not reaching the poor and vulnerable groups. This requires mobilization and possible support of grass-roots organizations; (ii) lack of, or inappropriate services for the poor and vulnerable groups; and (iii) lack of effort or focus on the needs of the poor and vulnerable groups. These need to be mitigated with proper planning, additional resources, and monitoring and assurances. Regional, cross-border and inter-sectoral cooperation also offers more long term opportunities to address the problems of vulnerable groups in border areas, e.g., through better targeting, reaching migrants and remote ethnic groups, and improving health financing for migrants.

85. Regional technical assistance will be provided to engage international consultants during the first project year to ensure a quick project start-up. The project will provide for international consultants including for chief technical adviser, gender and social safeguards, and other areas. In addition, Myanmar MOH will be assisted with upfront project implementation orientation and training. Several administrative risk and mitigating measures are summarized in the RRP.

Table 3: Potential Project Effects, Risks and Mitigating Actions

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
Output 1			
1.1 Regional Cooperation	Regional meetings and workshops	Insufficient strategic planning for improving access of MEVs to health services in border areas including health care financing of migrants and ethnic minorities and sharing best practices.	To mitigate the risk that this opportunity of planning for MEVs border areas is not used, this topic should be a permanent feature on any regional workshop agenda, and included in country reports.
1.2 Cross-border cooperation	Provincial and district meetings	Risk of not addressing health issues of ethnic groups and cross-border migrants in border areas.	Include this topic on all agendas and participants to report on progress and plans.
1.3 Intersectoral cooperation	Provincial meetings	Risk of not addressing high risk sexual behavior in youth and other priorities in border MEVs.	Include this topic on all agendas and participants to report on progress and plans
1.4 Outreach	District and health center staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons.	Ensure adequate resources, including motorbike, proper mapping and community consultations, include in AOP, supervise, monitor, covenant.
1.5 Communicable disease control in border areas	Provincial campaigns	Risk of not reaching vulnerable groups due to capacity constraints or other reasons.	Ensure adequate resources, proper mapping and campaign planning, include in AOP, supervise, monitor, covenant.
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of strategic focus on priority areas for CDC in GMS including reaching MEVs.	Ensure that workshops include strategic priority areas including reaching MEVs.
Output 2			
2.1 Surveillance	MOH, provincial staff, district staff	Weak surveillance at village level and in labor camps, factories and casinos and in the private sector, reach hard to reach places.	Provide motorbikes to improve mobility and provide training to improve local staff capacity in surveillance and response.

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
2.2 Risk Analysis 2.3 Outbreak Response 2.4 Community preparedness	MOH, provincial staff MOH, provincial staff, district staff MOH, district staff, health center staff	Insufficient data and data analysis Difficult to access remote places and labor camps. Difficult to access remote places and labor camps	Introduce syndromic reporting, and improve mobile phone reporting. Collaborate with the Ministry of Labor and provinces to pre-arrange legal cover for access of premises, and notify all company directors. Conduct mapping of all villages, labor camps, and private practices. Improve data collection system including disaggregated indicators and obtain specific information from MEVs including migrants.
Output 3			
3.1 Laboratory Planning and Management	CDCD, NCLE	Insufficient attention to setting up transport system to obtain samples from health centers	Include transport system in AOP and supply containers
3.2 Laboratory Pre-service training	DHS, Schools	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Encourage recruits from remote areas and inclusions of testing affecting the poor more
3.3 Laboratory Quality Improvement	NCLE, hospitals	Insufficient competencies peripheral laboratory staff	Give priority to these staff in training programs
3.4 Laboratory quality audit and assurance	CDCD, NCLE	Insufficient efforts in audit and QA for smaller laboratories	Include smaller laboratories in audit and QA
3.5 Laboratory Upgrading Services	CDCD, NCLE	Insufficient effort to include tests that benefit the poor more	Include tests that benefit the poor more as appropriate
3.6 Laboratory Studies: causes of fever and immunization efficacy	NCLE	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Stratify and enlarge sample to ensure adequate representation of vulnerable groups
3.7 Hospital Infection Prevention and Control	DHS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper education of patients and visitors
3.8 Management of Highly Infectious Cases	DHS, hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper information of patients and visitors, e.g., videos in various languages
Project Management			
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	DPIC, PMU, provinces	Insufficient attention to vulnerable groups for communicable disease control in border areas	Ensure mainstreaming of reaching vulnerable groups in AOPs, training, monitoring, covenant
4.2 Implement	DPIC, PMU,	Insufficient interest of PMU,	Provide training, include in central

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
Gender, Safeguards, monitoring and Governance assurances	provinces	provinces and districts in implementing these safeguards	and provincial AOPs, supervise, monitor, report, covenants
4.3 Efficient financial Management and Procurement	DPIC, DOF, PMU, provinces	Insufficient capacity in project management	Capacity building, monitoring, field inspection, audit

AOP: Annual Operational Plan; CDCD: Communicable Diseases Control Department; DHS: Department of Health Services; DPIC: Department of Planning and International Cooperation; NCLE: National Center for Laboratory and Epidemiology; PMU: project management unit; QA: quality assurance.

Appendix 1: Lao Project Location Details

Province Name	District Name	Villages	Population	Border	% Ethnic	% Poor (2013)
Phongsaly						**12.3**
	Phongsaly	82	37,408	China	95%	
	May	78	23,596	Vietnam	99%	
	Samphanh	78	26,877	Vietnam	95%	
	Boon neua	70	18,952	China	91%	
	Nhot ou	91	27,177	China	98%	
	Boontai	57	16,619	China	97%	
Luangnamtha						**16.1**
	Namtha	69	44,584	China	85%	
	Sing	85	30,790	China	85%	
	Long	75	28,705	Myanmar	80%	
Oudomxay						**30.1**
	Xay	89	68,726	China	75%	
	Namor	68	34,833	China	95%	
Bokeo						**44.4**
	Huoixai	98	68,380	Myanmar	65%	
	Tonpheung	51	27,186	Myanmar	70%	
	Meung	23	13,287	Thailand	65%	
	Paktha	47	20,254	Thailand	75%	
Huaphanh						**39.2**
	Xiengkhor	58	29,115	Vietnam	68%	
	Viengthong	65	26,392	Vietnam	64%	
	Viengxay	113	35,741	Vietnam	72%	
	Huameuang	74	30,820	Vietnam	54%	
	Xamtay	145	57,901	Vietnam	59%	
	Sopbao	58	27,735	Vietnam	74%	
	Add	65	27,324	Vietnam	67%	
Xiengkhuang						**31.9**
	Nonghed	85	39,432	Vietnam	45%	
	Morkmay	27	13,458	Vietnam	52%	
Borikhamxay						**16.4**
	Xaychamphone	38	37,401	Vietnam	34%	
	Khamkheuth	75	66,403	Vietnam	41%	
	Viengthong	41	31,573	Vietnam	38%	
Khammuane						**26.4**
	Bualapha	56	30,219	Vietnam	29%	
	Nakai	38	27,845	Vietnam	59%	
Saravane						**49.8**
	Ta Oi	44	34,208	Vietnam	87%	

Province Name	District Name	Villages	Population	Border	% Ethnic	% Poor (2013)
	Toomlarn	53	32,272	Thailand	65%	
	Samuoi	44	20,250	Vietnam	92%	
Sekong						**42.7**
	Kaleum	37	19,169	Vietnam	87%	
	Dakcheung	65	29,413	Vietnam	85%	
Champasack						**19.9**
	Paksxong	65	71,045	Thailand	73%	
	Pathoomphone	63	57,170	Cambodia	65%	
	Moonlapamok	45	47,125	Cambodia	43%	
	Khong	79	85,319	Cambodia	42%	
Attapeu						**8.9**
	Sanamxay	36	32,649	Vietnam	75%	
	Sanxay	34	22,194	Cambodia	68%	
	Phouvong	23	14,720	Vietnam & Cambodia	43%	
12	**41**	**2587**	**1,434,267**	**all border districts**	**959,410 (67%l)**	

Poverty and Social Analysis, Myanmar

Project number: 48118-REG
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R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

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Acronyms

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
AOP	annual operational plan
APSED	Asian-Pacific Strategy for Emerging Diseases
ASEAN	Association of South-East Asian Nations
CCS	community cost sharing
CEU	central epidemiology unit
DMF	design and monitoring framework
DMS	Department of Medical Services
DPH	Department of Public Health
EA	executing agency
EGM	effective gender mainstreaming
EMG	ethnic minority group
EID	emerging infectious diseases
GAP	gender action plan
GDP	gross domestic product
GMS	Greater Mekong Subregion
HIV	human immunodeficiency virus
HPAI	highly pathogenic avian influenza
IA	implementing agency
ICPS	interim country partnership strategy
IHLCA	integrated household living conditions assessment
IHR	international health regulations
INGO	international nongovernmental organization
IOM	International Organization for Migration
IPSA	initial poverty and social analysis
Lao PDR	Lao People's Democratic Republic
MDG	Millennium Development Goal
MEV	migrants and mobile people, ethnic minorities, and other vulnerable groups
MERS	middle-east respiratory syndrome
MICS	multiple integrated cluster survey
MOH	Ministry of Health
NCDP	national comprehensive development plan
NMPED	National Ministry of Planning and Economic Development
NGO	nongovernmental organization
NHL	national health laboratory
NTD	nontransmissible diseases
PCR	project completion report
PMU	project management unit
PPMS	project performance management system
PSA	poverty and social analysis
PSA	population services international
RRP	report and recommendations to the president
QA	quality assurance
SARS	severe acute respiratory distress syndrome
SPRSS	summary poverty reduction and social strategy
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Executive Summary

A Poverty and Social Analysis (PSA) was carried out for the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project), to be financed with support of the Asian Development Bank (ADB). The project will strengthen national health security systems and GMS cooperation for the prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance.

In 2014, Myanmar's population was estimated at 53.4 million, with about 20% living in urban areas and 40% belonging to ethnic minorities. Since 2011, following years of economic isolation, Myanmar has embarked on a program of four sets of reforms – political, institutional, economic and social – aimed at a return to democracy, inclusive economic growth, and social development. Parliamentary elections have been held and a new government has been formed. Myanmar's gross domestic product grew at 8.5% in 2014–2015, and may reduce to 6.5% in 2015–2016 due to floods and slowing investments, but is expected to continue at about 8.2% in the medium-term.[1] Per capita income reached $1,204 in 2015. Myanmar is richly endowed with natural resources, and well positioned for rapid economic growth among major economic powers in the region.

Myanmar's (extreme) poverty rate, based on an income poverty line of $1.20 per day, was reported by the Government as 25.6% in 2009–2010, while the World Bank reported the 2010 poverty rate to be 37.5% using a different methodology. To adjust for price increases, the World Bank has proposed to increase the income poverty line to $1.90.[2] The proportion of people living on less than $2 per day has remained about 70%. The rural poverty rate is twice the urban poverty rate, although there are signs of convergence. Multidimensional poverty rates are much higher.[3]

Health services are underutilized due to problems of access, availability of services, quality of care, but also high out of pocket spending. Since 2012, the Government has started to increase health sector financing and is planning to introduce health insurance towards universal health coverage. Communicable diseases are still the major burden of diseases, in particular among children and the poor, thereby also reflecting the state of the health system and living conditions.

With increasing regional connectivity and trade and an underperforming health system, the country, located in the center of the GMS, is particularly vulnerable to emerging infectious diseases (EIDs). Since 2000, there were outbreaks of SARS, avian influenza, swine flu, cholera, dengue, and hand, foot and mouth disease. It has a residual malaria problem with emerging drug resistance, a large burden of tuberculosis, and a concentrated HIV epidemic. Common communicable diseases such as diarrheal diseases and respiratory infections remain the major burden of diseases among children and the poor. Nosocomial infections and drug resistance are emerging public health problems. Infectious diseases that can easily spread with high mortality constitute a major public health and economic risks.

Migrants, isolated or traditional ethnic minorities and other vulnerable groups (MEVs) access health services even less. This partly explains, for example, low immunization coverage. However, these MEVs will often be more at risk of infections and may spread infections being

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[1] World Bank. 2015. *Myanmar Economic Monitor*. Washington DC.

[2] World Bank. 2015. *Myanmar: Empowering People for Inclusive Growth, Myanmar Country Partnership Framework for the Period 2015–2017.*

[3] UNICEF. 2015. *Social Protection in Myanmar: The Impact of Innovative Policies On Poverty.*

outside the health system. This leads to gaps in the surveillance, prevention, control, and management of infectious diseases, particularly along border areas.

Myanmar is committed to implementing the International Health Regulations (IHR) and the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), as well as implementing other WHO regional strategies for the control of major diseases such as dengue, malaria, tuberculosis and HIV/AIDS. Despite strong political commitments, insufficient effort is made for the control of these diseases. Myanmar is yet to comply with IHR and APSED standards.

The project will help strengthen national health security systems and GMS cooperation for the prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance, which, according to WHO, remain a major threat in the region. The project will enhance regional cooperation and disease control in border areas, strengthen disease surveillance and outbreak response, and improve laboratory services and infection control in hospitals. Total project costs in Myanmar for 2017 to 2022 are estimated at $14.9 million. The Department of Public Health, the Department of Medical Services, and the National Health Laboratory of the Ministry of Health (MOH) will lead project implementation in 5 states and one region along Myanmar's eastern border.

To help maximize project benefits and identify risks for the poor, a Poverty and Social Analysis (PSA) was carried out. In terms of project design, the project will help reduce poverty by contributing to protecting health and securing economic growth through the avoidance of major epidemics and reducing the burden of infectious diseases. The project will have only positive impacts on the poor and vulnerable groups in targeted border areas, in the form of village disease reporting, encouraging the use of health services and improving health screening for migrants, ethnic minorities and other vulnerable groups including women and youth (MEV). By targeting diseases that disproportionally affect the poor, targeting provinces with large numbers of poor people, and targeting MEVs, the project design helps maximize poverty impact.

However, the main concern is that central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its expected impact on extended millennium development goals (MDGs), in particular MDG*6*: halting or reducing the spread of communicable diseases. Through the containment of infections, the project will also have some indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the design and monitoring framework (DMF) and the project performance management system (PPMS).

I. Introduction

1. The Asian Development Bank (ADB) is planning to support the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project). A Poverty and Social Analysis (PSA) was carried out to help identify poverty reduction opportunities and risk and incorporate these in the project design to maximize poverty reduction impact. The PSA examines (i) project poverty dimensions, (ii) the links of the project to the national poverty reduction strategy and the country partnership strategy; (iii) the poverty targeting classification and its justification; (iv) key poverty and social issues of the potential beneficiaries, including impact channels and expected systemic changes; (v) opportunities and constraints for clients/beneficiaries - particularly poor and marginalized groups – stemming from project activities; and (vi) preparing design measures to achieve inclusive development outcomes during implementation. The PSA also summarizes gender impacts, scope of participation, social safeguards, and other social risks dimensions. The finding from the PSA will be reflected in the ADB Report and Recommendation from the President to the Board of Directors (RRP), the Design and Monitoring Framework (DMF), the Project Administration Manual (PAM), the Risk Analysis and Mitigation Plan, and the Project Performance Monitoring System (PPMS). The PSA follows the initial PSA (IPSA) prepared for the project concept, and is used to prepare the summary poverty reduction and social strategy (SPRSS), for the RRP.

2. Based on the issues flagged in the IPSA, the thematic areas that are covered in the PSA include (i) poverty and inequality; (ii) poverty and health; (iii) institutions, capacity, stakeholders, and participation; (iv) gender and social diversity; (v) social safeguards; and (vi) management of other social risks and vulnerabilities. The PSA includes (a) project summary, (b) poverty and social strategy and analysis, (c) results from the project PSA or due diligence including key poverty and social issues, beneficiaries, impact channels, other poverty and social issues, and design features, (d) participation and disclosure, (e) gender and social diversity, (f) social safeguards and other social risks, (g) monitoring and evaluation, and (h) risk assessment and mitigation.

II. Project Summary

a. The GMS Health Issue

3. Emerging infectious diseases (EID) are a global risk. The International Health Regulations (IHR),[1] 2005, of the World Health Organization (WHO) mandates all countries to achieve minimum health security standards against EIDs. Southeast Asia, with major population hubs and intensive livestock raising with associated biosafety problems, has been identified as being a likely site for outbreaks of EID – such as middle-east respiratory syndrome (MERS), highly pathogenic avian influenza (HPAI), or Ebola hemorrhagic fever (EHF)—with pandemic potential that may lead to significant mortality and economic meltdown.[2] The Asia Pacific Strategy for Emerging Disease (APSED),[3] 2010, of the WHO regional offices identifies 8 strategic areas for compliance by not later than 2016. At present, compliance has reached approximately 70–80% in the GMS, with specific gaps mainly relating to laboratory services,

[1] World Health Organization. 2005. *International Health Regulations*. Geneva.

[2] ADB ERD Policy brief no. 42 *Potential Economic Impact of an Avian Flu Pandemic on Asia* Erik Bloom, Vincent de Wit, and Mary Jane Carangal-San Jose. November 2005.

[3] WHO. Western Pacific Regional Office (WPRO). 2010. *Asia Pacific Strategy for Emerging Diseases 2010–2015*. Manila.

hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.[4]

4. There are increased risks for the spread of communicable diseases in Myanmar because of (i) improved connectivity, (ii) urbanization, industrialization with associated slum formation and labor camps, (ii) increased drug resistance, particularly for hospital infections, tuberculosis, malaria and HIV, (iii) reduced compliance with preventive measures like vaccination, and (iv) emerging and re-emerging diseases for which control measures are still being developed. The incidence of dengue has increased since 1980, with a major outbreak in 2007, and mainly affects children below 9 years.[5] Outbreaks of diarrheal diseases and other highly infectious conditions are also a major burden. Diseases preventable by immunization remain common due to low immunization coverage. While the burden of infectious diseases may have reduced, this is because of major efforts, and sustained financing will be needed to keep infectious diseases under control.

5. The Myanmar public health system has a large network of health facilities and health workers but has been seriously under-funded for a long time, resulting in serious underutilization and high out of pocket payment. The health sector will need time to recover and build up capacity. Despite these constraints, MOH has put in place a basic surveillance and response system that is connected to all hospitals and health centers. Villagers are obligated to report any outbreaks to health facilities, but sometimes this is not done or MOH lacks the means or time to investigate. Most of reporting is still done manually although mobile connectivity is good and internet connectivity is often up to township hospital level. Laboratory services are limited below state. Hospital hygiene and management of infectious diseases also needs to improve. Myanmar participates in cross-border and regional activities but needs to improve its regional preparedness and health security.

b. The Project

6. Under the GMS economic development program, ADB has been supporting various health projects for communicable diseases control, HIV, malaria, and related regional technical assistance.[6] This project aims to further reduce the burden of certain infectious diseases through a combination of preventive strategies, improved diagnosis and treatment protocols, better regional coordination, and improved health system management. The Governments of Myanmar, Cambodia, Lao PDR, and Viet Nam and ADB have prepared the project in order to strengthen national health security systems and regional cooperation for the prevention and control of EIDs and other diseases of regional importance in the GMS, and to help countries to comply with IHR 2005 and implement APSED of the WHO.[7]

7. The proposed project goal is strengthened GMS health security to reduce impact of outbreaks to less than 100 fatalities and less than 0.5% impact on GDP in any quarter of the year. The proposed project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED and (ii) increased communicable disease control coverage of MEV in border areas. The proposed project outputs are: (i) improved GMS collaboration and MEV access to communicable disease control in border areas; (ii)

[4] WHO WPRO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.
[5] Huy, R. et al. in bulletin of the WHO. 2010. *National Dengue Surveillance in Cambodia 1980–2008. Epidemiological and virological trends and in the impact of vector control*. Phnom Penh.
[6] In Myanmar: ADB. *Malaria and Communicable Diseases Control in the GMS*. Manila; ADB. *Myanmar: Capacity Building for HIV/AIDS Prevention.* Manila; and other technical assistance for the control of HPAI and malaria.
[7] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*. Manila.

strengthened national surveillance and response systems; and (iii) improved capacity to diagnose and manage infectious diseases. The project will focus on five states - Shan North, Shan East, Kayah, Kayin, and Mon – all of which have a majority ethnic minority population, and on region, Tanintharyi, which has a large migrant labor population.

8. With support of WHO, China and Thailand, MOH has made some progress with regional information sharing and cross-border cooperation for communicable disease control but needs to mainstream and formalize this. In border areas, MEV that are more likely to acquire and spread infectious diseases are not being reached through regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries, (ii) develops regional disease control strategies and evidence-based communicable disease control, and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring, as well as outreach and community mobilization to reach and engage MEV.

9. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong due in large part to investments from the Global Fund to Fight AIDS, Malaria and Tuberculosis. The system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level, (ii) web-based reporting including information technology support, (iii) integration of surveillance systems, (iv) risk analysis, communication, and community preparedness, (v) improving capacity of outbreak response teams including transport, and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

10. Health facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial or hospital-acquired infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance, (ii) in-service training, (iii) improving state/region laboratory services, and (iv) equipment and training for infection control and case management of dangerous diseases.

11. In Myanmar, the project is costed at $12.6 million, and financed by a $12.0 million loan from ADB and $0.6 million in government. The Ministry of Health (MOH) will be the Executing Agency (EA), represented by the Department of Public Health (DPH) and the Department of Medical Services (DMS). The National Health Laboratory (NHL), five states and one regional health department will be the implementing agencies (IAs). The project will be implemented over a period of five years beginning early 2017. The project completion date is 30 June 2022.

III. Poverty and Social Strategy

a. Government Strategy

12. Since 2011, following years of economic isolation, Myanmar has embarked on a program of four sets of reforms – political, institutional, economic and social - aimed at a return to democracy, inclusive economic growth, and social development. Parliamentary elections have been held and a new government has been formed.

13. The Government's strategic planning process of long term plans, five year plans, and medium-term frameworks is complex.[8] Reforms are guided by the framework for economic and social reforms, 2013[9] and the long-term national comprehensive development plan (NCDP).[10] The concept of equity has been included as part of the basic principles of the country, enshrined in successive constitutions.[11] The government's overall goal is inclusive economic growth and poverty reduction, while facilitating reduced vulnerability to natural disasters and climate change and the promotion of economic, social and political reform processes. Important new features are community driven development institutions that support local governance in service delivery; enhancement of employment opportunities for women and men; and township-led development plan, formulated through consultation with women, youth and marginalized populations. The national strategy on rural development and poverty alleviation.[12] has eight focus areas with an emphasis on rural productivity. The government has established planning and implementation committees and state/region, district and township levels.

14. The National Health Policy (1993) included an objective to extend health services to rural areas and to the border areas where the ethnic groups live.[13] Another important law is Prevention and Control of Communicable Diseases Law of 1995, revised in 2011.[14] The DPH is responsible for regional and cross-border cooperation, The Central Epidemiological Unit (CEU) in the DPH is in charge of surveillance and response. The NHL in the DMS is responsible for laboratory services, and the DMS is responsible for infection control in hospitals.

b. ADB Strategy

15. ADB's overall goal is poverty reduction according to ADB Strategy 2020, and regional cooperation is one of the pillars of this strategy.[15] The GMS partnership strategy prioritizes, among other issues, communicable diseases control, to mitigate the risks and negative impacts associated with increased regional connectivity, industrialization, urbanization, and economic growth, in particular in border areas and along economic corridors.[16]

16. ADB's Myanmar interim country partnership strategy (ICPS) 2012-2014, extended to 2016,[17] emphasizes transport; energy; agriculture and natural resources; education; and urban

[8] Government of Myanmar. Medium-term Priority Framework (2011–2014).
[9] Ministry of national planning and economic development. 2013. Framework for Economic and Social Reforms–Policy Priorities for 2012–2015 towards the Long-Term Goals of the National Comprehensive Development Plan, January 14, 2013 (MNPED, 2013).
[10] UNDP. 2012. Country Program for Myanmar (2013–2015).
[11] Government of Myanmar. 2008. Constitution of the Republic of Myanmar.
[12] International Fund for Agricultural Development. 2014. Myanmar Strategic Opportunity Program. Rome.
[13] Ministry of Health. 1993. National Health Policy.
[14] Ministry of Health. 2011. Prevention and Control of Communicable Diseases Law 1995, Revised 2011.
[15] ADB. 2008 Strategy 2020. Manila.
[16] ADB. 2012. GMS Strategic Framework. 2012–2022. Manila.
[17] ADB. Myanmar Interim Country Partnership Strategy 2015-2016. Manila.

development, including water and sanitation. Prior to reengagement with Myanmar in 2012, ADB had not had operations in the country since 1988. As a member of the Greater Mekong Subregion program, however, Myanmar has participated in ADB-assisted regional activities over the last 20 years, including in small activities in communicable disease control. ADB supports communicable disease control in Myanmar, with emphasis on integrating various communicable disease control initiatives for emerging diseases, malaria and HIV under one umbrella.

IV. General Poverty and Social Analysis

a. Poverty and Economic Growth

17. In 2015, Myanmar's population was estimated at 53.4 million, with about 20% living in urban areas and 40% belonging to ethnic minorities. Since 2011, following years of economic isolation, Myanmar has embarked on a program of four sets of reforms – political, institutional, economic and social – aimed at a return to democracy, inclusive economic growth, and social development. Parliamentary elections have been held and a new government has been formed.

18. Myanmar's gross domestic product grew at 8.5% in 2014-2015, and may reduce to 6.5% in 2015-2016 due to floods and slowing investments, but is expected to continue at about 8.2% in the medium-term.[18] Per capita income reached $1,204 in 2015, which is low in the Association of Southeast Asian Nations (ASEAN). Myanmar is richly endowed with natural resources, and well positioned for rapid economic growth among major economic powers in the region.

19. Myanmar's (extreme) poverty rate, based on an income poverty line of about $1.00 per adult per day, was reported by the Government and a group of experts as 25.6% in 2009–2010. The World Bank, using the 2009-2010 Integrated Household Living Conditions Assessment (IHLCA) of Myanmar reported that, if using MMK1,206 ($1.20 in 2015) per adult equivalent per day as the poverty line, the overall head count ratio of poverty is about 37.5%.[19] A $2 poverty line would include almost 75% of Myanmar people a poor.[20] Between 2005 and 2010, the poor person's gain in income was limited as the price of rice hiked in the same period.[21] To adjust for price increases, the World Bank has proposed to increase the income poverty line to $1.90. The rural poverty rate is twice the urban poverty rate, although there are signs of convergence. Multidimensional poverty rates are about twice as high.[22]

20. Transitory poverty (those that enter or escaped poverty) between 2005 and 2010 is substantial in Myanmar. About one-third of the population either fell into or escaped from poverty, suggesting that a sizeable part of the population is vulnerable to falling into and out of poverty. The number of 'transitory poor' is three times greater than the 'chronic poor', which means that a large share of the population may fall into poverty as a result of even minor shocks. Food expenses account for approximately 70% of household expenditure. Without sufficient savings or assets, many Myanmar households are also vulnerable to poverty as a result of a sudden increase in food prices. Accident or illness requiring hospitalization or long-term medical attention is likely to push households surviving just above the poverty level into

[18] World Bank. 2015. *Myanmar Economic Monitor*. Washington DC.
[19] IMNPED, UNDP. 2015. *Integrated Household Living Conditions Assessment* 2009–2010.
[20] World Bank. 2015. *Myanmar: Empowering People for Inclusive Growth, Myanmar Country Partnership Framework for the Period 2015–2017.*
[21] World Bank. 2014. Myanmar: *Rice Price Volatility and Poverty Reduction.* Washington.
[22] UNICEF. 2015. *Social Protection in Myanmar: The Impact of Innovative Policies On Poverty.*

poverty. Meanwhile, the poorest households are unable to cope financially, due to the combined lack of social protection mechanisms and the burden of out-of-pocket health expenditure.[23]

b. Poverty and Residence

21. Myanmar's population of 53.4 million, including about 40% ethnic minorities, is unevenly distributed across seven regions and seven states. Less than one-third of the population has access to the electricity grid, road density remains low, at 219.8 kilometers per 1,000 square kilometers of land area, and ICT connections are still underdeveloped, with mobile phone and Internet penetration rates at 20% and 10% in 2014, respectively. Two private telecom operators started operations in late 2014, which should facilitate significant increases in mobile phone and internet penetrations.

22. The incidence of poverty is linked to the poor having limited access to assets, public services, and education. The IHLCS shows poor families tend to have lower access to public services, such as proper sanitation and electricity. They also have limited access to credit, and poorer outcomes in education, as reflected in lower net enrollment rates for primary and secondary school compared to the non-poor. Chronic and severe underinvestment in education has limited the options available for the poor to escape from poverty and move to higher-paying jobs. While overall literacy rates are around 90%, there are differences between poor (84%) and non-poor (93%), and also in primary net enrollment rates between poor (81%) and non-poor (90%). Only 35% of children from poor households proceed to secondary school, compared with 59% of children from non-poor households. These gaps in access to assets, services, and education also appear across regions, with populations in the poorest regions having lower rates of access to services and education than better-off states and regions. For example, Rakhine state has one of the lowest net primary school enrollment rates of 71.4% (the union average is 87.7%) and 32.0% for secondary school (the union average is 52.5%).[24]

23. The NMPED reported that poverty rate in rural areas in 2009 was 1.8 times higher than in urban areas, based on IHLCA[25] compared to 1.6 in 2005, suggesting that inequality between urban and rural areas is increasing. UNICEF, in table 1, reports that, using the same data, urban and rural poverty are almost the same, using a different World Bank methodology.

24. While overall poverty trends are less clear, poverty rates are the highest in Rakhine region and Chin state; the highest numbers of poor households are found in Ayeyarwaddy (18.1%) and Rakhine (14.9%) followed by Mandalay (12.7%) and Yangon (11.8%), and the poverty incidence increased in Ayeyarwady, Kayin, Rakhine and Yangon.[26]

c. Poverty and Health

25. Among the 10 member countries of the Association of Southeast Asian Nations, Myanmar has the lowest life expectancy (65 years) and the second-highest rate of infant mortality (40 per 1,000 births) and child mortality (51 per 1,000 live births) for children below 5 years old.[27] The United Nations Development Programme's Human Development Index (HDI),

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[23] UNICEF. 2015. *Social Protection in Myanmar: The Impact of Innovative Policies On Poverty.*
[24] World Bank. 2014. *Ending Poverty and Boosting Shared Prosperity in A Time of Transition: A Systematic Country Diagnostic Report No. 93050-MM*.
[25] IMNPED, UNDP. 2015. *Integrated Household Living Conditions Assessment 2009–2010*.
[26] UNDP. *A Regional Perspective On Poverty in Myanmar. Stephan Schmitt-Degenhardt*. August 2013.
[27] ASEAN. 2015. *Statistics 2015.* Jakarta.

which measures achievements in terms of life expectancy, educational attainment and adjusted real income, ranked Myanmar at 149 out of 187 countries in 2012.[28]

26. The IHLCA (2009–2010)[29] and Multiple Indicator Cluster Survey[30] indicated a clear correlation between poverty and Millennium Development Goal (MDG) outcomes. About 33% of the children in the poorest wealth quintiles are underweight compared with only about 14% of those in the richest quintile. Myanmar is highly vulnerable to the spread of emerging diseases as there are many hotspots for the emergence of novel infections and drug resistance: border populations and isolated ethnic groups either lack services or do not want to access services.[31] The country is increasingly opening up by air, land and sea, thereby increasing its exposure to emerging diseases. The linkages between burden of disease and poverty and development are well known, as are the linkages between GDP growth and poverty reduction.[32]

27. Self-reported morbidity stood as 5.4% of the population in 2010, virtually identical to its 2005 level of 5.3%. Comparatively higher levels are found in Kayin (8.9%), Chin (8.1%), Kayah (8.0%) and Rakhine (8.0%). Moderate malnutrition levels stood at 32.0% in 2010, with the poor and non-poor at 35.0% and 30.6% respectively, and rural and urban dwellers, at 33.7% and 25.5% respectively. High levels are found in Rakhine (53.0%) and Shan (South) (48%). Severe malnutrition stood at 9.1% in 2010, a non-statistically significant decline from its 2005 level of 9.4%. There are differences in the rate of malnutrition between the poor and non-poor, at 10.2% and 8.6% respectively, and between rural and urban dwellers, at 9.7% and 6.9% respectively. Females have higher rates than males at 10.0% and 8.3% respectively. Particularly high levels of malnutrition among the poor are found in Shan (South) (18.5%) and Rakhine (16.3%). Overall, these data suggest a pattern of modest improvement over time, which is consistent with declines in food and income poverty.[33] The World Bank estimates that Myanmar loses nearly $400 million in GDP each year due to micronutrient deficiencies.[34]

28. Infant mortality and under-five mortality rates per thousand live births were 60 and 78, respectively, and maternal mortality ratio (MMR) was 255 per 100 000 live births for the whole country.[35] Mortality outcomes for both children and mothers were worst in the eastern Shan State. The Multiple Indicator Cluster Survey (MICS) in 2009[36] indicated consistently higher infant and child mortality in rural than urban areas throughout the period 1995-2010. While these mortality rates increased in rural areas between 2000-2001 and 2004-2005, urban areas showed consistent progress in mortality reduction. The same MICS revealed disparities in infant and child mortality by gender, maternal education and wealth quintiles, where male children, lower education status of mother and the two poorest quintiles had worse outcomes.[37]

29. Geographical access to health care was around 81% in 2010, compared to 65% in 2005. There are slight differences in access between the poor and non-poor, at 77% and 82% respectively, and larger differences between rural and urban dwellers, at 75% and 96%

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[28] UNDP. *Annual Report 2012*. Washington.
[29] NMPED, UNDP et al. 2001. *Integrated Household Living Conditions Assessment in Myanmar (2009–2010*).
[30] NMPED, MOH, UNICEF, 2011. *Multiple indicator Cluster Survey. 2009–2010*.
[31] Gupta, Indrani, and Pradeep Guin. Bulletin of WHO. 2010. *Communicable Diseases in the South-East Asia Region of the World Health Organization, towards a more effective response*.
[32] WHO Myanmar. 2014. *Country Cooperation Strategy Myanmar. 2014–2018*.
[33] Ministry of Health. 2013. *National plan of Action for Food and Nutrition (2011–2015).*
[34] World Bank. 2009. *Nutrition at a Glance: Myanmar.*
[35] Ministry of Planning and Economic Development, Ministry of Health, UNICEF. 2001. *Multi Indicator Cluster Survey.*
[36] NMPED, UNDP et al. 2011. *Integrated Household Living Conditions Assessment in Myanmar (2009-2010).*
[37] NMPED, MOH, UNICEF. 2011. *Myanmar Multiple Indicator Cluster Survey 2009–2010 Final Report.*

respectively. Low rates of access are found in Sagaing (62%) and Chin (68%).[38] Public health services are well planned but under resourced with limited staff capacity, in particular in rural areas and especially those having security problems. The challenges include overcoming the impact of prolonged and serious underfunding of the health sector, improving availability and distribution of human resources, and making agreements with local groups for the provision of health services.[39]

30. Following the health financing reform with the introduction of user charges in public hospitals, private households continued to be the main source of finance for health care, accounting for 82-91% of total health expenditure throughout the period 2001–2009, although declining to near 70% in 2010 and 2011. Out of pocket payments made by households were well beyond the benchmark of 30% recommended to avert catastrophic health payments. Out of pocket spending by private households remain the main source for financing health care in the country. This is highly regressive because poor families have to pay the same amount for healthcare as rich households.

31. There is no formal coordinated social protection mechanism to prevent families from falling into poverty as a result of health payments. Only a small proportion of formal-sector workers are covered by the current formal social-security system. The government has started to take the initiative to introduce formal social protection in the country and MOH is in the process of introducing some community-based and demand-side approaches as interim measures while the Social Protection System is in the developmental stage. Only 3.2% of Myanmar's population is covered by the government's social protection programs and only 0.1% focus on the poorest and most vulnerable.[40] Traditional support structures such as families and communities are, with increasing demand for essential care, insufficient to finance health services.

d. Poverty, Gender and Social Diversity

32. The risk of poverty is particularly acute among landless rural households. More than 7 out of 10 households in Rakhine and Chin are below the poverty line; households in those states are among the poorest in the world. In Rakhine, the depth of poverty compounds the high incidence of poverty and many poor households are at some distance below the poverty line.[41]

33. Myanmar is prone to natural disasters with its coastal regions being exposed to cyclones and tropical storms, and the whole country at risk from earthquakes. Cyclone Nargis had a severe impact on the health system and its capacity to deliver essential services.[42] Response to the cyclone, however, demonstrated the resilience of the affected villages and the capacity of communities of all ethnic and religious groups to help themselves and implement relief activities harmoniously. Traditional social welfare support systems played a role at village level and survivors spontaneously formed self-help groups. Following this devastating cyclone, opportunities for INGOs and other partners to work with the Ministry of Health (MOH) in a collaborative manner in the Ayeyarwady delta area have increased dramatically.

[38] WHO WPRO. 2014. *The Republic of the Union of Myanmar: Health System Review. Health Systems in Transition Volume 4, no 3 201*4. Manila.

[39] WHO WPRO. 2014. *The Republic of the Union of Myanmar: Health System Review. Health Systems in Transition Volume 4, no 3 2014. Manila*.

[40] Unicef. 2015. *Social Protection in Myanmar: The Impact of Innovative Policies On Poverty.* 2015

[41] SIDA UNICEF UNDP. 2011. *Integrated Household Living Conditions Assessment in Myanmar (2009–2010) Poverty Dynamics Report.*

[42] WHO Myanmar. 2014. Country Cooperation Strategy Myanmar. 2014–2018.

34. The role of women in Myanmar society has historically been more restricted. Daw Aung San Suu Kyi said, "*Women are generally regarded as home-makers, tenders of the hearth around which the family gathers, weavers of the gentle ties that bind faster than the strongest iron chains*".[43]

35. Myanmar has shown substantial improvement in women's health indicators. For example, the maternal mortality ratio reduced from 453 to 178 per 100,000 live births between 1990 and 2015.[44] Even so, about ¾ of deliveries take place at home, where nearly 90% of maternal deaths occur. Nearly 10% of all maternal deaths are abortion-related. Myanmar also has a high adolescent fertility rate at 16.9%, mainly because of the lack of sex education.[45] The health workforce has a high proportion of 75% female health workers, but half of these work in urban areas. Women are underrepresented in rural areas, at higher levels, and participating in regional meetings and outreach services.

36. Ethnic minority group (EMG) populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.[46]

37. Isolated EMGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel reluctant to access services.[47] Programs for behavior change are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EMG villages.

38. Provision of free health insurances has enabled poor EMGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered under the Government scheme. The Government is exploring how to move to Universal Health Coverage in accordance with the relevant Sustainable Development Goal.[48]

e. Poverty, Migration, and Resettlement

39. Population surveys indicate a shift from small towns or cities to bigger towns or cities in search of better social and economic opportunities. Migration also takes place as workers seek employment in rubber plantations, and gold and jade mines. About 0.7% of Myanmar's population emigrated during 2000 and at least 3 million people from Myanmar migrated to neighboring countries for economic, social and political reasons, with two million migrating to

[43] Sen B, Burma Lawyers' Council. 2015. Women and Law in Burma.

[44] http://data.worldbank.org/indicator/SH.HIV.1524.FE.ZS.

[45] United Nations Country Team (Myanmar). 2011. *Thematic Analysis 2011: Achieving the Millennium Development Goals in Myanmar*. Yangon.

[46] Gupta, Indrani, and Pradeep Guin. Bulletin of WHO. 2010. *Communicable Diseases in the South-East Asia Region of the World Health Organization, towards a more effective response.*

[47] WHO WPRO. 2014. *The Republic of the Union of Myanmar: Health System Review. Health Systems in Transition Volume 4, no 3 2014*. Manila.

[48] MOH. 2012. *Health System Assessment for Universal Health Coverage.* Nay Pyi Taw.

Thailand alone. The majority of these migrants are of irregular status, and unofficial migration is thought likely to be significantly higher than official migration.

40. Only 6.3% of households have migrant workers, with poor households being about 30% more likely to have migrant workers than non-poor households. There are variations between states: Chin, Taninthayi and Kayin have up to five times more households sending migrants than the national average, and send out the most migrant workers out per household. Remittances make up about 57% of overall household expenditures for those households who receive them (75% for rural and 45% for urban households), but at Union level the importance of remittances is not large at only 3.4%.[49]

41. Migrant workers are exposed to risks of acquiring malaria infections and HIV. In Myanmar, 71% of the population lives in malaria risk areas (29% in high-risk areas, 24% in moderate-risk areas, and 18% in low-risk areas). Alongside those who reside in high-risk areas, other populations at higher risk include internal migrants (laborers in development projects, construction and extraction industries such as dams, irrigations, road, mining, logging, rubber plantation); people who have resettled in endemic areas, subsistence farmers in the forest and forest fringes, wood and bamboo cutters; and other forest-related workers. Similar exposures to similar risks also exist among migrant workers working across the borders in neighboring countries. Although the government has launched special health programs for migrants from Myanmar (both internal and cross-border) at risk through collaboration with INGOs, there is a lack of appropriate government policies and programs to address the needs of migrants, addressing root causes like poverty and conflict.

42. Nearly seven decades of internal conflict in Myanmar have harmfully affected the lives of hundreds of thousands of civilians in Myanmar's border areas. WHO has estimated that more than one million people are internally displaced in the eastern border area of Myanmar.[50]

43. Ethnic minority groups (EMGs) in GMS border areas can no longer be thought of simply in terms of disadvantage due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. EMGs are beginning this process of integration from a very disadvantaged position. Migrants, EMGs and other vulnerable groups (MEVs) such a youth and pregnant women need special attention in any health administration, but this is often not happening, in part because health plans are disease-focused.

44. Relocation and/or resettlement of EMGs have been supported by governments and donors for various reasons. In some provinces, movements of highland EMGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas. When highland-dwelling EMGs move to lower altitudes, they are exposed to malaria, to which they have little acquired resistance, so in the early phase of relocation to lower altitudes, there have been high mortality rates from malaria, as well as morbidity resulting from exposure to other water-born and environmentally-related infectious diseases.

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[49] UNDP. *A Regional Perspective On Poverty in Myanmar. Stephan Schmitt-Degenhardt*. August 2013.

[50] WHO. *The Republic of the Union of Myanmar health system review (Health Systems in Transition*, Vol.4 No. 3 2014.

f. Institutions, Capacity, Stakeholders, and Participation

45. The Prime Minister's office, Myanmar, provides oversight to poverty reduction and social inclusion, through various ministries led by the national ministry of planning and economic development. The Ministry of Health (MOH) is mainly concerned with poverty reduction and social inclusion through the provision of public health services. Multiple religious, state-based and community-based organizations contribute to services, advocacy, mobilization and participation. State-based organizations and national and international non-government organizations (NGOs) play major roles in health services delivery, in part because of the government's constraints – financing, staff, security, regulations – to reach out to remote areas. As international partners are likely to seek adjustments, the new Government will need to make a decision on public and private roles in health services delivery. Currently, MOH appears to consider both wanting to expand public services, but also wanting to attract more partners to deliver health services.

46. Government agencies have limited capacity to reach out to isolated communities due to financing and transport constraints and small travel allowances. Other issues may also play a role, such as concerns about security, efficiency (focus on low hanging fruits) and language problems in addition to a lack of interest for fieldwork. At community level, community based midwives, a prestigious but seriously underpaid job, work as all-round health workers and on the whole do an outstanding job. Among others, they provide support to the village health committee, health volunteers, peer educators and others.

47. Given these constraints, the government has a long road ahead to achieve the overall goals of inclusive economic growth and poverty reduction, facilitating reduced vulnerability to natural disasters and climate change, and promoting economic, social and political reform processes. Important new features are community driven development institutions that support local governance in service delivery; enhancement of employment opportunities for women and men; and township-led development plan, formulated through consultation with women, youth and marginalized populations. The national strategy on rural development and poverty alleviation.[51] has eight focus areas with an emphasis on rural productivity. The government has established planning and implementation committees and state/region, district and township levels.

48. The concept of equity has been included as part of the basic principles of the country, enshrined in successive constitutions. The National Health Policy (1993) also included an objective to extend health services to rural areas and to the border areas, which are home to a high proportion of ethnic minority communities. In collaboration with the Ministry for Progress of Border Areas and National Races and Development Affairs, more health care facilities have been developed and incentives provided for the health staff working in these facilities.[52]

49. To protect the poor from financial burden related to seeking health care when user charges were introduced, MOH issued a directive to exempt indigents from paying. An evaluation of the equity implications of community cost sharing found no systematic arrangement for exempting the poor. Between 2001 and 2005, a Rural Health Development Plan was formulated, and public hospitals were instructed to raise and establish trust funds and to use the bank interest earned from these funds to cover the costs of waivers. However, these interventions did not raise sufficient revenue to bring down the out of pocket payment and

[51] International Fund for Agricultural Development. 2014. *Myanmar Strategic Opportunity Program*. Rome.
[52] MOH. 2012. *Health System Assessment for Universal Health Coverage*. Nay Pyi Taw.

financial burden faced by the poor. In addition, community-based financing mechanisms introduced by partners had limited coverage and were unable to generate sufficient revenues to cover the costs of the poor. A study published in 2015 estimated that 37.1% of 437 sampled households had suffered catastrophic health payments, defined as health spending of at least 10% of total household spending. If defined as 40% of non-food spending, this was 32.9%.[53]

V. Project Poverty and Social Analysis (Due Diligence)

a. Key Poverty and Social Issues

50. Back in 2010, 22.7% of Myanmar's citizens were earning less than $1.20 per day and almost 75% were earning less than $2.00 per day. Due to strong economic growth, the number of poor may have halved since then. Rakhine and Chin states were the poorest states in 2010. With industrialization and migration, rural-urban imbalances in poverty rate may be reducing. Myanmar is still among the poor countries in ASEAN, but developing rapidly.

51. In addition to the poor in general, there are vulnerable groups that are at increased risk of infectious diseases such as isolated ethnic minorities not using regular health services such as for tuberculosis control, migrant laborers in labor camps, and resettled people. Women are also more at risk due to high workload, poor nutrition, and pregnancy, and may also have less physical and financial access to services compared to men.

52. With better regional connectivity, trade, industrialization and urbanization, the country, located in the center of the GMS, is increasingly exposed to EIDs. Since 2000, there were outbreaks of several emerging and re-emerging diseases, cholera, dengue, and hand, foot and mouth disease. Other diseases of regional importance such as malaria, tuberculosis, and HIV/AIDS also need more efforts to bring these under control. Nosocomial infections and drug resistance are on the increase.

53. The public health system is basic and seriously underused due to resource constraints. Many rural people, in particular the poor, migrants and traditional ethnic groups, do not use these services because of poor physical access, social acceptability, quality of care, or affordability. This leads to gaps in the surveillance, prevention, control, and management of infectious diseases, particularly along border areas. People in border districts and migrants are less informed about health hazards, are more at risk, and have less access to services.[54] MEV are often not reached by any qualified health services. As the general public health status improves, those not reached by the health system will continue to pose health security risks to themselves and others.

54. Hard to reach populations, including MEV, are often not covered by national disease surveillance programs, including syndromic reporting by community volunteers at commune level. Hence, an outbreak of EID, dengue or other disease may go unnoticed for a while, thereby making control more difficult and costly. MEVs not accessing control programs also decreases the efficiency of these programs, and leaves these communities vulnerable to undetected slow epidemic outbreaks. Public health services need to strengthen strategy, means and commitment to reach these MEVs.

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[53] Oo Win Myint et al Myanmar Medical Journal. 2015. *Catastrophic Expenditure for Health care in Myanmar.*

[54] WHO. 2013. *Bilateral Meeting on Healthy Borders in the Greater Mekong Subregion, Session 5. Health Situation and Health Systems Analysis: Cambodia, Lao PDR, Myanmar, Thailand, Viet Nam.* Bangkok.

55. Until very recently, social protection interventions in Myanmar were minimal and fragmented, thereby forcing families to provide for themselves in dire and hazardous circumstances. In December 2014 the Office of H.E. the President of Myanmar endorsed a new national social protection strategy, introducing an innovative vision for the reduction of poverty and vulnerabilities affecting the Myanmar population. The challenges include overcoming the past low investment in rural health services and inadequate funding for expansion of universal health coverage.

56. The project will assist the government in reducing poverty by improving prevention and control of infectious diseases in general, and encouraging MEVs to access health services. Key feature will be strengthening surveillance and response systems, helping communities to improve disease identification and response, improving laboratory diagnostic capacity, and improving management of infectious diseases in hospitals.

57. This project does not explicitly target the poor, but communicable disease control, especially in areas of Myanmar bordering other GMS countries can contribute to poverty reduction both directly and indirectly. Migrant labor to Thailand and other adjoining countries makes a very significant economic contribution in Myanmar, and their remittances help poor households disproportionately. If a transmissible disease crosses a border and reaches the epidemic stage in urban areas, the poor are at greatest risk because of their living conditions, occupational exposure, and lower access to healthcare.[55]

58. To further enhance project impact, the Government needs to increase health sector financing to ensure that priority program for infectious diseases control are available and free of cost. This is a challenge as major partners may want to pull out of country assistance at some point. For the foreseeable future, the Government may want to consider developing a government-financed national health insurance system rather than a more complex social health insurance system.[56] This would need to be complemented with investments in hospitals and community-based investments to improve prevention, control, and management of diseases.

b. Beneficiaries

59. The larger part of investment of the project will benefit the general public, while a small part of the project is targeting MEVs. These MEVs are more likely to be exposed to and spread different types of diseases and drug resistance, depending on their location and occupation, and in general have less access to health services.

60. The project targets five states and one region out of a total of 14, in the eastern part of the country along the borders with Thailand, Lao PDR and PR China. The focus states and region have been selected because they are deemed to be at increased risk of epidemic outbreak of communicable diseases, not because these are mostly poor provinces. Nonetheless, the five focus states - Shan North, Shan East, Kayah, Kayin, and Mon - have a majority ethnic minority population (who are frequently also poor), and the one focus region, Tanintharyi, has a large migrant labor population. Targeting economic corridors will help safeguard gains in connectivity by reducing possibilities for disease outbreaks along these routes. Within these 5 states and one region, 6 capital townships and 6 border townships have been selected.

[55] ADB. *Myanmar: Unlocking the potential. 2014.* Manila.

[56] Arguments in favor of a revenue-based health insurance system could that Myanmar is partly a resource-based economy, has a large informal sector, has 75% poor or near poor, has high out of pocket payment, has poor quality of health services at low cost, and has very limited fund management or even book keeping capacity.

61. The total catchment population in the 5 states and 1 region is estimated at 11.1 million (2015), with about 2.2 million living in the 13 targeted townships including 2.0 million ethnic minorities and 0.7 million living in the 6 border townships (Appendix 1). The number of poor in 12 townships is estimated at 2.0 million, based on state-wide poverty rates. By targeting border areas, the project is disproportionally targeting the poor.[57] Within the states/region, the project is not specifically targeting the poor but generally improving surveillance and response, laboratory services, and hospital infection control. Within the selected townships, MEVs in transit, in isolated villages or in labor camps will be targeted for local priority interventions under output 1. Project inputs will be made available to reach these MEVs.

c. Impact Channels

62. The impact channels are shown in Table 1. The majority of resources will be used for state/region wide improvement of community preparedness, disease surveillance, and outbreak response. This will positively impact those in the project area through timely containment of epidemic outbreaks and the concurrent reduction of disease impact. MEV, who are negatively impacted by epidemic outbreaks, Public health services are well planned but under resourced with limited staff capacity, in particular in rural areas. Poor and vulnerable groups will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

63. In selected townships, the project will conduct mapping to identify and prioritize MEV communities at increased risk of communicable diseases and not being assisted otherwise. With participatory planning and project resources, MEV communities will be offered outreach services, campaigns, and referral for free health services to improve recognition and reporting of diseases, community preparedness, hygiene and sanitation, and access to free disease control programs. By focusing these activities in border areas, the project will ensure impact among MEV, including the poor, and hard to reach populations. Beneficiaries in the project area will have positive health impacts though closer and more immediate contact with health services, including more effective diagnosis and treatment through improved laboratory functions. Expenses incurred through travel to health service providers will be used more efficiently.

64. The project further aims to raise awareness among health care providers and communities of the importance of including all members of the population – including those in hard to reach populations – in order to achieve both public health security and universal health coverage. This will be done through meetings, workshops and training, and the annual planning and budgeting cycle and monitoring and supervision systems.

d. Other Poverty and Social Issues

65. Despite the general commitment of the government to strengthening and updating primary health care, the provision of recurrent budget for staffing, maintenance of facilities and supply of essential drugs is considered inadequate. Disparities still exist in access to services and health outcomes across regions and social economic status. The majority of households, particularly the poor, have to rely on private health care providers due to physical proximity, shorter waiting times, timely availability of staff and drugs, and perceived quality of care. The government introduced various strategies and measures including the community cost

[57] IMNPED, UNDP. 2015. *Integrated Household Living Conditions Assessment* 2009–2010.

sharing (CCS) scheme to increase community participation, private-sector involvement and cost recovery. Projects such as Population Services International (PSI) have been effective in bringing essential services and supplies to most parts of Myanmar.

66. Despite the policy statement to expand services to the rural and border areas, evidence indicates large disparities in access to and utilization of health services. Access to and utilization of services such as delivery in health care facility, childbirth attended by skilled personnel and children under five years of age with diarrhea treated with oral rehydration were more common in urban than in rural areas.[58] Educated mothers tended to deliver in health care facility and be attended by skilled personnel. Residents in large regions – for example, Yangon and Tanintharyi - were more likely to have better access to and utilization of health services in terms of delivery in facility and being treated with oral rehydration when having diarrhea, than those in smaller states, such as Chin and Shan.[59] Similarly, those better off economically had better access to and utilization of health services.[60]

67. To further illustrate differences in accessing health care, immunization coverage against measles stood at around 82% in 2010, with considerable differences in coverage between the poor and non-poor, at 76% and 86% respectively, and between rural and urban dwellers, at 80% and 92% respectively.[61] There is moderate regional/state variation, with particularly low levels in Rakhine (67%).[62] Antenatal care coverage stood at around 83% in 2010, with moderate differences in access between the poor and non-poor, at 77% and 86% respectively, and differences between rural and urban dwellers, at 81% and 93% respectively.[63] Particularly low levels are found in Chin (60%) and Rakhine (67%). Overall, 78% of births were attended by skilled personnel in 2010.[64] There are considerable differences between the poor and non-poor, at 69% and 81% respectively, and differences between rural and urban dwellers, at 74% and 93% respectively. Again, particularly low levels are found in Rakhine (55%) and Chin (61%).[65]

e. Design Features

68. Given the country's exposure and people's vulnerabilities, combined with a fragmented and under-resourced health system, investment in public health security is a high priority in Myanmar. Any major outbreak of EIDs or other epidemic diseases like malaria and dengue will have a major impact on the public in general, the poor, and MEVs who have less access and means for help.

69. Myanmar is committed to implementing the International Health Regulations (IHR) and the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), as well as implementing other WHO regional strategies for the control of major diseases such as dengue, malaria, tuberculosis and HIV/AIDS. Until recently, investment in health security, managed largely by the central epidemiology unit (CEU), was run on shoestring and

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[59] *The Republic of the Union of Myanmar 2014. Health System Review. Asia Pacific Observatory On Public Health Systems and Policies. Vol. 4 No. 3.*

[60] *The Republic of the Union of Myanmar 2014. Health System Review. Asia Pacific Observatory On Public Health Systems and Policies. Vol. 4 No. 3.*

[61] *UNICEF. 2015. Social Protection in Myanmar: The Impact of Innovative Policies On Poverty.*

[62] *UNICEF. 2015. Social Protection in Myanmar: The Impact of Innovative Policies On Poverty.*

[63] *UNDP. 2013. A Regional Perspective On Poverty in Myanmar.*

[64] *The Republic of the Union of Myanmar 2014. Health System Review. Asia Pacific Observatory On Public Health Systems and Policies. Vol. 4 No. 3.*

[65] The Republic of the Union of Myanmar *Health System Review. Asia Pacific Observatory On Public Health Systems and Policies. Vol. 4 No. 3 2014***.**

often coopted resources. The demonstrated know-how, commitment and efforts of the ENU in dealing with disasters and epidemics is impressive and a strong foundation for upgrading the public health security system. Myanmar is still years away from compliance with IHR and APSED standards due this year, 2016.

70. The project will help strengthen national health security systems and GMS cooperation for the prevention and control of EIDs and other diseases of regional importance, which, according to WHO, remain a major threat in the region. The project will enhance regional cooperation and disease control in border areas, strengthen disease surveillance and outbreak response, and improve laboratory services and infection control in hospitals. Total project costs in Myanmar for 2017 to 2022 are estimated at $12.6 million. The Departments of Public Health and Medical Services, the National Health Laboratory and 5 states and 1 region will be responsible for project implementation centrally and along Myanmar's eastern border with China, Lao PDR and Thailand.

71. The project helps prevent and control infectious diseases that disproportionally affect the poor. The first output, *enhanced regional cooperation and communicable disease control in border areas*, is specifically targeting cross-border cooperation and outreach for MEVs in border areas: groups that are also frequently poor. The second output*, strengthened surveillance and response*, is to further build on earlier investment in the CEU and state/region surveillance and response systems, including computerized reporting for all hospitals and introducing syndromic reporting at village level. The third output, *improved laboratory and hospital infection prevention and control* will focus on the state/region level, with additional training and supplies for township hospitals. The second and third outputs will benefit the general public in these targeted states and region.

72. Output 1 will actively seek to improve MEV access health services, in particular also accessing control programs for HIV, tuberculosis, and malaria. These programs are co-funded by the Global Fund and the Government and provide counseling, rapid test diagnosis, and follow up care including access to treatment. Many MEV are reluctant to access these services in view of concerns about availability and affordability of services and social stigma. Free health services for these diseases have been made available so MEV should be encouraged to use these services. Engaging MEV will also provide opportunities to improve community preparedness and public health security against emerging infectious diseases, as well as work with communities for the prevention of other diseases, such as dengue and cholera.

73. The linkages between the burden of disease and poverty and development are well known. The project's poverty reduction impact depends on (i) the project design, and (ii) implementation arrangements. To help maximize project benefits and mitigate risks for the poor, a Poverty and Social Analysis (PSA) was carried out. To enhance project impact for the poor, the project targets infectious diseases that affect the poor more at multiple levels, targets poor locations, and targets MEVs. Implementation arrangements including PMU and annual planning and monitoring should further enhance impact.

74. The main concern is that, during implementation, central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has

confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

75. The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its potential impact on the extended ***MDG6***: halting or reducing the spread of communicable diseases. Through the containment of infections, the project will also have some indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the design and monitoring framework (DMF) and the project performance management system (PPMS).

76. The project will require that provinces prepare annual operational plans (AOP) to receive project funding. Each province will propose, through needs assessment, consultations, and detailed preparation, project investment as part of its regular annual health planning cycle. As part of these AOP, provinces will need to identify focus MEV and propose strategies to reach these populations. Each AOP will also reflect on ethnic minority and gender issues as part of its safeguards requirements. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The project management unit (PMU) team will be tasked to check these AOP and assist the provinces with planning as needed. This has taken place for earlier ADB investments, but the practice should be strengthened.

77. Civil society representatives in this project will usually be village leaders, representatives from local organizations, village health volunteers, malaria health workers, and peer educators. They will be engaged in event reporting, community preparedness and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use of mobile phone for reporting. MOH is encouraged to engage NGOs to provide services for hard-to-reach forest dwellers and remote ethnic groups but has not yet decided to do so through this project. Access to migrant labor camps, factories and casinos also requires the collaboration of factory owners. This will be negotiated with the Ministry of Labor and Social Welfare (MOLSW).

78. ADB has limited experience working with MOH, but MOH has worked with many partners and is strengthening its financial and procurement capacity. While officers are highly competent, one concern is limited human resources in MOH and in the National Health Laboratory. A PMU will be established to support project implementation.

79. The current ADB ICPS 2015-2016 builds on the ICPS 2012–2014 which focuses inter alia on capacity building in ministries in core areas of ADB involvement, creating access and connectivity (rural livelihoods and infrastructure development). The project supports the ICPS in terms of regional, cross-border and intersectoral cooperation and capacity building of MOH, as well as mitigation of the impact of enhanced connectivity and regional integration.

VI. Participation and Disclosure

a. Participation

80. During project preparation, stakeholders were consulted at different levels in three states, as primarily reported in the indigenous people plan.[66] Among others, stakeholders noted the commitment of health staff but also delivery constraints for field work. Generally, it was confirmed that some MEVs are not using services and that here are no specific plans for MEVs. Second it was observed that MEVs vary considerably by location. Based on this assessment, it is evident that implementation planning is required for each of the project states and region, as each locale has unique challenges and opportunities, as well as to ensure buy-in from local government and beneficiaries.

81. To prepare the project implementation in each state/region, the health office, with representatives of operational districts, hospitals, laboratories and MEVs, will first conduct a needs assessment with the help of the PMU. This will involve mapping of MEVs, field visits and consultations. The state/region project health team including representatives of MEVs will prepare a five-year project plan and annual project plans as part of the regular provincial annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The team will also conduct participatory monitoring.

82. Each state/region will propose, through need assessment consultations, and detailed preparation, project investment as part of its regular annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, security, and sustainability. This being a modest first investment of ADB in health security in Myanmar, the geographical scope is limited to the hospital in the six state and region capitals and 13 townships.

83. Civil society representatives in this project will usually be members of the village health group, and will be engaged in community preparedness, syndromic disease surveillance and reporting, and counseling of patients for self-referral. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use mobile phone for reporting. In addition, MOH is considering engaging NGOs to provide mentoring for state/region laboratories but this is yet to be decided.

84. ADB will provide, in addition to the consultant currently attached to the ADB resident mission, under a regional technical assistance, a consultant to facilitate this planning process. As part of project implementation, a chief technical adviser and a gender and social development expert will be engaged to assist the project management unit (PMU) to continue this process of support for implementing agencies in participatory planning of project activities, in particular to reach MEVs.

b. Disclosure

85. The project purpose and outline were shared with representatives of beneficiaries at the design stage. As part of the bottom up planning approach, there will be a preparatory planning process in each of the 12 participating townships to identify MEVs and their health priorities,

[66] ADB. *Project Preparatory Technical Assistance for the GMS Health Security Project. 2016. Myanmar Indigenous People Plan.*

jointly prepare plans, and jointly conduct interventions. This will ensure that beneficiaries are informed and participate at all project stages, and their views are incorporated. The project design and implementation progress will be accessible on the website of the regional coordination unit: gmshealthsecurityprojectrcu@gmail.com (website to be added) and on the ADB website.

VII. Gender and Social Diversity

a. Issues

86. The project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve access of women to health services. The patterns of infectious diseases differ substantially among women and men, because of differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and childcare. Multiple factors contribute to women's access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.

87. The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas. Sufficient gender legislation is in place. MOH has a central focal point for gender, but this may be lacking at provincial level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level.

b. Actions

88. Active engagement of women's associations is proposed to mobilize communities and reach at risk groups. Accordingly, the project's gender action plan (GAP) needs to follow the overall GAP or equivalent for the health sector, but the understanding is that apart from general capacity building and awareness raising, gender action plans are project or program specific.

89. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the RRP, the DMF, the Poverty and Social Analysis (PSA), covenants, and the GAP.[67] The project, based on general good practice for gender endorsed by MOH, will enhance participation of women in all its activities:

- (i) The executing and implementing agencies have active gender focal points for project activities;
- (ii) The project engages a gender and social development expert with a focus on community activities;
- (iii) Project implementation plans and AOPs will address gender dimensions;
- (iv) The project will collect, analyze and report gender-disaggregated data;
- (v) All project reports report on gender issues;

[67] ADB. *Policy on Gender and Development*. June 1998. Manila; and Operations Manual Bank Policies Section C2/BP issued in December 2010.

(vi) The project will proactively target youth and women at increased risk of infectious diseases;
(vii) Education materials and care procedures will be gender-sensitive;
(viii) Outbreak response and outreach services will ensure female participation;
(ix) Participation of female and male staff in training programs and scholarship will be equitable;
(x) Refurbishment of laboratories and isolation wards will be gender sensitive; and
(xi) All regional, cross-border and intersectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions

VIII. Social Safeguards and other Social Risks

a. Ethnic Minorities

90. Myanmar is ethnically diverse, with eight major ethnic groups, 135 subgroups and 108 different ethno-linguistic groups. Exploitation by outsiders of the ancestral lands of ethnic groups has led to conflicts, and ethnic groups suffer from physical, social and economic isolation because of difficult topography and political neglect. The majority Burman (Bamar) ethnic group makes up about two-thirds of the population and controls the military and the government. The minority ethnic nationalities, making up the remaining one-third, live mainly in the resource-rich border areas and hills of Burma. The seven largest minority nationalities are the Chin, the Kachin, the Karenni (sometimes called Kayah), the Karen (sometimes called Kayin), the Mon, the Rakhine, and the Shan. Burma is divided into seven states, each named after these seven ethnic nationalities, and seven regions (formerly called divisions), which are largely inhabited by the Bamar (Burmans). The Rohingya people are not recognized by the government as an ethnic nationality of Burma, and suffer discrimination and human rights abuses. Estimates put the Rohingya population of Burma at close to two million, living mainly in Rakhine State, and many more live as refugees in neighboring countries.[68]

91. Most of the majority ethnic Burman live in the river valleys and coastal regions, while the major indigenous minorities, such as the Shan, Kachin, and Chin, live in the upland interior and border regions. Measures of income and non-income poverty show sharp divisions along these lines of geography and ethnicity. Poverty in the western state of Chin, bordering Bangladesh and Assam, for example, is nearly three times higher than the national average of 25%. By contrast, poverty is below 18% in most of the ethnic Burman areas in the dry zone and delta regions.[69]

92. Nonetheless, income inequality in Myanmar is low for the region. In 2010, the Gini coefficient of per capita household consumption expenditure was 21, while it was above 35 in Viet Nam, the Lao PDR, and Cambodia, and over 40 in China, Malaysia, the Philippines, and Thailand. Myanmar's income inequality is mostly due to within-group inequality. In comparison to other Asian countries, inequality is low across different areas and groups, such as between urban and rural areas, states, education and occupation groups, sectors of employment, and across religious groups. Inequality across states, though significant, is lower than in other Asian countries. Access to basic services, however, is starkly unequal, varying significantly across states and between rural and urban areas. Access to safe drinking water from 2005–2010 increased overall from 63% to 69%, similar to Asian nations of similar income levels. Even so,

[68] https://en.wikipedia.org/wiki/List_of_ethnic_groups_in_Myanmar.
[69] World Bank. 2014. *Ending Poverty and Boosting Shared Prosperity in A Time of Transition: A Systematic Country Diagnostic Report No. 93050-MM* World Bank Group.

only 65% of rural residents had access to safe drinking water, compared with 81% of the urban population—a clear indication that urban areas benefit more from access to basic services.[70]

93. The project is expected to have a positive impact on ethnic minorities in the proposed project areas given the type of project activities, including identification of disease outbreaks and major infections in ethnic minority communities, and linking them with better diagnostic health services. An indigenous people's plan has been prepared to help ensure that benefits for ethnic groups are realized.[71] Proposed interventions are not considered sensitive for ethnic minority groups.

b. Other Social Risks

94. Paradoxically for a resource-rich country, there is a strong association between agriculture and poverty in Myanmar. Long-term economic growth has not been sufficiently broadly based, as reflected in the structure of the economy where agriculture and low value-added services account for 76% of gross domestic product.[72] This structure has remained relatively constant since 2005. Generally, poverty declines as the economy advances and employment shifts from agriculture and low value-added services to manufacturing, other industry, and higher value-added services. A consequence of this slow structural change in the economy has been a relatively high incidence of poverty and income inequality.

95. While it produces a surplus of food in aggregate terms, many rural areas suffer from chronic and acute food insecurity. In addition, the incidence of poverty in rural areas is significantly higher than in urban areas, and rural areas also lag behind in terms of health, social and educational indicators.[73] The rural poor typically consist of landless farmers with access to small and marginal landholdings, and ethnic groups. Most of the poor live either in the central dry zone where soils are sandy, rainfall low and population density high, or in hill tracts populated by ethnic groups, which are remote, have limited arable land and have been affected by conflict.

IX. Monitoring and Evaluation

96. Poverty and social indicators overlap with overall DMF indicators. Indicative DMF indicators are in table 1 and an indicative outline of poverty and social indicators is in table 2. These indicators will need to be disaggregated by gender/ethnic minority status, or, if this is not feasible, by location or key beneficiary group including the general public, migrants, ethnic minorities and other vulnerable groups. Project baselines and targets will vary considerably by province and are yet to be established through the provincial planning process.

[70] World Bank. 2014. *Ending Poverty and Boosting Shared Prosperity in A Time of Transition: A Systematic Country Diagnostic Report No. 93050-MM.*

[71] ADB. 2016*. Project Preparatory Technical Assistance for the GMS Health Security Project. 2016. Myanmar Indigenous People Plan.*

[72] ADB. 2014. *Myanmar: Unlocking the Potential.*

[73] UNDP, SIDA, UNICEF 2011. *Integrated Household Living Conditions Survey in Myanmar (2009–2010) Poverty Dynamics Report***.**

Table 1: Suggested Project Indicators

a) Number of casualties due to any epidemic remains below 100 persons in any one-year period. Source: national communicable diseases control reports
b) Economic impact of any outbreak should remain below 0.5% of GDP in any quarter. Source: economic reports
c) APSED compliance increases from 70% to 85% from 2016 to 2021. Source: WHO/IHR assessment.
d) MEVs accessing health services in targeted areas doubled from 2016 to 2021 Source: health program and health facility statistics by gender and ethnic group;
e) All hospitals doing web-based disease reporting increases from 50% to 100% from 2016 to 2021. Source: Web-based surveillance and reporting system reports.
f) Targeted laboratories and hospitals meeting national quality and biosafety standards increased from 40% to 70% from 2016 to 2021 Source: Baseline and end-of-project assessments.
g) MEV communities contacted reach twice per year from 0% to 100% from 2016 to 2021. Source: outreach team reports
h) Regional, cross-border and intersectoral events conducted from 30 to 100 from 2016 to 2021. Event reports
i) Female participation in scholarships, workshops, training and other events doubled from 2016 to 2021. Source: event reports.
j) Provincial annual operational plans include special activities for MEVs from 0% to 100% from 2016 to 2021. Source: Management assessment

APSED: Asia Pacific Strategy for Emerging Diseases; CDC: communicable diseases control; IHR: GDP: gross domestic product; International Health Regulations; MEV: mobile and migrant people, ethnic minorities, and other vulnerable groups; WHO: World Health Organization.

Table 2: Indicators for Project Effects, Risks, Enhancements, and Mitigating Actions

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
1.1 Regional Cooperation	Regional meetings and workshops	Benefits poor living in border areas, potential for addressing issues of cross-border migrants including health care financing of migrants	Number of events that substantially address poverty and social issues
1.2 Cross-border cooperation	Cross-border meetings	Potential for addressing health issues of ethnic groups and cross-border migrants in border areas	Proportion of project provinces that substantially address poverty and social issues in cross-border activities
1.3 Intersectoral cooperation	Intersectoral meetings	Potential for addressing high risk behavior in youth	Proportion of project provinces that address poverty and social issues in intersectoral meetings
1.4 Outreach	Local health staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Completion of mapping of MEVs being reached
1.5 CDC in border areas	Local health staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Number of MEV beneficiaries being reached
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of focus on vulnerable groups	Number of regional workshops substantially address poverty and social issues
2.1 Surveillance	Central/State/ Region staff	Difficult to get reports from hard to reach places	Number of MEV groups reporting
2.2 Risk Analysis	Central/State/ Region staff	Lack of information from hard to reach communities including migrants	Information quality received from MEV groups including migrants

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
2.3 Outbreak Response	State/Region staff	Difficult to access remote places and labor camps	Tracking of MEV groups being reached including migrants
Community preparedness	Local health staff	Difficult to access remote places and labor camps	Community preparedness sessions conducted
3.1 Laboratory Planning and Management	NHL	Insufficient attention to setting up transport system to obtain samples from health centers	Specimens received from other health facilities
3.2 Laboratory Pre-service training	NHL	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Profile of recruits and range of tests
3.3 Laboratory Quality Improvement	NHL	Insufficient competencies peripheral laboratory staff	Training of laboratory staff from district hospitals and health centers
3.4 Laboratory quality audit and assurance	NHL	Insufficient efforts in audit and QA for smaller laboratories	Pilot audit of smaller laboratories to understand the scale of the problem
3.5 Laboratory Upgrading Services	Hospitals	Insufficient effort to include tests that benefit the poor more	Range of tests provided
3.6 Laboratory Studies: causes of fever and immunization efficacy	NHL	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Survey generates specific data for ethnic minorities and migrants
3.7 Hospital Infection Prevention and Control	DMS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Protocols being followed based on one-day observation (also staff)
3.8 Management of Highly Infectious Cases	DMS, hospitals	Cultural and language barriers to behavior of patient and visitors	Use of services by isolated ethnic minorities
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	DPH, DMS	Insufficient attention to vulnerable groups for CDC in border areas	Number of AOPs meet standards for addressing poverty and social concerns
4.2 Implement GAP, Safeguards, monitoring and Governance assurances	DPH, DMS	Insufficient interest of PMU, provinces and districts in implementing these	Number of provinces implementing gender action plan and social safeguards
4.5 Efficient financial Management and Procurement	DPH, DMS	Insufficient capacity	Audit report, timeliness of procurement

AOP: Annual Operational Plan; CDCD: DMS: Department of Medical Services; DPH: Department of Public Health; NHL: National Health Laboratory; Project Management Unit; QA: quality assurance.

X. Risk Assessment and Mitigation Plan

97. The project builds on the experiences gained in the first and second GMS communicable diseases control projects,[74] HIV projects, a malaria and dengue control technical assistance, and is considered in general implementation terms medium risk for MOH Myanmar in view of limited ADB experience.

[74] ADB. 2004. *Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila; and ADB. 2010. *Second Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila.

98. The project addresses poverty and social issues through its overall pro-poor and pro-vulnerable group design, and through its implementation arrangements to ensure proper project implementation. The project effects, risks, and enhancing or mitigating actions are in Table 3.

Table 3: Potential Project Effects and Risks and Mitigating Actions

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
Output 1			
1.1 Regional Cooperation	Regional meetings and workshops	Benefits poor living in border areas, potential for addressing issues of cross-border migrants including health care financing of migrants	Share information among countries about best practices, organize workshops, develop strategies and plans
1.2 Cross-border cooperation	Cross-border meetings	Potential for addressing health issues of ethnic groups and cross-border migrants in border areas	Provide guidance to provinces
1.3 Intersectoral cooperation	Intersectoral meetings	Potential for addressing high risk behavior in youth	Provide guidance to provinces
1.4 Outreach	Local health staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Ensure adequate resources, including motorbike, proper mapping and community consultations, include in AOP, supervise, monitor, covenant
1.5 CDC in border areas	Local health staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Ensure adequate resources, proper mapping and campaign planning, include in AOP, supervise, monitor, covenant
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of focus on vulnerable groups	Proper planning of workshops, strategies target special needs of vulnerable groups
Output 2			
2.1 Surveillance	Central/State/ Region staff	Difficult to get reports from hard to reach places	Provide motorbikes, improve mapping, connectivity, reporting by mobile phone introduce syndromic reporting
2.2 Risk Analysis	Central/State/ Region staff	Lack of information from hard to reach communities including migrants	Improve data collection system to obtain specific information from vulnerable groups including migrants
2.3 Outbreak Response	State/Region staff	Difficult to access remote places and labor camps	Motorbikes, provinces arrange legal cover, collaboration with Ministry of Labor, allowances
2.4 Community preparedness	Local health staff	Difficult to access remote places and labor camps	Collaboration with grassroots organizations
Output 3			
3.1 Laboratory Planning and Management	NHL	Insufficient attention to setting up transport system to obtain samples from health centers	Include transport system in AOP and supply containers
3.2 Laboratory Pre-service training	NHL	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Encourage recruits from remote areas and inclusions of testing affecting the poor more
3.3 Laboratory Quality Improvement	NHL	Insufficient competencies peripheral laboratory staff	Give priority to these staff in training programs
3.4 Laboratory quality audit and assurance	NHL	Insufficient efforts in audit and QA for smaller laboratories	Include smaller laboratories in audit and QA I

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
3.5 Laboratory Upgrading Services	Hospitals	Insufficient effort to include tests that benefit the poor more	nclude tests that benefit the poor more as appropriate
3.6 Laboratory Studies: causes of fever and immunization efficacy	NHL	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Stratify and enlarge sample to ensure adequate representation of vulnerable groups
3.7 Hospital Infection Prevention and Control	DMS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper education of patients and visitors
3.8 Management of Highly Infectious Cases	DMS, hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper information of patients and visitors, e.g., videos in various languages
Project Management			
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	DPH, DMS	Insufficient attention to vulnerable groups for CDC in border areas	Ensure mainstreaming of reaching vulnerable groups in AOPs, training, monitoring, covenant
4.2 Implement Gender, Safeguards, monitoring and Governance assurances	DPH, DMS	Insufficient interest of PMU, provinces and districts in implementing these	Provide training, include in central and provincial AOPs, supervise, monitor, report, covenants
4.3 Efficient financial Management and Procurement	DPH, DMS	Insufficient capacity	Capacity building, monitoring, field inspection, audit

AOP: Annual Operational Plan; CDCD: DMS: Department of Medical Services; DPH: Department of Public Health; NHL: National Health Laboratory; Project Management Unit; QA: quality assurance.

99. The major challenges in this project in terms of addressing the needs of the poor and vulnerable groups are (i) not reaching the poor and vulnerable groups. This requires mobilization and possible support of grass-roots organizations; (ii) lack of, or inappropriate services for the poor and vulnerable groups; and (iii) lack of effort or focus on the needs of the poor and vulnerable groups. These need to be mitigated with proper planning, additional resources, and monitoring and assurances. Regional, cross-border and inter-sectoral cooperation also offers more long term opportunities to address the problems of vulnerable groups in border areas, e.g., through better targeting, reaching migrants and remote ethnic groups, and improving health financing for migrants.

100. Regional TA will be provided to engage international consultants during the first project year to ensure a quick project start-up. The project will provide for international consultants including for chief technical adviser, gender and social safeguards, and other areas. In addition, Myanmar MOH will be assisted with upfront project implementation orientation and training. Several administrative risk and mitigating measures are summarized in the RRP.

Appendix 1: Myanmar Project Location Details

No State/ Region	State/Region/Districts	District/*Townships*	Selected Project township	Selected Population	Border	Ethnic	Poverty
1	**Shan State North**	**8 districts**		**1,800,000**			
	Lashio District	*4 ts*	Lashio	323,405		323,405	
	Muse District	*3 ts*	Muse	117,507	117,507	117,507	
2	**Shan State East**	**4 districts**		**620,000**			
	Kengtung District	*4 ts*	Keng Tung	171,620		171,620	
	Tachileik District	*1 ts*	Tachileik	148,021	148,021	148,021	
3	**Kayah State**	**2 districts**		**286,627**			
	Loikaw District	*3 ts*	Loikaw	128,401		128,401	
	Bawlakhe District	*4 ts*	Mese	63,190	63,190	63,190	
4	**Kayin State**	**4 districts**		**1,574,079**			
	Hap an District	*3 ts*	Hpa An	421,575		421,575	
	Myawaddy District	*1 ts*	Myawaddy	195,624	195,624	195,624	
5	**Mon State**	**2 districts**		**2,054,393**			
	Mawlamyine District	*6 ts*	Mawlamyaing	289,388		289,388	
	Mawlamyine District	*6 ts*	Ye	152,485	152,485	152,485	
6	**Tanintharyi Region**	**3 districts**		**1,408,401**			
	Dawei District	*4*	Dawei	125,605			
	Kawthoung District	*2*	Kawthoung/	116,980	116,980		
Total	**11,147,932**			**2,196,930 (19%)**	**736,936 (34%)**	**1,954,345 (89)**	

Source: The 2014 Myanmar Population and Housing Census - The Union Report, May 2015 (web), HMIS (for population estimates Shan North and East).

Table 2: Myanmar Project Beneficiaries

Selected States and Region	Total Districts*Townships*	Selected Project township	Selected Population	Border District	Township Population with ethnic majority	Poverty %
Shan State North	**8 districts**		**1,800,000**			**37**
Lashio District	*4 ts*	Lashio	323,405		323,405	
Muse District	*3 ts*	Muse	117,507	117,507	117,507	
Shan State East	**4 districts**		**620,000**			**46**
Kengtung District	*4 ts*	Keng Tung	171,620		171,620	
Tachileik District	*1 ts*	Tachileik	148,021	148,021	148,021	
Kayah State	**2 districts**		**286,627**			**11**
Loikaw District	*3 ts*	Loikaw	128,401		128,401	
Bawlakhe District	*4 ts*	Mese	63,190	63,190	63,190	
Kayin State	**4 districts**		**1,574,079**			**29**
Hap an District	*3 ts*	Hpa An	421,575		421,575	
Myawaddy District	*1 ts*	Myawaddy	195,624	195,624	195,624	
Mon State	**2 districts**		**2,054,393**			**16**
Mawlamyine District	*6 ts*	Mawlamyaing	289,388		289,388	
Mawlamyine District	*6 ts*	Ye	152,485	152,485	152,485	
Tanintharyi Region	**3 districts**		**1,408,401**			**33**
Dawei District	*4*	Dawei	125,605			
Kawthoung District	*2*	Kawthoung	116,980	116,980		
5 State / 1 region	**23 districts**		**7,743,500**			
Targeted population	**12 Townships**		**2,196,930 (28%)**	**736,936 (10%)**	**1,954,345 (25%)**	

Sources: The 2014 Myanmar Population and Housing Census - The Union Report, May 2015 (web); ADB ICPS 2012–2014 – Poverty Analysis (source: Integrated Household Living Conditions Survey 2009–2010) for poverty data. Population for Shan North and East are based on UNICEF reported estimated (to be

Poverty and Social Analysis, Viet Nam

Project number: 48118-REG
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R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

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Acronyms

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
AOP	annual operational plan
APSED	Asian-Pacific Strategy for Emerging Diseases
CDC	communicable diseases control
CEMA	Committee for Ethnic Minority and Mountainous Area Affairs
CPS	country partnership strategy
CPRGS	comprehensive poverty reduction and growth strategy
DMF	design and monitoring framework
DMS	Department of Medical Services
EID	emerging infectious diseases
GAP	gender action plan
GDP	gross domestic product
GDPM	General Department of Preventive Medicine
GMS	Greater Mekong Subregion
HIV	human immunodeficiency virus
IHE	institutes of hygiene and epidemiology
IHR	international health regulations
IPSA	initial poverty and social analysis
Lao PDR	Lao People's Democratic Republic
MDG	Millennium Development Goal
MEV	migrants and mobile people, ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
MOLISA	Ministry of Labor, Invalids and Social Security
MPI	Ministry of Planning and Investment
NGO	nongovernmental organization
NTP	national target programs
NTPSPR	national target programs on sustainable poverty reduction
PHO	provincial health office
PMU	project management unit
PPMC	provincial preventive medicine center
PPMS	project performance monitoring system
PSA	poverty and social analysis
RRP	report and recommendation to the president
VND	Viet Nam dong
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Executive Summary

Poverty and Social Analysis (PSA) was carried out for the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project) to be financed with support of the Asian Development Bank (ADB). The project will strengthen national health security systems and GMS cooperation for the prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance.

Viet Nam, with a population of 94.5 million in 2015, has maintained rapid economic growth of about 6%. Average per capita gross domestic product was estimated at $2,111 per year in 2015 (the World Bank). Viet Nam needs to increase labor productivity to maintain such rapid growth. It faces both internal challenges such as human resources development, financial restructuring, and public debt management; and external threats from a slowing down of the global economy.

Viet Nam has made remarkable progress in reducing poverty. Between 2010 and 2014, the proportion of the population living below the national poverty line decreased from 21% to 14%; and between 2002 and 2012, the proportion of population living on less than $1.90 per day decreased from 39% to 3%.[1] The country has experienced from rapid industrialization and increased connectivity. These factors have also catalyzed substantial rural-urban migration and rapid urbanization.

With increasing regional connectivity and trade and an underperforming health system, the country, located in the GMS, is particularly vulnerable to emerging infectious diseases. Since 2000, there were outbreaks of severe acute respiratory distress syndrome, highly pathogenic avian influenza, swine flu, cholera, dengue, and hand, foot and mouth disease. It has a residual malaria problem with emerging drug resistance, a large burden of tuberculosis, and a concentrated HIV epidemic. Common communicable diseases such as diarrheal diseases and respiratory infections remain the major burden of diseases among children and the poor. Nosocomial infections and drug resistance are emerging public health problems. Infectious diseases that can easily spread with high mortality constitute a major public health and economic risks.

The Government of Viet Nam has built up an extensive network of health services, which is demonstrated, for example, in high immunization coverage. However, some rural poor, migrants, and isolated ethnic groups do not have access to formal health services, or may not receive proper care if they do. They may not use services because of poor physical access, social acceptability, quality of care, or affordability. This leads to gaps in the surveillance, prevention, control, and management of infectious diseases, particularly along border areas.

Viet Nam is committed to implementing the international health regulations (IHR) and the Asia Pacific Strategy for Emerging Diseases (APSED), as well as implementing regional strategies for the control of major diseases such as dengue, malaria, tuberculosis and HIV/AIDS. Despite major political commitments and past investments - including by the Asian Development Bank (ADB) - insufficient effort is made for the prevention of these diseases. Viet Nam is yet to comply with IHR and APSED standards.

The project will help strengthen national health security systems and GMS cooperation for the prevention and control of EIDs and other diseases of regional importance, which, according to the World Health Organization, remain a major threat in the region. The project will enhance

[1] (http://povertydata.worldbank.org/ poverty/country/VNM).

regional cooperation and disease control in border areas, strengthen disease surveillance and outbreak response, and improve laboratory services and infection control in hospitals. Total project costs in Viet Nam for 2017 to 2022 are estimated at $84 million. The General Department of Preventive Medicine (GDPM) represents the Ministry of Health (MOH), and with support of the Department of Medical Services and 4 institutes of hygiene and epidemiology will lead the implementation in 36 provinces targeting 250 districts, most of these being poor border districts (Appendix 1).

To help maximize project benefits and identify risks for the poor, a PSA was carried out. In terms of project design, the project will help reduce poverty by contributing to protecting health and securing economic growth through the avoidance of major epidemics and reducing the burden of infectious diseases. The project will have only positive impacts on the poor and vulnerable groups in targeted border areas, in the form of village disease reporting, encouraging the use of health services and improving health screening for migrants and mobile people, ethnic minorities and other vulnerable groups including women and youth (MEV). By targeting diseases that disproportionally affected the poor, targeting provinces and districts with more poverty, and targeting MEVs within these provinces, the project design helps maximize poverty impact.

However, the main concern is that, during implementation, central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its expected impact on extended millennium development goals (MDGs), in particular ***MDG6*****: halting or reducing the spread of communicable diseases**. Through the containment of infections, the project will also have some indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the design and monitoring framework and the project performance management system.

I. Introduction

1. The Asian Development Bank (ADB) is planning to support the Greater Mekong Subregion (GMS) Health Security Project for Cambodia, Lao PDR, Myanmar and Viet Nam (the project). A Poverty and Social Analysis (PSA) was carried out to help identify poverty reduction opportunities and risk and incorporate these in the project design to maximize poverty reduction impact. The PSA examines (i) project poverty dimensions, (ii) the links of the project to the national poverty reduction strategy and the country partnership strategy (CPS); (iii) the poverty targeting classification and its justification; (iv) key poverty and social issues of the potential beneficiaries, including impact channels and expected systemic changes; (v) opportunities and constraints for clients/beneficiaries - particularly poor and marginalized groups—stemming from project activities; and (vi) preparing design measures to achieve inclusive development outcomes during implementation. The PSA also summarizes examine gender impacts, scope of participation, social safeguards, and other social risks dimensions. The finding from the PSA will be reflected in the Report and Recommendation from the President to the Board of Directors (RRP), the Design and Monitoring Framework (DMF), the Project Administration Manual, the Risk Analysis and Mitigation Plan, and the Project Performance Monitoring System (PPMS). The PSA follows the initial PSA (IPSA) prepared for the project concept, and is used to prepare the summary poverty reduction and social strategy (SPRSS) for the RRP.

2. Based on the issues flagged in the IPSA, the thematic areas that are covered in the PSA include (i) poverty and inequality, (ii) poverty and health; (iii) institutions, capacity, stakeholders, and participation; (iv) gender and social diversity; (v) social safeguards; and (vi) management of other social risks and vulnerabilities. The PSA includes (a) project summary, (b) poverty and social strategy and analysis, (c) results from the project PSA or due diligence including key poverty and social issues, beneficiaries, impact channels, other poverty and social issues, and design features, (d) participation and disclosure, (e) gender and social diversity, (f) social safeguards and other social risks, (g) monitoring and evaluation, and (h) risk assessment and mitigation.

II. Project Summary

a. The GMS Health Issue

3. Emerging infectious diseases (EID) are a global risk. The International Health Regulations (IHR)[2], 2005, of the World Health Organization (WHO) mandates all countries to achieve minimum health security standards against EIDs. Southeast Asia, with major population hubs and intensive livestock raising with associated biosafety problems, has been identified as being a likely site for outbreaks of EID - such as middle-east respiratory syndrome (MERS), highly pathogenic avian influenza (HPAI), or Ebola hemorrhagic fever (EHF) – with pandemic potential that may lead to significant mortality and economic meltdown[3]. The Asia Pacific Strategy for Emerging Disease (APSED),[4] 2010, of the WHO regional offices identifies 8 strategic areas for compliance by not later than 2016. At present, compliance has reached approximately 70-80% in the GMS, with specific gaps mainly relating to laboratory services, hospital infection control,

[2] World Health Organization. 2005. *International Health Regulations*. Geneva.

[3] ADB ERD Policy brief no. 42 Potential Economic Impact of an Avian Flu Pandemic on Asia Erik Bloom, Vincent de Wit, and Mary Jane Carangal-San Jose November 2005.

[4] WHO. Western Pacific Regional Office (WPRO). 2010. *Asia Pacific Strategy for Emerging Diseases 2010–2015*. Manila.

and cooperation for outbreak prevention and control with communities, other sectors, and countries.[5]

4. Viet Nam, located in Southeast Asia, is vulnerable to many emerging and re-emerging infectious diseases and, since 2003, has had several outbreaks including severe acute respiratory distress syndrome (SARS), highly pathogenic avian influenza (HPAI), swine flu, cholera, and hand, foot and mouth disease (HFMD). It also has major outbreaks of dengue, a residual malaria problem with emerging drug resistance, a large burden of tuberculosis, and a concentrated HIV epidemic. While immunization coverage is high,[6] the burden of common communicable diseases such as diarrheal diseases and respiratory infections remains among children and the poor. Hospital acquired (nosocomial) infections and drug resistance are emerging public health problems. All these constitute major public health and economic risks.

5. The burden of communicable diseases has declined overall in Viet Nam, falling by about 16% between 2005 and 2013.[7] Mortality due to infectious diseases has declined slightly since the year 2000: in 2012, infectious diseases caused 86,100 deaths, compared with 97,700 in 2000. Nonetheless, there are increased risks for the spread of communicable diseases due to (i) improved connectivity, (ii) urbanization and industrialization with associated slum formation and labor camps; (iii) increased drug resistance, particularly for nosocomial infections, tuberculosis, malaria and HIV; (iv) reduced compliance with preventive measures including vaccination; and (v) diseases for which control measures are still insufficient such as dengue.[8] Viet Nam is highly vulnerable to epidemic outbreaks as there are many hotspots for the emergence of new infections and drug resistance. Viet Nam is particularly vulnerable to outbreaks of zoonotic diseases due to its informal trade in animal products with China, and intensive livestock keeping in the region.[9] While the burden of communicable diseases may have reduced, this is because of major efforts, and sustained financing will be needed to keep infectious diseases under control.

6. While Viet Nam has an extensive health infrastructure, it does not yet reach all populations. As such, actual and potential outbreaks may not always be detected. In addition to strengthening provincial and district capacities, the Ministry of Health (MOH) is making a concerted effort to reach out to villages and improve village conditions to address the prevention and control of infectious diseases.

b. The Project

7. Under the GMS economic development program, ADB has been supporting various health projects for communicable diseases control, HIV, malaria, and related regional technical assistance.[10] This project aims to further reduce the burden of certain infectious diseases through a combination of preventive strategies, improved diagnosis and treatment protocols, better regional coordination, and improved health system management. The governments of Viet

[5] WHO WPRO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.
[6] WHO. Vietnam Statistical Profile. 2016.
[7] Institute for Health Metrics and Evaluation (IHME), Seattle USA. *The Global Burden of Diseases, Injuries, and Risk Factors Study 2015 (GBD).*
[8] WHO WPRO. The Dengue Strategic Plan for the Asia Pacific Region 2008–2015. Manila.
[9] World Organization for Animal Health (OIE). *Biosafety, Biosecurity, and Prevention of Diseases*. 2016. Paris.
[10] Including: Strengthening Preventive Health System Project; Community Action for HIV Prevention in 2001; GMS Regional Communicable Diseases Control Project in 2004; Second GMS Communicable Diseases Control Project in 2010; GMS Capacity Building for HIV/AIDS Prevention Project in 2012; Japan Fund for Poverty Reduction projects such as the Model Healthy Village; and technical assistance for malaria and dengue control, health education, e-Health, and related areas.

Nam, Cambodia, Lao PDR, and Myanmar and ADB have prepared the project in order to strengthen national health security systems and regional cooperation for the prevention and control of EIDs and other diseases of regional importance, and to help countries to comply with IHR 2005 and implement APSED of the WHO.[11]

8. The proposed project goal is **strengthened GMS health security**. Key indicators include (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased use of public health services by migrants and mobile people, ethnic minorities, and other vulnerable groups (MEV) in border areas. The proposed project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED and (ii) increased communicable disease control coverage of MEV in border areas. The proposed project outputs are: (i) improved GMS collaboration and MEV access to communicable disease control in border areas; (ii) strengthened national surveillance and response systems; and (iii) improved capacity to diagnose and manage infectious diseases. The proposed project targets 250 districts in 36 provinces in Viet Nam, along the borders with China, Cambodia, and Lao PDR.

9. MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. This still needs to be mainstreamed and formalized. In addition, some groups of MEV that are more likely to acquire and spread infectious diseases are not being reached through regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries; (ii) develops regional disease control strategies and evidence-based communicable disease control strategies; and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring, as well as outreach and community mobilization to reach MEV.

10. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong. The system, however, still needs to be further computerized and extended to communities by employing syndromic reporting. Linkages and integration among surveillance systems will also be improved. MOH further needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level; (ii) web-based reporting including information technology support; (iii) integration of surveillance systems; (iv) risk analysis, communication, and community preparedness; (v) improving capacity of outbreak response teams including transport; and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

11. District facilities are currently unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems include substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance; (ii) in-service training; (iii) improving district laboratory services; and (iv) equipment and training for infection control and case management of dangerous diseases.

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[11] World Health Organization. Asia Pacific Strategy for Emerging Diseases. 2010.

12. In Viet Nam, the project is estimated to cost $84 million to be financed by a loan of $80 million and $4 million in counterpart funds. The project will be implemented by MOH through the General Department of Preventive Medicine (GDPM) representing the Executing Agency; and the Department of Medical Services (DMS), 4 institutes of hygiene and epidemiology, and 36 provincial health offices and preventive medicine centers as implementing agencies (IA). The project will be implemented over a five-year period from 2017 to 2022. The project completion date is 30 June 2022.

III. Poverty and Social Strategy

a. The Government Strategy

13. Viet Nam has developed rapidly and achieved substantial poverty reduction since adopting a socialist-oriented market economy in 1986 (*Doi Moi*). The Comprehensive Poverty Reduction and Growth Strategy (CPRGS),[12] approved in 2003, was a major turning point for Viet Nam towards a decentralized, participatory planning process, with greater attention given the social sectors. It featured, among others, the development of community health services, efforts to combat diseases that affect the poor more (with a focus on infectious diseases and reproductive health), and improving access to better quality, more affordable health services for the poor.

14. The Prevention and Control of Communicable Diseases Law (1995, revised 2011) describes the functions and responsibilities of health personnel and citizens in relation to prevention and control of communicable diseases. The National Comprehensive Development Plan (2010–11 to 2030–31) includes programs for health system strengthening. There is no mention, however, of control of emerging diseases or common infections, vaccination, or mental health. Viet Nam is mandated to implement the IHR 2005 and WHO's APSED 2010, for the control of EIDs and other public health events.

15. Viet Nam's CPRGS has been rolled out through successive national and provincial five-year socio-economic development plans. The current Ten Year Strategy for Socio-Economic Development 2011–2020 and the tenth Five Year Plan (2016–2020)[13] have maintained this pro-poor focus, with greater attention being given to ethnic minorities in borders and remote areas, who tend to lag behind the greater population in terms of socio-economic development and access to health care. Viet Nam is committed to universal health coverage as part of the Sustainable Development Goals (SDGs). Pro-poor actions include improving the quality of services in rural areas where poorest reside, in particular through human resources development, and improving health insurance coverage.

16. Viet Nam has put an array of national target programs (NTPs) in place, primarily to plan and implement these priorities. NTPs on sustainable poverty reduction (NTPSPR) have been initiated since 1998.[14] The NTPSPR targets poor rural districts, for, among other things, health service infrastructure improvements, as well expansion of the national health insurance program which covers all children below the age of six years and all households below the poverty line. The NTPSPR further includes social welfare services and women and child protection and social equity measures, in support of the 2007 Gender Equity and Gender Violence Laws and the Social Protection Strategy 2011–2020.[15]

[12] Government of Viet Nam. *Comprehensive Poverty Reduction and Growth Strategy*. 2003. Hanoi.
[13] Government of Viet Nam. *Ten-Year Strategy for Socio-Economic Development 2011–2020*.
[14] Do Kim Chung et al. 2015. *Implementation of Poverty Reduction Strategies: An Analysis of National Targeted Program for Poverty Reduction in the Northwest Region of Viet Nam*. Hanoi.
[15] https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/6258.pdf.

17. In November 2015, the National Assembly approved a draft resolution on investment policy for various NTPs for 2016–2020.[16] The National Rural Development Program aims to have half of communes nationwide meet all criteria by 2020 and all communes fulfilling at least five criteria. The 19 criteria cover socio-economic development and politics and defense, and are aiming to boost rural development. The NTPSPR (2016–2020) aims to see an average decrease of 1.0–1.5% in the household poverty rate, and an annual 4% decrease in impoverished localities. The program will prioritize poor districts and disadvantaged communes in coastal, island, mountainous and border areas, and directly influences the targeting of districts under this project. The government will review 21 current targets with a view to erasing targets that overlap with these two programs.[17]

b. ADB Strategy

18. According to ADB's Strategy 2020, ADB's overall goal is poverty reduction, and regional cooperation is one of the pillars of this strategy.[18] The regional ADB/GMS partnership strategy prioritizes, among other issues, communicable diseases control, to mitigate the risks and negative impacts associated with increased regional connectivity, industrialization, urbanization, and behavioral change, in particular in border areas and along economic corridors.

19. ADB's Viet Nam CPS 2012–2015[19] is aligned with the Government's 9th Five Year Socio-Economic Development Plan 2011–2015,[20] and focuses on the constraints faced by Viet Nam as it continues its transition to a modern economy. In the health sector, the CPS supports regional health security, management, improving quality of services, and support for the disadvantaged. ADB is committed to regional cooperation as one of the pillars of Strategy 2020.[21]

IV. General Poverty and Social Analysis

a. Poverty and Economic Growth

20. Viet Nam, with a projected population of 94.5 million in 2016,[22] has maintained high economic growth at around 6% on average,[23] with growth projected to be sustained at this level.[24] Average per capita gross domestic product was estimated at $2,111 per year in 2015 (the World Bank). Viet Nam needs to increase labor productivity to maintain such rapid growth. It faces both internal challenges such as human resources development, financial restructuring.[25]

21. As a result of recent economic growth, poverty rates have been steadily decreasing for at least the past two decades.[26] Viet Nam's income distribution across the population is in line with other lower middle-income countries. There is a trend, however, towards increasing income inequality.[27] Trends in poverty rates have been confusing as different government and partner

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[16] Central Institute for Economic Management, 2015. Viet Nam Economic Portal. NA pass resolution on national target programs for 2016-2020. Vietnam Economic Portal.
[17] MPI. 2015, NA Standing Committee's Resolution 1023/NQ-UBTVQH13 dated August 28, 2015.
[18] ADB. 2008. Strategy 2020. Manila.
[19] ADB. Viet Nam *Country Partnership Strategy 2012-2015*. 2012. Manila.
[20] The Government of Viet Nam *9th Socio-Economic Development Plan 2011-2015*. 2010. Hanoi.
[21] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila.
[22] Socialist Republic of Viet Nam. *Fifteen Years Achieving the Viet Nam Millennium Development Goals*. 2015. Hanoi.
[23] ADB 2016 Asian Development Outlook: *Asia's Potential Growth.*
[24] ADB 2016 Asian Development Outlook: *Asia's Potential Growth.*
[25] ADB 2016 Asian Development Outlook: *Asia's Potential Growth.*
[26] The World Bank *Well Begun, Not Yet Done: Vietnam's Remarkable Progress on Poverty Reduction and the Emerging Challenges.* 2012.
[27] General Statistics Office. *Viet Nam Household Living Standards Survey (VLHSS).* 2010 Hanoi.

agencies have applied different thresholds. Local officials of the Ministry of Labor, Invalids and Social Security (MOLISA) determine which households fall below the poverty line through a variety of methods including village discussion, surveys, and local officials' personal knowledge. These poverty lines remain subjective and vary by urban or rural setting and across administrative units.[28] The government recognizes this as a problem and is taking steps to assure uniformity and comparability of poverty measurements.[29]

22. Whichever criteria are applied, two conclusions are clear: (i) poverty rates have fallen dramatically over the past 20 years; and (ii) there are serious imbalances in poverty rates. Much higher poverty rates are observed in the north-western mountains, which tend to have larger populations of ethnic minorities who rely on subsistence agriculture, and, to a lesser extent, among other upland regions and the central coastal region, which experiences frequent droughts and floods.[30] Poverty density mapping, however, revealed that greatest numbers of poor live in the two major deltas regions around Hanoi and Ho Chi Minh City.[31]

23. Based on the government's most commonly used criteria (consumption of 2,100 calories or about $1 per day), the proportion of people living at or below the poverty line fell from 58% in 1993 to 14.5% in 2008. Another commonly used criteria include a cutoff of $2 per day in 2005 PPP (purchasing power parity) (86% in 1998, 43% in 2008).[32] This amounts to an impressive yearly reduction rate of 3.2% and 1.5% in general and extreme poverty respectively. After 2008, the rate of poverty reduction slowed. MOLISA has introduced a new poverty line of about $1.33 and $1.66 per person per day in respectively rural and urban areas. Accordingly, the poverty rate was reported as 7.8% in 2013, and the near poor were 6.3%.[33] This is based on different rural and urban income cut off points.[34]

b. Poverty and Residence

24. The average per capita income at current price of the country increased more than fourfold between 2004 and 2012, from VND 484,000 per month to VND 2 million per month.[35] It should be noted, however, that disparity in average per capita income between areas, regions and population groups has yet to be improved. Average per capita income in urban areas was almost double that of rural areas. In the richest region of the southeast that figure is approximately 250% higher than in the poorest region of the midlands and northern delta areas. Average per capita income per month of the richest 10% cohort was 9.4 times higher than that of the poorest 10% cohort (VND 4.784 million compared to VND 0.512 million).[36]

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[28] http://siteresources.worldbank.org/INTPGI/Resources/342674-1092157888460/493860-1192739384563/10412-14_p261-286.pdf.

[29] The World Bank *Well Begun, Not Yet Done: Vietnam's Remarkable Progress on Poverty Reduction and the Emerging Challenge*s. 2012.

[30] CEMA Hanoi*, Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study SUB-PRPP Project.* Dec. 2013.

[31] Swinkels, Rob. and Carrie Turk. 2006. *Explaining Ethnic Minority Poverty in Viet Nam: summary of recent trends and current challenges*. 2006. World Bank; World Bank 2004. Poverty Mapping in Viet Nam. Washington DC.

[32] http://www.worldbank.org/content/dam/Worldbank/document/vn_PA2012Executive_summary_EN.pdf.

[33] Demombynes, Gabriel, Linh Hoang Vu. 2011. Demystifying Poverty Measurement in Viet Nam.

[34] Cutoff points for rural poor and near-poor were VND 400,000 and $520,000, and for urban poor and near-poor VND 520.00 and 650,000, respectively.

[35] The World Bank *Well Begun, Not Yet Done: Vietnam's Remarkable Progress on Poverty Reduction and the Emerging Challenge*s. 2012.

[36] MOH. 2015. JAHR 2015. Source: General Statistics Office (2014). Statistical Year Book 2013. Statistical Publishing House, Hanoi.

25. In 2010, the poverty rate was 39.2% in the northwest mountains, 24.6% in the northeast mountains, 22.7% in the north central coast, and 22.5% in the central highlands, compared with 2.1% in the southeast, 8.3% in the Red River Delta, 13.5% in the Mekong delta, and 17.3% in the south central coast (table 2).[37] In 2012, 90% of the poor were living in rural areas, with 64% of all poverty concentrated in remote, isolated and mountainous areas. Although Viet Nam's 53 ethnic minority groups make up less than 15% of the population, they accounted for 47% of the poor in 2010, compared to only 29% in 1998. Using a new poverty line that better reflects living conditions of the poor (see below), 66.3% of minorities were poor in 2010 compared to only 12.9% of the Kinh majority population.[38]

26. Urban poverty has been increasing following privatization of state-owned enterprises and an increase in unregistered migrant workers for new industries and plantations. Almost half of all the remaining poor are ethnic minorities who make up 15% of the population in Viet Nam. These income differences persist among ethnic groups living in the same location. Some border districts in the central highlands also show a recent increase in poverty rates.[39]

c. Poverty and Health

27. Since 1990, the health status of the Vietnamese people has improved considerably and Viet Nam has achieved or almost achieved its MDGs.[40] In 2013, Viet Nam's life expectancy was 73.1 years: the highest among Asian countries with similar per capita incomes. Basic health-related MDG indicators are summarized in Table 1.

Table 1: Basic health indicators, Viet Nam, 1990–2015

Indicators	1990	2000	2010	2014	2015 goal
Maternal mortality ratio (per 100,000 live births)	139	81	68	49	**35**
Infant mortality rate (per 1,000 live births)	44.4	30.0	15.8	14.9	**14.8**
Child mortality rate (per 1,000 live births)	58.0	42.0	23.8	22.4	**19.3**
Malnutrition rate under 5 years (underweight) (%)	38.8	26.7	17.5	14.5	**15.0**
HIV/AIDS prevalence (%)			**0.3**	**0.3**	

Source: Joint Annual Health Review 2014, World Bank Indicators (for MMR and malnutrition 1990, 2000).

28. Health patterns are consistent with regional and rural/urban income disparity. The northern mountainous region and central highlands, which are home to a high proportion of ethnic minority communities, tend to perform less well across all health indicators than other geographic regions. Infant and child mortality rates declined the least among the poorest fifth of the population.

[37] MOLISA. 2011. National Survey on Poor and Near Poor Households 2010. Ha Noi.

[38] The World Bank *Well Begun, Not Yet Done: Vietnam's Remarkable Progress on Poverty Reduction and the Emerging Challenge*s. 2012.

[39] http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/08/20/000445729_20130820124256/Rendered/PDF/749100REVISED00al000Eng000160802013.pdf

[40] Socialist Republic of Viet Nam. *Fifteen Years Achieving the Viet Nam Millennium Development Goals*. 2015. Hanoi.

Table 2: Basic health indicators, 1990–2015

Geographic Region	Life expectancy	IMR	U5MR	Malnutrition rate (underweight)	Poverty Rate 2010
Red River Delta	74.3	13.2		10.2	8.3
Northern midlands and mountains region	70.4	22.2	33.9	19.8	39.2-24.3
North Central and Central Coast	72.5	17.0		17.0	22.7-17.3
Central Highlands	69.5	26.1	39.5	22.6	22.5
Southeast	75.7	9.1		8.4	2.1
Mekong River Delta	74.4	12.0		15.0	13.5
By Residence					
Urban	75.8	8.7	13.1		6.0
Rural	72.0	18.0	26.9		27.0
National average	73.1	14.9	22.4	14.5	20.7

Sources: MOH. 2015.Joint Annual Health Review 2015, based on data from General Statistics Office (2015). Summary report on major findings from midterm Population and Housing Census 1/4/2014.
Thanh H Et al. International Institute for Environment and Development. human settlement working papers. 2013. poverty in urban areas-40: urban poverty in Viet Nam – a view from complementary assessments.

29. Access relates to the presence or absence of economic, physical, cultural or other barriers that people might face in using health services. Each commune of 3,000 to 10,000 inhabitants has a commune health station, sometimes with a medical officer and always with paramedical staff. The distribution of health facilities and human resources across geographic areas allows for access to most rural areas.

30. The average distance to the nearest district and provincial hospital across the whole population is 13km and 42km, respectively. The mean distance to the nearest district hospital ranges from 7km in the Red River Delta to 24km in the Northeast region. The mean distance to the nearest provincial hospital ranges from 22km in the Red River Delta to 70km in the northwest region. Kinh and Hoa (ethnic majority) populations tend to live substantially closer to both district and provincial hospitals than members of ethnic minorities (mean distance to district hospital 10.9km vs 21.9km; mean distance to provincial hospital 35.0km vs 72.0km).[41] Hospital access is further affected by road conditions, availability of transport, and transportation costs.[42] While overall utilization of health facilities increased from 2002 to 2010, use of these services by lower income quintiles has remained static. The greatest increase has been in the highest quintile.[43]

31. The 2010 Viet Nam Health and Living Standards Survey (VHLSS) provides disease incidence data in terms of communes reporting cases. In 2010, some 10.5% of all communes reported incident cases of tuberculosis. When disaggregated by geographic region, rates of TB incident reporting ranged from 2.5% of communes in the northwest to 15.7% of communes in the

[41] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study SUB-PRPP Project.* Dec. 2013.
[42] Viet Nam Health and Living Standards Survey, 2010.
[43] Viet Nam Health and Living Standards Survey, 2010.

south central coastal region. This disparity cannot be explained through demographics and epidemiology alone.

32. Accessibility in terms of human resources is reflected in availability of health care staff or the ratio of health care professionals to the population. Due to shortages of administrative management staff, a number of highly skilled health professionals in Viet Nam have moved to higher positions of administration. The loss of skilled professionals from the public to the private sector is a further concern. This is due in large part to the much higher salaries offered in private clinics, compared with the public sector. This issue is more widespread in the larger cities. For this and other economic reasons, it is becoming very challenging to recruit well-trained new health care staff.[44]

33. The transition from a health system in which the Vietnamese government provided free health care to a system increasingly relying on out of pocket expenditures at the point of treatment has resulted in financial barriers that prevent the poor and near poor from accessing health care. To strengthen the government's response to this issue, Decision 139 of the Prime Minister of Viet Nam in October 2002 established the Health Care Fund for the Poor (HCFP). The decision consolidated previous schemes for the poor, such as free health care cards, into one single scheme. The purpose of the fund is to provide free access to services and financial protection to all poor people who cannot afford to pay user fees at health facilities. Coverage includes drugs on the essential drug list, but not non-prescription drugs bought from vendors. Services offered by private providers were also not included in the scheme. Other health services such as TB Direct Observation Therapy and antiretroviral drugs for treatment of people living with HIV/AIDS are also provided free.[45]

34. By 2012, almost one million households faced catastrophic health spending (health spending exceeding 40% of ability to pay),[46] and over half a million households (2.5% to 4.1% of the population) slipped into poverty because of medical spending. The proportion of health spending for self-medication and private sector services (not covered by health insurance) and use of costlier referral services remain high. Co-payments are still a financial burden for low-income households. Informal payments and payments for non-treatment costs related to healthcare seeking remain high. The household out of pocket payment share of total health spending in Viet Nam is much higher than the WHO recommendation of 30–40%.[47] Household out of pocket spending on health accounts for from 8.3% to 11.0% of household capacity to pay and approximately 4.6% to 6.0% of total household expenditure[48].

35. Public health spending for ethnic minorities, the poor and children under age six has been increasing since around 1998. The proportion of the total population without any medical insurance decreased from 86% in 1998 to about 30% in 2014, with almost 100% coverage of the poor and ethnic minority groups, who receive subsidized insurance premiums and are not

[44] Ministry of Health *Joint Annual Health Review 2008 Health Financing in Viet Nam*, Viet Nam Health Partnership Group.
[45] WHO. *Case Study On Health Care for The Poor in Vietnam: How Evidence and Politics Came Together* Nguyen Hoang Long et al. Meeting On Evidence-Informed Policy and Action to Promote Health Equity Phnom Penh, Oct 16-18, 2007.
[46] The definition of catastrophic spending varies by country, but is commonly expressed as a percentage of total non-food household spending for a given year. In the case of Viet Nam this is commonly given as 40%. In Myanmar, 30% is more common, perhaps because average income is lower. See World Bank Quantitative Techniques for Health Equity Analysis. Technical Note # 18.
[47] WHO *Health systems financing: the path to universal coverage World health report 2010.*
[48] Joint Annual Health Review 2014 Health Financing in Viet Nam Ministry of Health, Viet Nam Health Partnership Group.

required to make any copayments for government medical care.[49] This has significantly reduced out of pocket health spending among the poor. The revised Law on Health insurance[50] allows the poor and ethnic minority people living in disadvantaged areas to bypass the commune to seek care at the district hospital, or to seek inpatient care at provincial or central hospitals and still receive health insurance reimbursement. In 2016, this policy will allow all patients covered by government health insurance to seek health care at any district or commune health facility within the province and still receive full reimbursement.

36. Differences exist in financial access among different cohorts. Supply-side subsidies for recurrent costs of medical facilities are gradually being replaced by demand-side subsidies for users of health services through state budget funding of social health insurance premiums.[51] The near-poor have a 30% premium share and 20% co-payment. Only about 25% of the near poor have been enrolled in health insurance. Utilization of health services among the poor is lower than for other income groups, leading to a vicious circle of underfunded services, with only an average 75% of funds contributed to health insurance for the poor used to reimburse facilities (falling to as low as 40% in some localities).[52] Progress in issuing health insurance cards for children under age six and the elderly over 80 is still slow. In 2011, about 19.7% of children under age six were not issued with health insurance cards, notably, children from ethnic minority groups or those living in locations other than where they have permanent household registration.[53]

d. Poverty, Gender and Social Diversity

37. Ethnic minority groups represent a larger share of the poor in Viet Nam. As such, they account for a proportionately larger share of population who are granted free health care cards. Having a free healthcare card does not, however, necessarily mean better quality health care for those holding these cards. Ethnic minority communities tend to be located in areas with less access to health facilities than areas with high ethnic majority populations. This accounts, in part, for their lower health care expenditure. In addition, it has been noted that the treatment readily accessible to poor ethnic minority people at commune health centers is frequently deficient and constrained by expenditure ceilings. Language barriers and differences in cultural traditions and perceptions have been offered as explanations to discrepancies in quality of care. For example, there is no health information material at most local health stations written in any minority language.[54]

38. Due to the lower degree of financial risk protection, the medical cost burden of illness including communicable diseases falls largely on the poor. In addition, epidemics such as avian influenza often result in unreimbursed poultry culling, the cost of which once again disproportionally affects poorer households. Infections such as HIV, malaria, and tuberculosis

[49] 24 September 2008, the MOH and Ministry of Finance issued Joint Circular No. 10/2008/TTLT-BYT-BTC Circular No.09/2009/TTLT-BYT-BTC Guiding the Implementation of Some Articles of the Law on Health Insurance, and Decree No 62/2009/ND-CP. Hanoi: Government 2009.

[50] Dung, N. Health Insurance Department, MOH. 2010. *Social Health Insurance in Viet Nam*. Hanoi.

[51] The World Bank HPN Series Health Financing and Delivery in Vietnam Looking Forward. Samuel S. Lieberman, Adam Wagstaff. 2009.

[52] WHO. *A Health Financing Review of Viet Nam with A Focus On Social Health Insurance* Tran Van Tien et al. August 2011.

[53] Joint Annual Health Review 2014 Health Financing in Viet Nam Ministry of Health, Viet Nam Health Partnership Group.

[54] Global Health Action. 2013; 6: 10. *Ethnic minority health in Vietnam: a review exposing horizontal inequity* Mats Målqvist et al.

tend to be more prevalent among the poor than the wealthier.[55] The costs of illness also include income lost as a result of disease-related morbidity and mortality. Epidemics adversely affect labor productivity by inhibiting the movement of labor within and between countries.

39. Compared to national averages, ethnic minority groups have experienced a much slower pace (3.7%) of increased income and improvement in other related indicators such as education, health, housing, sanitation and water.[56] In 2012, the general poverty rate for ethnic minority groups was 45%, about five times that of the ethnic majority population. The extreme poverty rate for ethnic minority groups was 29%, more than nine times greater than amongst the majority population. While the general poverty rate for the ethnic majority groups went down by 71% from 1993 to 2006, the general poverty rate for ethnic minority groups declined by only 42% in the same period.[57] Similarly, extreme poverty rates decreased by 85% among the majority population but decreased by only 48% for members of ethnic minorities from 1993 to 2006.[58] Comparative rates of poverty between minority and majority ethnic groups are estimated to have increased threefold or more between 1993 and 2006.[59]

40. In response, the Government of Viet Nam in 2011 issued Resolution 80/NQ-CP,[60] providing new directions for sustainable poverty reduction for 2011–2020. The Resolution aims to accelerate poverty reduction in the poorest districts, communes and villages of the country, by setting poverty reduction target of 4% per annum in these areas (compared to the national target of 2%), and by prioritizing mobilization of resources and support to these areas. The NTPSPR (2012–2015)[61] was approved in early October, 2012 to accelerate poverty reduction and improve livelihood in these areas. The Government has identified poor households to improve targeting of investments, with female-headed households considered among the more vulnerable.

41. Household incomes are about 20% higher for female-headed households than male-headed households for the country as a whole,[62] and the difference in income poverty rates between households headed by women and those headed by men is small.[63] Differences in income at an individual level, however, remain. The average female worker earns 21% less than the average male worker. By comparison, the average ethnic minority worker earns 15% less than the average ethnic majority worker.[64]

42. The male-female sex ratio has increased to almost 112 due to female feticide. On this basis alone, it is predicted that Viet Nam will have a shortage of 2.3 to 4.3 million women by 2050.[65] If the exportation of brides continues, this figure may increase. It is likely to result in major hardship

[55] WHO *Macroeconomics and Health: Investing in Health for Economic Development Report of the Commission on Macroeconomics and Health* 2001.
[56] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study Sub-PRPP Project* - Dec. 2013.
[57] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study Sub-PRPP Project* - Dec. 2013.
[58] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study SUB-PRPP Project.* Dec. 2013.
[59] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study SUB-PRPP Project.* Dec. 2013.
[60] Government of Viet Nam. *Resolution 80/NQ-CP*. 2011.
[61] Government of Viet Nam. *The National Targeted Programme for Sustainable Poverty Reduction 2012–2015*.
[62] 2010 VLHSS.
[63] 2010 VLHSS.
[64] World Bank. *A Widening Poverty Gap for Ethnic Minorities (Ch. 8) Hai-Anh Dang* January 2010.
[65] MOH. 2015. JAHR.

for women and social and economic instability.[66] As yet, there are no serious national attempts to redress this situation.

43. Public social welfare programs are often poorly funded, ad-hoc and offer little protection to households outside the formal economy.[67] While the 2006-2010 Socio-Economic Development Plan incorporates gender-specific indicators in areas such as agriculture, employment, environment, health and education, the NTPSPR pays very little attention to the gendered nature of poverty and vulnerability. Despite the lack of gendered targets, the NTPSPR appears to be meeting some important practical gender needs. All focus group participants considered the health insurance card to be extremely valuable. The school fee exemption policy was also appreciated, but the poorest discussants still felt that there were other financial barriers to education. Improved access to credit emerged as another key program impact, with representative from the Viet Nam Women's Union acting as intermediaries for poor women to access credit. Nonetheless, a case study on impacts of the NTPSPR concluded that impacts on reducing pockets of food insecurity and malnutrition, especially in highland communities, had been limited.[68]

44. In the health sector, much attention is given to maternal and child health and reproductive health, with much less focus on gendered issues. The Joint Annual Health Report (JAHR) 2015 gives little attention to gender and health, and lacks gender disaggregated data for many indicators. Disaggregated data available are from surveys and specific disease control programs such as for HIV/AIDS and immunization. While the gender of patients is recorded at the health facility level, the general MOH health management information system does not collect data by gender and ethnicity.

e. Poverty, Migration, and Resettlement

45. With improving rural access, men and women are increasingly engaged in migrant labor. Internal migration is much more prevalent than external migration, and is estimated to affect some 10% of the population each year, and one out of four households. This creates important social and economic shifts that are insufficiently taken into account in current government policy. The formation of economic zones in the south and the north are key catalysts for internal migration. The driving force of migration tends to include not only employment, but also urban facilities such as private education and health services. These factors may contribute to longer-term poverty reduction.

46. Many ethnic minorities have traditionally lived in resource-rich upland areas. These areas are now frequently the target of mineral and land developments, leading to relocation of ethnic minority communities in those areas. In some cases, whole communities have been relocated to entirely different provinces. These resettled villages tend to suffer much higher mortality rates, because they are forced to abandon traditional livelihoods and switch to intensive, often monoculture farming.[69] Relocation has also contributed to a rural-urban migration, with well-established associated social, health and economic issues.

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[66] http://vietnamnews.vn/society/274537/gender-imbalance-in-viet-nam-rises-steeply.html.

[67] Institute for Family and Gender Studies. 2010. Gendered risks, poverty and vulnerability in Viet Nam: A case study of the National Targeted Programme for Poverty Reduction.

[68] Institute for Family and Gender Studies. 2010. Gendered risks, poverty and vulnerability in Viet Nam: A case study of the National Targeted Program for Poverty Reduction.

[69] UNDP, *Poverty of the Ethnic Minorities in Vietnam: Situation and Challenges from the CT 135-II Communes,* Pham. H., Le. T, Nguyen C. State Committee for Ethnic Minority Affairs of Vietnam. Hanoi 2011.

47. Unlike other GSM countries, Viet Nam experiences relatively low rates of external migration. Those who do migrate externally tend to go to neighboring Lao PDR for farming and services, and to the GMS in general for skilled labor.[70] Cross-border migration is common among women, the youth, and the educated, but low levels of formal education and ethnic differences are impediments to rural people considering migration. About 5-10% of the migrants are estimated to be youth (under 18 years of age). Most of them have little or no access to reliable information about labor and living conditions and health risks as migrant workers. Women are more vulnerable to exploitation, are paid less, and do more work than men.[71] While surveys conducted by the World Bank and IOM provide data for some indicators, sound statistics on migrants are lacking.

48. Migrants are not a clearly articulated social safeguard group in terms of ADB projects, nor are they well recognized by the Government of Viet Nam. This is due in part to the fact that planning and budgeting of services are based on the registered population. Until recently, illegal or unregistered migrants had difficulty accessing health services. Poor migrants do not have access to health equity fund support, as this is only made available to registered residents.[72]

f. Institutions, Capacity, Stakeholders and Participation

49. Viet Nam is unique in the GMS in terms of having specific programs for poverty reduction and social inclusion targeting vulnerable groups. The Prime Minister's office directly leads government efforts for poverty reduction and social inclusion through the various ministries. The main thrust is through the NTPSPR. The National Assembly approved the most recent NTPSPR (2016–2020) in 2015. The Ministry of Planning and Investment (MPI) is responsible for the overall management and supervision of all NTPs, in cooperation with the other implementing ministries, as well as the Committee for Ethnic Minorities. Program 135 is a specific program to invest in areas with ethnic minorities, and may be more extensive than the related NTPs in some provinces. The Government supports several institutions for poverty analysis and policy development.

50. At provincial, district and commune level, the People's Committee plays a key role in poverty reduction and social inclusion. As a one party state, Viet Nam relies on the Women's Union, the Youth Union, The Farmer's Association, the Fatherland Front and other state sponsored organizations for advocacy, social mobilization and community participation. There are regular biannual meetings of the provincial, district and commune people's counsels where voters – through representatives—present their views and questions on a variety of topics. Provincial and district authorities organize discussion forums and specific mass mobilization days for various public health priorities, and community appreciation and awards.

51. MOH is responsible for the provision of public health services and health insurance for the poor and other vulnerable groups. Health programs and projects are implemented through provincial and district health offices, and for some up to village health committee and village health workers. The Government has not encouraged non-governmental organizations (NGOs) or the private sector to play a major role in the rural health sector and discourages their engagement in sensitive border areas. Some NGOs work in assisting subsector development with limited geographical coverage.

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[70] Migration Policy Institute. Karl. L. Miller 2015.

[71] Institute for Family and Gender Studies. *Gendered risks, poverty and vulnerability in Viet Nam: A case study of the National Targeted Programme for Poverty Reduction.* 2010.

[72] Joint Annual Health Review 2014 Health Financing in Viet Nam Ministry of Health, Viet Nam Health Partnership Group.

52. MOH has limited capacity to access hard-to-reach communities. Reasons for this include financing and transport constraints and low travel allowances. Other aspects may also play a role, such as concerns about efficiency (focus on low hanging fruits in view of overall financial constraints), concerns about staff security, and concerns about language challenges and lack of interest of targeted communities. MOH has struggled to effectively tailor programs for poor, migrant, ethnic minority and other vulnerable groups, particularly along border areas. The greatest benefit for these groups is perhaps derived from health insurance, which is not directly implemented by MOH.[73]

53. Nonetheless, MOH and provincial agencies have demonstrated that with appropriate incentives, remote villages can be reached with polio and measles vaccination and emergency outbreak control.[74] MOH has implemented the Model Healthy Village in some remote villages. The general constraints under which the health sector operates, however, does not encourage provincial and district teams to focus on migrants, ethnic minorities, and other vulnerable groups. MOH further lacks a suitable structure through which it can engage with poverty reduction and social inclusion programs outside the ministry. It is necessary to include these concerns in annual operational plans, provincial capacity and additional resources for outreach in order to address them effectively.

54. MOH frequently organizes forums to solicit public inputs on issues of priority selection, resources and service delivery.[75] Health forums are aimed at soliciting public opinions, including from MEV and people with particular health problems that are routinely supported by local authorities and health care service providers of Viet Nam through the current political and social institutions.[76]

55. The case study conducted in 2010 by the Institute for Family and Gender on the NTP for Poverty Reduction[77] concluded that policies to promote growth must be complemented by effective social insurance and social assistance policies; and that Viet Nam should protect social spending and social assistance in the process of economic restructuring. Better measures are needed to protect poor and vulnerable households from the rising cost of basic services. These measures are even more pressing in light of increasing costs for public health and education services, arising from the current economic reform program. Migrant workers have been hard hit by the rising cost of living in urban areas.[78] They are further disadvantaged by lack of equal access to basic services, exclusion from health insurance programs, and lack of access to social protection programs at their new place of residence. These are challenges that still need to be addressed.

V. Project Poverty and Social Analysis (Due Diligence)

[73] Ministry of Health *Joint Annual Health Review 2008 Health Financing in Viet Nam*, Viet Nam Health Partnership Group.

[74] USAID *Assessing Provincial Health Systems in Vietnam: Lessons from Two Provinces. Bethesda, Md: Health Systems 20/20 Project, Abt Associates Inc.* March 2015.

[75] USAID *Assessing Provincial Health Systems in Vietnam: Lessons from Two Provinces. Bethesda, Md: Health Systems 20/20 Project, Abt Associates Inc.* March 2015.

[76] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study Sub-PRPP Project* - Dec. 2013.

[77] Institute for Family and Gender Studies. 2010. Gendered risks, poverty and vulnerability in Viet Nam: A case study of the National Targeted Program for Poverty Reduction.

[78] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study Sub-PRPP Project* - Dec. 2013.

a. Key Poverty and Social Issues

56. On a national level, rates of poverty fell from 14.2% to 9.8% between 2010 and 2013. Nonetheless, significant regional disparities remain. Ethnic minority groups account for less than 15% of the total population but more than half of the poor.[79] Large numbers of households remain vulnerable to out of pocket health expenditures that could push them into – or further into – poverty. High prices and perceived poor quality of public health services, lead many to resort to traditional medicine and self-medication.[80]

57. Building on previous national efforts, in November 2015 the National Assembly approved investment for various national target programs for 2016–2020,[81] including the NTP for Rural Development, which focuses on development of infrastructure and service delivery, largely at commune level; and a new NTP for Sustainable Poverty Reduction (2016-2020).[82] These NTP identify and prioritize poor districts and communes within each province. The project will also operate largely in these priority districts and communes, ensuring that the project harmonizes with GVN and that those most in need will benefit from project activities.

58. MOH has limited capacity to reach MEV. Challenges include prioritizing MEV, financing and transport constraints, small travel allowances, concerns about efficiency and staff security, and communication challenges between different language groups.

59. The project aims to address the following challenges in meeting the needs of MEV:

(i) Difficulty in reaching these populations;
(ii) A general lack of access to health services among MEV; and
(iii) A lack of focus on the specific needs of MEV.

60. These issues will be mitigated through supporting comprehensive provincial annual planning, staff training, additional resources, assurances, and monitoring. Regional, cross-border and intersectoral cooperation offer greater long-term opportunities to address the problems of vulnerable groups in border areas. Mobilization and possible support of grassroots organizations will be implemented to improve access to MEV.

b. Beneficiaries

61. The project will target 36 out of 64 provinces in Viet Nam. Twenty-five of these 36 provinces are border provinces. Within the 36 provinces, there are 250 focus districts, including 82 border districts and 56 poor districts. Within the project focus area, approximately 23% of the population is from ethnic minorities and some 17% are classified poor (Appendix 1).

62. A majority of project resources will be allocated to strengthening disease control and hospital services, and integrating services at district level. These activities will benefit everyone living in the project province. These benefits will further contribute to national and regional improvements.

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[79] Government of Viet Nam. *The National Targeted Programme for Sustainable Poverty Reduction 2012–2015*.
[80] Joint Annual Health Review 2014 Health Financing in Viet Nam Ministry of Health, Viet Nam Health Partnership Group.
[81] Central Institute for Economic Management, 2015. Viet Nam Economic Portal. NA pass resolution on national target program for 2016–2020.
[82] Government of Viet Nam. *Resolution 80/NQ-CP*. 2011.

63. Select project activities will target high-risk groups, including the poor, to address issues such as communicable diseases control among these populations. The project will specifically help improve health coverage for MEV. MEV frequently have less access to health services, and MEV subgroups maybe at greater risk of infection and developing drug resistance, depending on their location and occupation.

64. The total catchment population in these 36 provinces is estimated at 40 million (2014), with about 13 million living in the 82 border districts, a population average of about 92,000 people per district. Proposed spending is approximately $2 per person in the 36 provinces, with approximately $8 per person directly focusing on communicable disease control among MEV in border areas.

c. Impact Channels

65. A major share of project resources will be used for province-wide improvement of community preparedness, disease surveillance, and outbreak response. This will positively impact those in the project area through timely containment of epidemic outbreaks and the concurrent reduction of disease impact. MEV, who are currently disproportionally negatively impacted by epidemic outbreaks will likely notice the greatest benefits.

66. In mostly poor border districts, the project will conduct mapping to identify and prioritize MEV communities at increased risk of communicable diseases and not being assisted otherwise. With participatory planning and project resources, MEV communities will be offered outreach services, campaigns, and referral for free health services to improve recognition and reporting of diseases, community preparedness, hygiene and sanitation, and access to disease control programs and HEFs. By focusing these activities in border areas, the project will ensure impact among MEV including the poor, and hard to reach populations. Beneficiaries in the project area will have positive health impacts though closer and more immediate contact health services, including more effective diagnosis and treatment through improved laboratory functions. Expenses incurred through travel to health service providers will be used more efficiently.

67. The project further aims to raise awareness among health care providers and communities of the importance of including all members of the population – including those in hard to reach populations – and mobilize public and external resources to this effect to achieve both public health security and universal health coverage. This will be achieved through meetings, workshops and training, and the annual planning and budgeting cycle and monitoring and supervision systems.

d. Other Poverty and Social Issues

68. The use of health services often results in financial hardship for patients and their relatives, with 3.9% of households experiencing catastrophic health care costs in 2010, and 2.5% of households impoverished by health care costs in the same year.[83] The Social Protection Strategy 2011–2020, among others, aims to achieve universal health coverage by 2020 (from about 65% at present). The project will support this strategy by improving access to health services, including enrolment in the national health insurance program, along Viet Nam's border with Cambodia, Lao PDR and China.

[83] Joint Annual Health Review, Viet Nam 2013. http://jahr.org.vn/downloads/JAHR2013/JAHR2013_Final_EN.pdf.

69. Improved connectivity is facilitating the spread of communicable diseases such as EIDs, HIV, tuberculosis, malaria, dengue and neglected tropical diseases.[84] People in border districts and migrants are less informed about the health hazards of connectivity, and have less access to services, thereby putting them at greater risk of negative health outcomes. As the general public health status improves, the negative impact on those not reached by the health system becomes proportionally greater. Hard to reach populations, including MEV, are often not covered by national disease surveillance programs, including syndromic reporting by community volunteers at commune level. This decreases the efficiency of these programs, and leaves these communities vulnerable to undetected epidemic outbreaks.

70. Public health services in border areas are under-resourced with limited staff capacity. As the project makes efforts to mobilize these communities to access services, there will be issues of lack of access to services, including diagnostic and treatment services for HIV, malaria and tuberculosis (currently largely supported through the Global Fund). Government funding for the health sector has increased substantially in recent years, and improvements are likely in both financial (through recurrent budget, program funds, and health equity fund) and high quality human resources. The project will need to monitor these resources and harmonize implementation accordingly.

71. Gaps in Viet Nam's laboratory services affect diagnostics and case management, including shortages of staff and supplies in rural areas, which severely curtails access to these services. Laboratory support services have received little attention, including undergraduate education, laboratory management, registration and inspection/audit, medical-laboratory linkages, and transport and maintenance systems. It is critical to address these laboratory services gaps to ensure better use of past investments in staff and equipment.

72. Hospitals are the most likely recipients for patients with any emerging disease, and also pose a major concern in terms of spreading these and other diseases. In addition, hospitals are a source of nosocomial infections and drug resistance. Current facilities and practices in health facilities regarding infection prevention and control were observed to be substandard during the site visits. This is linked, in part, with socio-cultural norms and behaviors. For example, patients are usually accompanied by many family members, which creates additional hygiene challenges.

e. Design Features

73. The linkages between the burden of disease and poverty and development are well known. The project addresses key poverty and social issues by strengthening surveillance and outbreak response down to village level; by strengthening regional control strategies, by improving prevention and care for MEV, and by improving laboratory diagnostics and hospital infection control. This will be monitored through the annual evaluation of the regional disease control strategy, national surveillance and response monitoring system, laboratory and hospital quality control systems, and provincial health services and outreach statistics in focus provinces.

74. In terms of poverty impact, the project will help reduce poverty by contributing to protecting health and securing economic growth through the avoidance of major epidemics and reducing the burden of infectious diseases. The project will have only positive impacts on the poor and

[84] Emerg Infect Dis [Internet]. *Prospects for emerging infections in East and Southeast Asia 10 years after severe acute respiratory syndrome. Horby P, Pfeiffer D, Oshitani H.* 2013.

vulnerable groups in targeted border areas, in the form of village disease reporting, encouraging the use of health services and improving health screening for MEV. By targeting diseases that disproportionally affected the poor, targeting provinces with large numbers of poor people, and targeting MEVs within these provinces, the project will maximize impact.

75. The main concern is that, during implementation, central and provincial agencies will make insufficient efforts to target and assist these hard-to-reach MEV beneficiaries during project implementation. Based on experiences in previous projects, both central and provincial agencies have the capacity to reach out to MEV beneficiaries. However, there are challenges in terms of management commitment, legal implications, physical access, social obstacles, and additional costs that will need to be addressed during project implementation. MOH has confirmed its commitment to do so, primarily by mainstreaming these concerns in the planning cycle, allocating designated funds, and strengthening its implementation capacity.

76. The project is categorized as a ***targeted poverty intervention*** based on ADB categorization through its expected impact on the extended ***MDG6***: halting or reducing the spread of communicable diseases. Through the containment of infections, the project will also have some indirect impact on the extended MDG1 (reduce malnutrition) and MDG4 (reduce child mortality). A set of interventions and indicators is proposed to monitor social and poverty related impact. The findings of the PSA have been incorporated in the overall project design including the DMF and the PPMS.

77. The project will require that provinces prepare annual operational plans (AOP) to receive project funding. Each province will propose, through needs assessment, consultations, and detailed preparation, project investment as part of its regular annual health planning cycle. As part of these AOP, provinces will need to identify focus MEV and propose strategies to reach these populations. Each AOP will also reflect on ethnic minority and gender issues as part of its safeguards requirements. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The Project Management Unit (PMU) team will be tasked to check these AOP and assist the provinces with planning as needed. This has taken place for earlier ADB investments, but the practice should be strengthened.

78. Civil society representatives in this project will usually be village leaders, representatives from the Women's Union and other mass organizations, village health volunteers, malaria health workers, and peer educators. They will be engaged in event reporting, community preparedness, and syndromic disease surveillance and reporting. They will be trained in symptoms of major groups of infections, take precautions to contain the spread of infection, inform and refer patients for health services, and use of mobile phone for reporting. MOH is encouraged to engage NGOs to provide services for hard-to-reach forest dwellers and remote ethnic groups but has not yet decided to do so through this project. Access to migrant labor camps, factories and casinos requires the collaboration of factory owners. This will be negotiated with MOLISA.

VI. Participation and Disclosure

a. Participation

79. For the past 30 years, extensive exchanges of views have taken place between MOH, provincial and district officers, other government agencies, health centers, village leaders, and beneficiaries. There is quite a good understanding of priorities of the poor and ethnic groups, stemming in part, through implementation of the Model Healthy Village activity,[85] the GMS Strengthening Strategies for Malaria Control Project,[86] and other disease management and infrastructure projects.

80. The development of migrant labor is a more recent phenomenon. Efforts to document and address the specific health priorities of migrants are fewer to date, and tend to be limited to specialized agencies such as the International Organization of Migration and the International Labor Organization. There is little information on the actual health status and health behavior of migrants. As such, there is a recognized need to enhance exchange of views with migrants to achieve at a better understanding of their health priorities.

81. .Consultation of migrants is complicated: they often work in off-bounds plantations, factories and casinos and many are not registered or illegal, making them reluctant to report to health services. The government does not yet fully recognize the value of migrant workers as a major contributor to the economy, and as a group with specific needs and vulnerabilities, including labor rights, and specific health risks. Migrants face challenging working and living conditions making it more difficult for them to take part in participatory planning activities, or to engage them in health services. MOH will need to facilitate the project by obtaining clearances and participation from the Ministry of Labor and other concerned agencies.

82. For project preparation, stakeholders were consulted at provincial, district, health center and community levels in Ha Giang, Thay Ninh, Dak Lak and Dien Bien Phu provinces. Based on this assessment, it is evident that there are no specific efforts to address the needs of MEVs. MEVs and their needs vary considerably by location. Specific implementation planning is required for each project province to response to these unique challenges and opportunities, as well as to ensure buy-in from local government and beneficiaries.

83. To prepare the project implementation in each province, each provincial health office, with representatives of operational districts, hospitals, laboratories and MEVs, will first conduct a needs assessment with the help of the PMU. This will involve mapping of MEVs, field visits and consultations. The provincial project team including representatives of MEVs will prepare a five-year project plan and annual project plans as part of the regular provincial annual health plan. Investments will have to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, and sustainability. The team will also conduct participatory monitoring.

84. ADB will provide, in addition to the consultant currently attached to the ADB resident mission, under a regional technical assistance, a consultant to facilitate this planning process. As part of project implementation, a chief technical adviser and a gender and social development expert will be engaged to assist the project management unit (PMU) to continue

[85] ADB. Second GMS Regional Communicable Diseases Control Project. 2009.
[86] ADB. GMS Strengthening Malaria Control for Ethnic Minorities. 2005.

this process of support for implementing agencies in participatory planning of project activities, in particular to reach MEVs.

b. Disclosure

85. The project purpose and outline were shared with representatives of beneficiaries at the design stage. In view of the specific needs in the 36 provinces and 250 districts, there will be a preparatory planning process in each participating province to identify MEVs and their health priorities, jointly prepare a five-year plan and annual plans, and jointly conduct interventions and monitoring. Field visits with group discussions, meetings, consultations and collection of information will be used.

86. This participatory planning process will also be included in the annual operational plans and budgeted accordingly. The process is important in view of an emphasis on top-down planning processes in the past, with less appreciation of know-how at lower level, and will ensure that beneficiaries are informed and participate at all project stages, and their views incorporated. The project design and implementation progress will be accessible on the website of the regional coordination unit: gmshealthsecurityprojectrcu@gmail.com and on the ADB website.

VII. Gender and Social Diversity

a. Issues

87. The project has been ranked as Category II: **effective gender mainstreaming (EGM)** as it will directly improve access of women to health services. Patterns of infectious diseases differ substantially among women and men, due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's' access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members. Increased economic links with neighboring countries present a number of opportunities and risks for women.

88. The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas.

89. Sufficient gender legislation is in place although it is not always well enforced. MOH has a central focal and provincial focal point for gender, but this may be lacking or inactive at district level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level. Consultants will provide support to help PMU and provinces implement gender action plans.

b. Actions

90. The Viet Nam Women's Union (VWU) is mandated to represent women of all ethnic groups and to protect women's rights and interests. It is a quasi-governmental organization with representation at all administrative levels, from central to hamlet and has substantial local powers. Instead of a Ministry of Women's Affairs, Viet Nam has opted for a crosscutting National

Commission for the Advancement of Women for gender mainstreaming in development policies and programs. Its recommendations are implemented through five-year plans but often lack funding. Gender equality is reflected in the Constitution and in multiple international commitments. One major concern is the fragmentation of gender efforts in projects. Unlike in Cambodia, there has not been a movement to articulate comprehensive sector-wide gender programs. Accordingly, the project's gender action plan (GAP) may need to be adjusted based on later developments.

91. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the RRP, the DMF, the PSA, covenants, and the GAP.[87] The project, based on general good practice for gender endorsed by MOH, will seek to enhance participation and benefits of women in all its activities:

(i) The executing and implementing agencies have active gender focal points for project activities;
(ii) The project engages a gender and social development expert with a focus on community activities;
(iii) Project implementation plans and AOPs will address gender dimensions;
(iv) The project will collect, analyze and report gender-disaggregated data;
(v) All project reports report on gender issues;
(vi) The project will proactively target youth and women at increased risk of infectious diseases;
(vii) Education materials and care procedures will be gender-sensitive;
(viii) Outbreak response and outreach services will ensure female participation;
(ix) Participation of female and male staff in training programs and scholarship will be equitable;
(x) Refurbishment of laboratories and isolation wards will be gender sensitive;
(xi) All regional, cross-border and intersectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

92. The Government of Viet Nam pays some attention to the welfare of ethnic minority groups. There is a ministerial-level government body, the Committee for Ethnic Minority and Mountainous Area Affairs (CEMA), which is in charge of management of ethnic minorities and mountainous areas. In geographically strategic areas or areas with an ethnic minority population of 5,000 or more, CEMA has its own district level representative agencies. Programs that specially target ethnic minority groups are numerous and diverse. They cover a wide range of issues including poverty reduction, resettlement and sedentarization, forest-land allocation, education, health and communication. They benefit those minority groups through several channels such as: (i) their ethnic identity, (ii) their (usually mountainous or remote) residence areas, (iii) their (usually poor) economic status, and (iv) via general social programs for households with war martyrs, war invalids, or recognized as having contributed to the government. However, concerns have been expressed that several programs may be overlapping and not adequately supervised in their implementation, and in most instances their costs and benefits have not been evaluated.

[87] ADB. *Policy on Gender and Development*. June 1998. Manila; and Operations Manual Bank Policies Section C2/BP issued in December 2010.

VIII. Social Safeguards and other Social Risks

a. Ethnic Minorities

93. Ethnic minorities constitute about 14% of the population and are mainly located in the hills and mountains in the north and center of the country. They mainly belong to the Tai-Kadai, Khmer, Hmong-Mien, Cham, Chinese, and Tibeto-Burman language groups with a total of 54 officially recognized subgroups and many languages. They largely participate in the national economy through migrant labor or business, and sometimes through resettlement. Studies report increased rates of infections among these communities associated with changing behavior and environment, but also among Kinh migrants moving into ethnic minority areas.[88] There remain remote ethnic minorities with a disproportionate burden of infectious diseases due to lack of awareness, poor living conditions, and malnutrition. Some 88% of ethnic minority populations fall into the lower half of the population consumption distribution.[89]

94. The project is expected to have a positive impact on ethnic minorities in the proposed project areas through identification of disease outbreaks and major infections in ethnic minority communities, and linking them with better diagnostic health services. An Indigenous People's Plan has been prepared to help ensure that benefits for ethnic groups are realized. Proposed interventions are not considered unduly sensitive for ethnic minority groups.

b. Other Social Risks

95. The World Bank Country Social Analysis report (2009), identifies six areas where ethnic minorities are disadvantaged compared with the ethnic majority (Kinh and Hoa).[90]

- (i) Less access to education, higher dropout rates, and later school enrolment. Lack of ethnic minority teachers and bilingual education for ethnic minorities and school fees also represent a burden for ethnic minorities.
- (ii) Less mobility, with Kinh migrant households enjoying better benefits from government programs and their social networks.
- (iii) Kinh migration has had negative effects on local minorities in certain places.
- (iv) Less access to formal financial services.
- (v) Less productive land and they are more dependent on swidden agriculture and have less off-farm employment.
- (vi) Lower market access and poorer returns from markets. While this varies among ethnic groups, ethnic minorities engage in trading activities less than the Kinh group. Furthermore, they are subject to stereotyping and misconceptions, not just among Kinh households but even among ethnic minorities themselves, which can hinder participation by ethnic minorities in their own development.

96. Overall, ethnic minority people have high access to social programs such as preferential credit, free health care, tuition exemption or reduction and agricultural promotion activities.[91] However, they appear to have lower access to community services, including utilities such as potable water, electricity, sanitary conditions, internet connection, housing, and garbage collection, ethnic minority people have lower access than ethnic majority people. The same is

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[88] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study Sub-PRPP Project* - Dec. 2013.

[89] General Statistics Office. *Viet Nam Household Living Standards Survey (VLHSS).* 2010 Hanoi.

[90] World Bank. 2009. Country Social Analysis: Ethnicity and Development in Viet Nam. Washington DC.

[91] VLHSS 2006.

true for all people living in rural areas compared to people living in urban areas. The gap in utility access ranges from 4% to as much as 50% in favor of Kinh versus ethnic minorities, and from 5% to 39% in favor of people in urban areas.[92] For example, only 57% of ethnic minority people have potable water, compared with 90% of Kinh. The corresponding numbers for people living in rural and urban areas are 82% and 96%, respectively.[93]

97. Generally, ethnic minority communes are least served by or farthest away from the available community facilities, followed by mixed ethnicity communes, and Kinh communes. While the average distance to provincial hospital is 86 kilometers for ethnic minority communes, it is 46 kilometers for mixed ethnicity communes, and 30 kilometers for ethnic majority communes.[94] The average distance to a paved road is around one kilometer for ethnic minority commune and mixed ethnicity communes; for Kinh communities, it is a matter of meters. Ethnic minority people tend to have fewer household assets than ethnic majority people and people living in rural areas have fewer than those living in urban areas.

98. The project will not entail land acquisition or civil works except for minor repair of laboratories and wards. A resettlement framework has been prepared in the event of a change of project scope. The proposed project is categorized C for involuntary resettlement.

99. The project is categorized as B for environment, as it involves improving laboratory and hospital waste management. The Initial Environmental Examinations (IEEs) have been prepared, and an Environmental Framework is being prepared. Each province will prepare an Environmental Management Plan for all its project interventions.

100. There will be no substantial impact on the local labor market. There will be short-term employment benefits from avoiding and containing epidemics, such in factories, schools and tourism. There will be long term health and labor standards benefits from improving education and health care of migrants.

101. The project will not increase the price of health services but increased availability of services may increase health spending among the poor. Health interventions provided under current arrangements are usually free for public goods, and subsidized for the poor through the health equity funds. No payments are required for diagnosis and treatment associated with major communicable diseases. Increasing diagnostic facilities will also reduce travel time and costs. Subsidizing supplies will further reduce out of pocket spending. Selecting the most cost-effective diagnosis and treatment strategies will help ensure financial sustainability.

IX. Monitoring and Evaluation

102. Poverty and social indicators overlap with overall DMF indicators. Indicative DMF indicators are in table 3 and an indicative outline of poverty and social indicators is in table 4. These indicators will need to be disaggregated by gender/ethnic minority status, or, if this is not feasible, by location or key beneficiary group including the general public, migrants, ethnic minorities and other vulnerable groups. Project baselines and targets will vary considerably by province and are yet to be established through the provincial planning process.

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[92] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study Sub-PRPP Project* - Dec. 2013.

[93] CEMA Hanoi, *Poverty Situation Analysis of Ethnic Minorities in Vietnam 2007–2012 Key Findings from Quantitative Study Sub-PRPP Project* - Dec. 2013.

[94] UNDP, *Poverty of the Ethnic Minorities in Vietnam: Situation and Challenges from the CT 135-II Communes,* Pham. H., Le. T, Nguyen C. State Committee for Ethnic Minority Affairs of Vietnam. Hanoi 2011.

Table 3: Suggested Project Indicators

a) Number of casualties due to any epidemic remains below 100 persons in any one-year period. Source: national communicable diseases control reports
b) Economic impact of any outbreak should remain below 0.5% of GDP in any quarter. Source: economic reports
c) APSED compliance increases from 70% to 85% from 2016 to 2021. Source: WHO/IHR assessment.
d) MEV accessing health services in targeted areas doubled from 2016 to 2021 Source: health program and health facility statistics by gender and ethnic group;
e) All hospitals doing web-based disease reporting increases from 50% to 100% from 2016 to 2021. Source: Web-based surveillance and reporting system reports.
f) Targeted laboratories and hospitals meeting national quality and biosafety standards increased from 40% to 70% from 2016 to 2021 Source: Baseline and end-of-project assessments.
g) MEV communities contacted reach twice per year from 0% to 100% from 2016 to 2021. Source: outreach team reports
h) Regional, cross-border and intersectoral events conducted from 30 to 100 from 2016 to 2021. Event reports
i) Female participation in scholarships, workshops, training and other events doubled from 2016 to 2021. Source: event reports.
j) Provincial annual operational plans include special activities for MEV from 0% to 100% from 2016 to 2021. Source: Management assessment

APSED: Asia Pacific Strategy for Emerging Diseases; CDC: communicable diseases control; GDP: gross domestic product; IHR: International Health Regulations; MEV: mobile and migrant people, ethnic minorities, and other vulnerable groups; WHO: World Health Organization.

Table 4: Suggested Indicators for Potential Project Effects, Risks, and Mitigating Actions

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
1.1 Regional Cooperation	Regional meetings and workshops	Benefits poor living in border areas, potential for addressing issues of cross-border migrants including health care financing of migrants	Number of events that substantially address poverty and social issues
1.2 Cross-border cooperation	Provincial and district meetings	Potential for addressing health issues of ethnic groups and cross-border migrants in border areas	Proportion of project provinces that substantially address poverty and social issues in cross-border activities
1.3 Intersectoral cooperation	Provincial meetings	Potential for addressing high risk behavior in youth	Proportion of project provinces that address poverty and social issues in intersectoral meetings
1.4 Outreach	District and health center staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Completion of mapping of MEV being reached
1.5 Communicable disease control in border areas	Provincial campaigns	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Number of MEV beneficiaries being reached
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of focus on vulnerable groups	Number of regional workshops substantially address poverty and social issues
2.1 Surveillance	Provincial staff	Difficult to get reports from hard to reach places	Number of MEV groups reporting

Project Outputs and Activities	Channel of Effects	Potential Effects on the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested Indicators
2.2 Risk Analysis	Provincial staff	Lack of information from hard to reach communities including migrants	Information quality received from MEV groups including migrants
2.3 Outbreak Response	Provincial staff	Difficult to access remote places and labor camps	Tracking of MEV groups being reached including migrants
2.4 Community preparedness	District and Health center team	Difficult to access remote places and labor camps	Community preparedness sessions conducted
3.1 Laboratory Planning and Management	IHEs	Insufficient attention to setting up transport system to obtain samples from health centers	Specimens received from other health facilities
3.2 Laboratory Pre-service training	IHEs, laboratories	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Profile of recruits and range of tests
3.3 Laboratory Quality Improvement	IHEs laboratories	Insufficient competencies peripheral laboratory staff	Training of laboratory staff from district hospitals and health centers
3.4 Laboratory quality audit and assurance	IHEs	Insufficient efforts in audit and QA for smaller laboratories	Pilot audit of smaller laboratories to understand the scale of the problem
3.5 Laboratory Upgrading Services	IHEs	Insufficient effort to include tests that benefit the poor more	Range of tests provided
3.6 Laboratory Studies: causes of fever and immunization efficacy	IHEs	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Survey generates specific data for ethnic minorities and migrants
3.7 Hospital Infection Prevention and Control	DMS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Protocols being followed based on one-day observation (also staff)
3.8 Management of Highly Infectious Cases	DMS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Use of services by isolated ethnic minorities
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	GDPM, PMU, PHOs, PPMCs	Insufficient attention to vulnerable groups for communicable disease control in border areas	Number of AOPs meet standards for addressing poverty and social concerns
4.2 Implement GAP, Safeguards, monitoring and Governance assurances	GDPM, PMU, PHOs, PPMCs	Insufficient interest of PMU, provinces and districts in implementing these	Number of provinces implementing gender action plan and social safeguards
4.3 Efficient financial Management and Procurement	GDPM, PMU, PHOs, PPMCs	Insufficient capacity	Audit report, timeliness of procurement

AOP: annual operational plan; DMS: Department of Medical Services; GAP: gender action plan; GDPM: General Department of Preventive Medicine and Hygiene; IHEs: Institutes of Hygiene and Epidemiology; PHO: Provincial Health Office; PMU: project management unit; PPMC: Provincial Preventive Medicine Center; QA: quality assurance.

X. Risk Assessment and Mitigation Plan

103. The project builds on the experiences gained in the GMS Communicable Diseases Control (CDC) Projects[95] and HIV projects and is considered in general implementation terms low risk for MOH Viet Nam, similar to Cambodia and Lao PDR. MOH Myanmar has limited ADB experience, and is considered moderate to high risk. As mentioned, the main concern is that MEV are not being reached, which would reduce poverty impact of the project.

104. The project addresses poverty and social issues through its overall pro-poor and pro-vulnerable group design, and through its implementation arrangements to ensure proper project implementation. The project effects, risks, and enhancing or mitigating actions are in Table 5.

105. The major challenges in this project in terms of addressing the needs of the poor and vulnerable groups are (i) not reaching the poor and vulnerable groups. This requires mobilization and possible support of grass-roots organizations; (ii) lack of, or inappropriate services for the poor and vulnerable groups; and (iii) lack of effort or focus on the needs of the poor and vulnerable groups. These need to be mitigated with proper planning, additional resources, and monitoring and assurances. Regional, cross-border and inter-sectoral cooperation also offers more long term opportunities to address the problems of vulnerable groups in border areas, e.g., through better targeting, reaching migrants and remote ethnic groups, and improving health financing for migrants.

106. Regional technical assistance will be provided to engage international consultants during the first project year to ensure a quick project start-up. The project will provide for international consultants including for chief technical adviser, gender and social safeguards, and other areas. In addition, Myanmar MOH will be assisted with upfront project implementation orientation and training. Several administrative risk and mitigating measures are summarized in the RRP.

Table 5: Project Effects, Risks and Mitigating and Enhancing Actions

Project Outputs and Activities	Channel of Effects	Potential Effects and Risks for the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
Output 1			
1.1 Regional Cooperation	Regional meetings and workshops	Insufficient strategic planning for improving access of MEV to health services in border areas including health care financing of migrants and ethnic minorities and sharing best practices.	Planning for MEV in border areas should be a permanent feature on any regional workshop agenda, and included in country reports.
1.2 Cross-border cooperation	Provincial and district meetings	Risk of not addressing health issues of ethnic groups and cross-border migrants in border areas.	Include this topic on all agendas and participants to report on progress and plans.
1.3 Intersectoral cooperation	Provincial meetings	Risk of not addressing high risk sexual behavior in youth and other priorities in border MEV.	Include this topic on all agendas and participants to report on progress and plans
1.4 Outreach	District and health center staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons.	Ensure adequate resources, including motorbike, proper mapping and community consultations, include in AOP, supervise, monitor, covenant.
1.5 Communicable	Provincial campaigns	Risk of not reaching vulnerable groups due to capacity constraints	Ensure adequate resources, proper mapping and campaign planning,

[95] ADB. 2013. *Completion Report. GMS Regional Communicable Diseases Control Project*. Manila.

Project Outputs and Activities	Channel of Effects	Potential Effects and Risks for the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
disease control in border areas		or other reasons.	include in AOP, supervise, monitor, covenant.
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Risk of lack of strategic focus on priority areas for CDC in GMS including reaching MEV.	Ensure that workshops include strategic priority areas including reaching MEV.
Output 2			
2.1 Surveillance	MOH, provincial staff, district staff	Weak surveillance at village level and in labor camps, factories and casinos and in the private sector, reach hard to reach places.	Provide motorbikes to improve mobility and provide training to improve local staff capacity in surveillance and response.
2.2 Risk Analysis	MOH, provincial staff	Insufficient data and data analysis	Introduce syndromic reporting, and improve mobile phone reporting.
2.3 Outbreak Response	MOH, provincial staff, district staff	Difficult to access remote places and labor camps.	Collaborate with the Ministry of Labor and provinces to pre-arrange legal cover for access of premises, and notify all company directors.
2.4 Community preparedness	MOH, district staff, health center staff	Difficult to access remote places and labor camps	Conduct mapping of all villages, labor camps, and private practices. Improve data collection system including disaggregated indicators and obtain specific information from MEV including migrants.
Output 3			
3.1 Laboratory Planning and Management	IHEs	Insufficient attention to setting up transport system to obtain samples from health centers	Include transport system in AOP and supply containers
3.2 Laboratory Pre-service training	IHEs, laboratories	Lack of students from remote areas and insufficient attention for diseases affecting the poor more	Encourage recruits from remote areas and inclusions of testing affecting the poor more
3.3 Laboratory Quality Improvement	IHEs laboratories	Insufficient competencies peripheral laboratory staff	Give priority to these staff in training programs
3.4 Laboratory quality audit and assurance	IHEs	Insufficient efforts in audit and QA for smaller laboratories	Include smaller laboratories in audit and QA
3.5 Laboratory Upgrading Services	IHEs	Insufficient effort to include tests that benefit the poor more	Include tests that benefit the poor more as appropriate
3.6 Laboratory Studies: causes of fever and immunization efficacy	IHEs	Sample doesn't include hard to reach vulnerable groups including ethnic minorities and migrants	Stratify and enlarge sample to ensure adequate representation of vulnerable groups
3.7 Hospital Infection Prevention and Control	DMS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper education of patients and visitors
3.8 Management of Highly Infectious Cases	DMS, Hospitals	Cultural and language barriers to behavior of patient and visitors	Arrange proper information of patients and visitors, e.g., videos in various languages
Project Management			
4.1 Mainstreaming project in Annual Planning and Budget Cycle and ensure monitoring and reporting	GDPM, PMU, PHOs, PPMCs	Insufficient attention to vulnerable groups for communicable disease control in border areas	Ensure mainstreaming of reaching vulnerable groups in AOPs, training, monitoring, covenant
4.2 Implement	GDPM, PMU,	Insufficient interest of PMU,	Provide training, include in central

Project Outputs and Activities	Channel of Effects	Potential Effects and Risks for the Poor and Vulnerable including migrants, ethnic groups, women and youth	Suggested mitigation or enhancements
Gender, Safeguards, monitoring and Governance assurances	PHOs, PPMCs	provinces and districts in implementing these safeguards	and provincial AOPs, supervise, monitor, report, covenants
4.3 Efficient financial Management and Procurement	GDPM, PMU, PHOs, PPMCs	Insufficient capacity in project management	Capacity building, monitoring, field inspection, audit

AOP: annual operational plan; DMS: Department of Medical Services; GAP: gender action plan; GDPM: General Department of Preventive Medicine and Hygiene; IHEs: Institutes of Hygiene and Epidemiology; PHO: Provincial Health Office; PMU: project management unit; PPMC: Provincial Preventive Medicine Center; QA: quality assurance.

Appendix 1: Viet Nam Project Location Details

	PROVINCE	#	DISTRICT	Total CHS	Population 2009	Border district	Poor district	Ethnic %	Poor (2012) %
1	**Bac Kan**				**293,826**			**86.70**	**23.53**
		1	Ba Bể	16	46,350		1		
		2	Bạch Thông	17	30,216				
		3	Chợ Mới	16	36,747				
		4	Chợ Đồn	22	48,122				
		5	Na Rì	22	36,000				
		6	Ngân Sơn	11	27,680				
		7	Pác Nặm	10	26,131		1		
					251,246				
2	**Cao Bằng**				**507,183**			**95.32**	**32.98**
		1	Bảo Lâm	14	55,936	1	1		
		2	Bảo Lạc	17	49,362	1	1		
		3	Hà Quảng	19	33,261	1	1		
		4	Hòa An	21	63,515				
		5	Hạ Lang	14	25,294	1	1		
		6	Nguyên Bình	20	39,420				
		7	Phục Hòa	9	22,501	1			
		8	Quảng Uyên	17	39,572				
		9	Thông Nông	13	22,223	1	1		
		10	Thạch An	16	30,563	1			
		11	Trà Lĩnh	10	21,558	1			
		12	Trùng Khánh	20	48,713	1			
					507,183				
3	**Điện Biên**				**490,306**			**80.00**	**45.28**
		1	Dien Bien	25	106,313				
		2	Mường Chà	12	52,080	1			
		3	Mường Nhé	11	32,977	1	1		
		4	Mường Ảng	10	47,279		1		
		5	Tuần Giáo	19	74,031				
		6	Tủa Chùa	12	47,279		1		
		7	Điện Biên Đông	14	48,990		1		
		8	Nậm Pồ	15	43,542	1			
					490,306				
4	**Hà Giang**				**724,537**			**87.90**	**35.38**
		1	Bắc Mê	13	47,339				
		2	Bắc Quang	23	45,286				
		3	Hoàng Su Phì	25	59,427				
		4	Mèo Vạc	19	58,944	1			
		5	Quang Bình	15	56,824				
		6	Vị Xuyên	24	95,725	1			
		7	Xín Mần	20	50,307	1			
		8	Yên Minh	19	77,625	1			
		9	Đồng Văn	20	64,757	1			
		10	Quản Bạ	13	44,506	1			
					491,561				
5	**Hòa Bình**				**785,217**			**72.27**	**26.09**

	PROVINCE	#	DISTRICT	Total CHS	Population 2009	Border district	Poor district	Ethnic %	Poor (2012) %
		1	Lạc Sơn	29	132,337				
		2	Mai Châu	23	55,663				
		3	Đà Bắc	20	52,381				
					240,381				
6	**Lai Châu**				**370,502**			**79.14**	**38.88**
		1	Mường Tè	13	39,921	1	1		
		2	Phong Thổ	18	66,372	1	1		
		3	Sìn Hồ	22	74,703	1	1		
		4	Tam Đường	14	46,767				
		5	Than Uyên	12	57,837		1		
		6	Tân Uyên	10	58,439		1		
		7	Nậm Nhùn	11	24,165	1			
					368,204				
7	**Lạng Sơn**				**732,515**			**83.50**	**24.81**
		1	Bình Gia	20	52,087				
		2	Bắc Sơn	20	65,836				
		3	Cao Lộc	23	73,516	1			
		4	Chi Lăng	21	73,887				
		5	Hữu Lũng	26	112,451				
		6	Lộc Bình	29	78,324	1			
		7	Tràng Định	28	58,441	1			
		8	Văn Lãng	20	50,210	1			
		9	Văn Quan	24	54,068				
		10	Đình Lập	12	26,429	1			
					645,249				
8	**Lào Cai**				**614,595**	**1**		**66.88**	**35.29**
		1	Bát Xát	23	70,015	1			
		2	Bảo Thắng	15	99,974				
		3	Bảo Yên	18	76,415	1			
		4	Bắc Hà	21	53,587		1		
		5	Mường Khương	16	51,993	1	1		
		6	Sa Pa	18	53,549				
		7	Si Ma Cai	13	31,323	1	1		
		8	Văn Bàn	23	79,220				
					516,076				
9	**Quảng Ninh**				**1,144,988**			**12.53**	**4.89**
		1	Bình Liêu	9	27,629	1			
		2	Hải Hà	20	52,729	1			
		3	Tiên Yên	12	44,352				
		4	Đầm Hà	10	33,219				
					157,929				
10	**Sơn La**				**1,076,055**			**82.58**	**31.35**
		1	Bắc Yên	16	56,796		1		
		2	Mai Sơn	23	137,341	1			
		3	Mường La	16	91,377		1		
		4	Mộc Châu	15	104,730	1			
		5	Phù Yên	27	106,892		1		
		6	Quỳnh Nhai	16	58,300		1		

	PROVINCE	#	DISTRICT	Total CHS	Population 2009	Border district	Poor district	Ethnic %	Poor (2012) %
		7	Sông Mã	20	126,099	1			
		8	Sốp Cộp	11	39,038	1	1		
		9	Thuận Châu	30	147,374				
		10	Yên Châu	15	68,853	1			
		11	Vân Hồ	16	55,797	1			
					992,597				
11	**Phú Thọ**				**1,316,389**			**14.11**	**16.55**
		1	Cẩm Khê	31	125,790				
		2	Đoan Hùng	28	103,743				
		3	Hạ Hoà	33	104,872				
		4	Lâm Thao	14	99,859				
		5	Phù Ninh	19	94,094				
		6	Tân Sơn	17	76,035				
		7	Thanh Ba	27	108,015				
					712,408				
12	**Bắc Giang**				**1,554,131**			**12.00**	**15.39**
		1	Lạng Giang	23	191,048				
		2	Sơn Động	23	68,724				
		3	Tân Yên	24	158,547				
		4	Việt Yên	19	159,936				
		5	Yên Dũng	21	162,497				
					549,704				
13	**Yên Bái**				**740,397**			**46.00**	**32.53**
		1	Lục Yên	24	102,946				
		2	Mù Căng Chải	14	49,255				
		3	Trạm Tấu	12	26,704				
		4	Trấn Yên	22	79,397				
		5	Văn Chấn	31	144,152				
		6	Văn Yên	27	116,000				
		7	Yên Bình	26	39,420				
					557,874				
14	**Hà Nam**				**784,045**			**1.00**	**10.68**
		1	Bình Lục	19	133,978				
		2	Duy Tiên	20	115,011				
		3	Kim Bảng	18	116,054				
		4	Lý Nhân	23	175,878				
		5	Thanh Liêm	17	113,077				
					653,998				
15	**Nam Định**				**1,828,111**			**1.00**	**8.3**
		1	Giao Thủy	22	188,875				
		2	Hải Hậu	35	256,864				
		3	Vụ Bản	18	129,669				
		4	Xuân Trường	20	165,739				
		5	Ý Yên	32	227,160				
					968,307				
16	**Vĩnh phúc**				**999,786**			**3.45**	**8.69**
		1	Bình Xuyên	13	108,246				
		2	Lập Thạch	20	118,646				

	PROVINCE	#	DISTRICT	Total CHS	Population 2009	Border district	Poor district	Ethnic %	Poor (2012) %
		3	Sông Lô	17	88,616				
		4	Tam Dương	13	94,692				
		5	Tam Đảo	9	69,084				
					479,284				
17	**Ninh Bình**				**898,999**			**2.00**	**9.85**
		1	Gia Viễn	21	115,708				
		2	Hoa Lư	11	66,187				
		3	Kim Sơn	27	164,735				
		4	Nho Quan	27	143,083				
					489,713				
18	**Hà Tĩnh**				**1,227,038**			**1.00**	**17.44**
		1	Can Lộc	23	127,515				
		2	Cẩm Xuyên	29	141,216				
		3	Hương Khê	22	100,212	1			
		4	Hương Sơn	32	117,167	1			
		5	Kỳ Anh	21	120,518				
		6	Lộc Hà	13	78,802				
		7	Nghi Xuân	19	97,830				
		8	Vũ Quang	12	30,989	1			
					814,249				
19	**Nghệ An**				**2,912,041**			**13.35**	**18.79**
		1	Anh Sơn	21	99,358	1			
		2	Kỳ Sơn	21	69,524	1	1		
		3	Nghi Lộc	30	184,148				
		4	Quế Phong	14	62,129	1	1		
		5	Quỳ Hợp	21	116,554				
		6	Thanh Chương	40	248,952	1			
		7	Tương Dương	18	72,405	1	1		
		8	Đô Lương	33	183,584				
		9	Con Cuông	13	64,240	1			
		10	Nam Đàn	24	149,826				
		11	Quỳnh Lưu	22	279,977				
		12	Tân Kỳ	22	129,031				
					1,659,728				
20	**Quảng Bình**				**844,893**			**8.90**	**21.17**
		1	Bố Trạch	30	178,464	1			
		2	Lệ Thủy	28	140,527	1			
		3	Minh Hóa	16	47,083	1	1		
		4	Quảng Ninh	15	86,845	1			
		5	Quảng Trạch	18	95,542				
		6	Tuyên Hóa	20	77,700	1			
					626,161				
21	**Quảng Trị**				**598,324**			**9.00**	**16.41**
		1	Cam Lộ	9	44,731				
		2	Gio Linh	21	72,083				
		3	Hướng Hóa	22	74,216	1			
		4	Hải Lăng	20	86,335				
		5	Triệu Phong	19	94,610				

	PROVINCE	#	DISTRICT	Total CHS	Population 2009	Border district	Poor district	Ethnic %	Poor (2012) %
		6	Vĩnh Linh	22	85,584				
		7	Đakrông	14	36,437	1	1		
		8	Dảo Cồn Cỏ	13	400				
					494,396				
22	**Thanh Hóa**				**3,400,595**			**14.40**	**20.37**
		1	Bá Thước	23	101,323		1		
		2	Hoằng Hóa	43	250,534				
		3	Lang Chánh	11	45,346	1	1		
		4	Mường Lát	9	33,182	1	1		
		5	Như Xuân	18	64,319		1		
		6	Quan Hóa	18	43,789	1	1		
		7	Quan Sơn	13	35,435	1	1		
		8	Quảng Xương	30	227,971				
		9	Thường Xuân	17	83,218	1	1		
		10	Thạch Thành	28	136,221				
					1,021,338				
23	**Ninh Thuận**				**1,021,338**			**22.70**	**13.47**
		1	Bác Ái	8	24,304				
		2	Ninh Hải	9	89,420				
		3	Ninh Phước	9	135,146				
		4	Thuận Bắc	6	37,769				
					286,639				
24	**Quảng Nam**				**1,422,319**			**6.80**	**20.9**
		1	Bắc Trà My	13	38,218				
		2	Hiệp Đức	12	38,001				
		3	Nam Giang	12	19,570	1			
		4	Nam Trà My	10	25,464		1		
		5	Nông Sơn	7	34,524				
		6	Phước Sơn	12	22,586		1		
		7	Tiên Phước	15	68,877				
		8	Tây Giang	10	16,534	1	1		
		9	Đông Giang	11	23,428				
					287,202				
25	**Quảng Ngãi**				**1,216,773**			**11.60**	**20.69**
		1	Ba Tơ	20	51,468		1		
		2	Bình Sơn	25	174,939				
		3	Minh Long	5	15,498		1		
		4	Lý Sơn	3	18,223				
		5	Sơn Hà	14	68,345		1		
		6	Sơn Tây	8	18,092		1		
		7	Sơn Tịnh	11	95,597				
		8	Trà Bồng	10	29,699		1		
		9	Tây Trà	9	17,798		1		
		14	Đức Phổ	15	140,093				
					629,752				
26	**Đăk Lăk**				**1,733,624**			**31.30**	**17.39**
		1	Buôn Đôn	8	59,959	1			
		2	Cư Kuin	10	99,551				

	PROVINCE	#	DISTRICT	Total CHS	Population 2009	Border district	Poor district	Ethnic %	Poor (2012) %
		3	Cư M gar	17	157,295				
		4	Ea H'Leo	12	120,968				
		5	Ea Kar	16	141,331				
		6	Krông Búk	7	57,387				
		7	Krông Ana	8	81,010				
		8	Krông Năng	12	118,223				
		9	Lắk	11	59,954				
					895,678				
27	**Đăk Nông**				**489,382**			**33.00**	**22.52**
		1	Cư Jút	9	88,264	1			
		2	Đắk Glong	6	29,248				
		3	Đắk Mil	11	87,831	1			
		4	Đắk RLấp	11	74,087				
		5	Đắk Song	9	41,774	1			
		6	Krông Nô	10	62,888				
		7	Tuy Đức	6	38,656	1			
					422,748				
28	**Gia Lai**				**1,274,412**			**38.48**	**23.75**
		1	Chư Păh	15	67,315				
		2	Chư Pưh	9	54,890				
		3	KBang	14	61,682				
		4	Kông Chro	14	42,635				
		5	La Grai	16	88,613	1			
		6	Mang Yang	12	43,734				
		7	Phú Thiện	10	70,881				
		8	Đăk Pơ	8	38,017				
		9	Đức Cơ	11	62,031	1			
					529,798				
29	**Kon Tum**				**430,133**			**53.64**	**27.91**
		1	Kon Rẫy	7	22,622				
		2	Ngọc Hồi	8	41,828	1			
		3	Sa Thầy	11	41,228	1			
		4	Tu Mơ Rông	11	22,498		1		
		5	Đắk Tô	9	29,015				
		6	Đắk Hà	11	61,665				
		7	La H'Drai	3	11,644	1			
					230,500				
30	**Lâm Đồng**				**1,187,574**			**22.80**	9.7
		1	Bảo Lâm	14	109,236				
		2	Cát Tiên	12	37,112				
		3	Lạc Dương	6	19,298				
		4	Đam Rông	8	38,407		1		
		5	Đạ Huoai	10	34,039				
		6	Đạ Tẻh	11	48,590				
					286,682				
31	**Bình Phước**				**873,598**			**19.30**	**6.9**
		1	Bù Đăng	16	131,296				
		2	Bù Đốp	8	45,253	1			

	PROVINCE	#	DISTRICT	Total CHS	Population 2009	Border district	Poor district	Ethnic %	Poor (2012) %
		3	Bù Gia Mập	9	147,967	1			
		4	Lộc Ninh	15	115,268	1			
					439,784				
32	**Tây Ninh**				**1,066,513**			**1.69**	**4.27**
		1	Tân Châu	12	94,112				
		2	Bến Cầu	9	62,934	1			
		3	Châu Thành	15	130,101	1			
		4	Hòa Thành	8	139,011				
					426,158				
33	**An Giang**				**2,142,709**			**5.06**	**7.84**
		1	An Phú	14	191,328	1	1		
		2	Thoại Sơn	17	112,000				
		3	Tri Tôn	15	127,426	1	1		
		4	Thị Xã Tân Châu	14	172,088	1	1		
		5	Tịnh Biên	14	47,128	1	1		
					649,970				
34	**Bạc Liêu**				**856,518**			**10.59**	**15.29**
		1	Phước Long	8	117,700		1		
		2	Hòa Bình	8	106,800				
		3	Hồng Dân	9	105,200				
					329,700				
35	**Vĩnh Long**				**1,024,707**			**2.78**	**7.91**
		1	Bình Tân	11	93,142				
		2	Long Hồ	15	160,537				
		3	Mang Thít	13	99,201				
		4	Vũng Liêm	20	159,183				
					512,063				
36	**Kiên Giang**				**1,688,248**			**14.43**	**7.23**
		1	Thị Xã Hà Tiên	7	44,721		1		
		2	An Biên	9	122,068				
		3	Giang Thành	5	28,910		1		
		4	Hòn Đất	14	166,860				
		5	Kiên Hải	4	20,807		1		
		6	Phú Quốc	10	91,241		1		
		7	U Minh Thượng	6	67,764				
					542,371				
	CHS			4,107					
	Districts	250			22,848,551	82	56		
	Provinces	36			40,272,321			9,317,503 23.1%	6,939,423 17.2%
	Nation	63			86,020,000			13.8%	14.5%

Source: Population data based on 2009 census.
CHS: commune health stations.

Ethnic Group Development Plan, Cambodia

Project number: 48118-REG

July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS
(as of 7 April 2016)

Currency Unit	–	riel (KHR)
KHR1.00	=	$0.000248
$1.00	=	KR4,029

NOTES

(i) The fiscal year (FY) of the Government of Cambodia and its agencies ends on 31 December. "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

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ACRONYMS

ADB	Asian Development Bank
AH	affected household
AOP	annual operational plan
APSED	Asia-Pacific Strategy for Emerging Diseases
CDC	communicable diseases control
CDCD	communicable diseases control department
CDC1	First GMS Regional Communicable Diseases Control Project
CDC2	Second GMS Regional Communicable Diseases Control Project
CENAT	National Center for Tuberculosis and Leprosy
CHASS	National Center for AIDS, Dermatology, and Sexually Transmitted Infections
CLMV	Cambodia, Lao PDR, Myanmar and Viet Nam
CTA	chief technical adviser
DEMD	Department of Ethnic Minority Development
DHS	Department of Hospital Services
DMF	design and monitoring framework
DPHIS	Department of Planning and Health Information Systems
EG	ethnic group
EGDP	ethnic group development plan
EID	emerging infectious diseases
EMDP	ethnic minority development plan
EMG	ethnic minority group
GAP	gender action plan
GMS	Greater Mekong Subregion
HSP	health sector program
HSSP	health sector support program
HMIS	health management information system
IA	implementing agency
IP	indigenous people
IHR	international health regulations
ILO	International Labor Organization
IMR	infant mortality rate
IOM	International Organization of Migration
IPC	infection prevention and control
IPP	indigenous peoples plan
IT	information technology
MEF	Ministry of Economy and Finance
MEV	migrants and mobile people, ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
MOL	Ministry of Labor
NGO	nongovernmental organization
NIPH	National Institute of Public Health
OD	operational district
PAM	project administration manual
PDR	People’s Democratic Republic (Lao-)
PHD	public health department
PHO	provincial health office
PMU	project management unit
PPMS	project performance monitoring system

RCU	regional coordination unit
RSC	regional steering committee
SPS	safeguard policy statement
TB	tuberculosis
UHC	universal health coverage
UNAIDS	United Nations Joint Program for the Control of HIV/AIDS
UNOPS	United Nations Office for Project Services
WHO	World Health Organization

EXECUTIVE SUMMARY

This Ethnic Group Development Plan (EGDP) summarizes the Cambodia-specific analysis, strategy, and plan for addressing indigenous peoples aspects for the GMS Health Security Project based on the Government's policy on indigenous people[1] and ADB's Safeguard Policy Statement (SPS).[2] Indigenous People (IP) make up about 4% of the population in Cambodia. They particularly live in targeted project area, in particular in the poor north-eastern provinces. About two thirds of IP are considered fully mainstreamed in Khmer society.[3] It is practical to focus on vulnerable IP that are poor and lack access to services, are being displaced, or lack citizen rights and empowerment. In the context of the Project, this EGDP focuses on IP laking access to services, as well as internal and external migrants, some of whom are IP. The control of regional infectious diseases in these two subgroups is a priority in this project.

The proposed GMS Health Security Project (the project) for Viet Nam, Cambodia, the Lao PDR and Myanmar aims to improve regional public health security by strengthening health security systems and communicble diseases control (CDC) in border areas, in particular for migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs). Three components or outputs[4] are proposed: (i) improved regional cooperation and CDC in border areas, (ii) strengthened surveillance and response systems, and (iii) improved diagnostics and management of infectious diseases.

The project is designed to support regional cooperation and national capacity building for prevention and control of emerging infectious diseases (EID) and other diseases of regional importance such as malaria, dengue, cholera, tuberculosis, HIV/AIDS, and drug-resistant infections. The project will cover 13 provinces in Cambodia, in addition to 12 provinces in the Lao PDR, 36 provinces in Viet Nam, and 5 states and one region in Myanmar. In Cambodia, about 7.6 million people live in the project area, of whom just under half are IP. The targeted provinces in Cambodia are Banteay Meanchey, battambang, Kampot, Kandal, Kratie, Mondulkiri, Preah Vihear, Prey Veng, Ratanakiri, Stung Treng, Svay Rieng, Pailin, Tbong Khmum.

According to SPS, the Borrower is required to ensure benefits and mitigate adverse impact for IP. To this effect, the Borrower prepares an Indigenous Peoples Plan (IPP), sometimes called EGDP. According to the Indigenous Peoples Safeguards Sourcebook.[5] "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook*, "IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* As per the ADB SPS, *"if Indigenous Peoples are the sole or the overwhelming majority of direct project beneficiaries and when only positive impacts are*

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1 Government of Cambodia. 2009. *National Policy on Indigenous Peoples Development*, Phnom Penh.
2 ADB. 2009. *Safeguard Policy Statement*. Manila
3 In Cambodia, the official policy used by the Ministry of Rural Development is the National Policy on the Development of Indigenous Peoples (NPDIP) of 2009 uses the term 'indigenous peoples' rather than 'ethnic minority people'
4 Government uses the term 'components' and ADB uses 'outputs', therefore both terms are used in this document
5 ADB. 2013. *Indigenous Peoples Safeguards: A Planning and Implementation Good Practice Sourcebook* (Draft Working Document)

identified, the elements of an IPP could be included in the overall project design in lieu of preparing a separate IPP."

This EGDP for Cambodia summarizes the findings of the assessment and consultation process. Rather than referring to 'indigenous peoples', the Government of Cambodia uses the term 'ethnic group' as many of the affected ethnic minorities are not indigenous, and are in fact recent migrants. Therefore, the term Ethnic Group Development Plan (EGDP) will be used for the Cambodia documentation.

The project is expected to have only positive impact on IP. However, IP are not the sole or overwhelming majority of project beneficiaries. Given the scale and complexity of this regional project, and the potential for not achieving certain intended positive impact on IP justifies a **category B** and warrants preparation of an EGDP to help achieve intended impact on IP and other vulnerable groups. This EGDP for Cambodia summarizes the findings of the assessment and consultation process and proposed project implementation measures.

No negative impact is forseen. It appears that sufficient legislation is in place to address the needs of IP, except for migrants. MOH gives high priority to services for IP. However, the major concern is that proposed benefits for ethnic minority groups (EMGs) do not fully materialize. Implementation of EGDPs in earlier, similar projects for communicable diseases control was not fully satisfactory in terms of effort and use of opportunities, even though it has improved over the years. Also for this project, the major IP concern is that, during project implementation, proposed benefits for IP, migrants, and other vulnerable groups are not fully realized. Potential shortcomings may concern: (i) project relevance and appropriateness for certain IP, (ii) project effort and efficiency and (iii) sustainability of interventions.

In particular for Output 1 - CDC in border areas, activities such as community engagement for diseases prevention and case finding, training, campaigns and outreach services should be appropriate for the particular IP. Surveillance and response systems should also be appropriate given limited local capacity. IP should be facilitated to access screening and manage infections. Sustainability of interaction of communities and health services will depend on appropriateness of staff and affordability of services, as well as on integration of IP needs in provincial annual plans and budgets. Inclusivity in the central and provincial planning and monitoring processes along with special efforts to reach certain IP and other vulnerable groups will be critical success factors.

For this project, MOH has committed to provide the necessary leadership and inputs to fully implement the EGDP. MOH aims to maximize project benefits for vulnerable groups likely to be at increased risk of infectious diseases in border areas. Vulnerable groups include migrants and mobile people, ethnic minorities, and other vulnerable groups including youth and poor women. In alignment with national policy and context, MOH proposes to mainstream IP concerns in all project activities. The EGDP is to (i) enhance equal opportunity, (ii) target vulnerable groups, and (iii) promote IP in alignment with priorities.

The Government is facing several challenges in implementing the EGDP such as MOH capacity, provincial priorities, staff shortage in remote health centers and health posts, and financial and logistic constraints. MOH is aware of its constraints to reach isolated villages and migrants. MOH has experience and mechanisms in place to work with other agencies and grassroot organizations for social mobilization and village health development. MOH is encouraging partners to help finance these investments.

MOH plans to engage beneficiaries in participatory planning and monitoring processing. IP engagement and services, along with other activities to be supported by the project will all be included in provincial and district annual operational plans and budgets, and in staff training and project management.

Key features of the EGDP are mirrored in the project design and monitoring framework, loan covenants, and project administration manual. The PMU and implementing provinces will have a focal point for implementing the EGDP to ensure that IP issues are being addressed. MOH will also engage a chief technical adviser and a gender and social safeguards expert to assist in this process. The PMU will also seek to include MEV disaggregated indicators, and report on progress of implementing the EGDP in every quarterly and annual project report, and on the project website.

I. PROJECT DESCRIPTION

1. GMS leaders are committed to enhance regional health security following outbreaks of emerging infectious diseases (EIDs), notably severe acute respiratory syndrome (SARS) in 2003, and avian influenza in 2004. Recent outbreaks of Ebola hemorrhagic fever (EHF) in West Africa and middle-east respiratory syndrome (MERS) in South Korea show respectively, how EIDs can get out of control with major human impact, and how a relatively small outbreak in a hospital can have major economic impact. New zoonosis poses a constant threat in the region.

2. Misuse of antibiotics for bacterial infections is causing drug resistance, while new antibiotics are few and expensive. Nosocomial infections in hospitals are increasing due to poor infection prevention and control (IPC). Common infections like dengue and cholera show genetic adaptation. Climate change including global warming and frequent flooding may also increase the disease burden of infectious diseases. While the incidence of HIV/AIDS, tuberculosis and malaria have declined following major investments, drug resistant types are also considered EIDs and major threats for the control of these diseases. Childhood infections preventable through immunizations are resurging due to weak vaccination systems. Continued investment will be needed to keep communicable diseases under control.

3. The overarching drivers for GMS control of emerging and re-emerging infectious diseases (EIDs) are the International Health Regulations (IHR, 2005) and the Asia Pacific Strategy for Emerging Diseases (APSED, 2010) and related disease control and health system building strategies of the World Health Organization (WHO). The IHR and APSED strategic areas guide efforts to improve public health security, including surveillance and outbreak response, risk analysis and communication, community preparedness, laboratory services, hospital infection control, and regional cooperation. Other WHO global and regional strategies also guide control efforts, such as for the control of HIV/AIDS, malaria, tuberculosis, dengue, and neglected tropical diseases; strengthening of laboratory services, infection control in hospitals, and the control of fake drugs.

4. The term health security[6] refers to a public health goal of prevention of major epidemics or other disasters with major impact on health and the economy, and is concerned with the health of populations, in contrast to universal health coverage, which is concerned with the right of every individual to affordable, quality health care. Investment in the control of emerging diseases has strong public goods, market failure and equity rationale, in addition to potential economic and political consequences of a major epidemic or pandemic.

5. MOH and WHO have conducted evaluation of APSED implementation in 2015. Cambodia has not yet achieved IHR and APSED targets. Core functions owned by MOH are well in place, but other functions depending more on collaboration with other countries, sectors, partners, community, and the private sector are less advanced. Here is major progress in the control of malaria, less progress in the control of HIV/AIDS, tuberculosis, and dengue, and major emerging concerns of nosocomial infections and multiple drug resistance.

6. Overall, public health security systems for APSED and other significant diseases need to become more mainstreamed, standardized, reliable, and financially sustainable. Second, in view of the increase in communication, urbanization and industrialization, the traditional dependence on a single public health system no longer holds, and MOH will need to strengthen its capacity

[6] According to WHO, health security is achieved through a set of activities, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations.

for collaboration with other sectors. Progress in APSED is affected by health system limitations, but these are not clearly identified. Key areas are IT connectivity, basic staff capacity and administrative and management capacity. In general, the private sector is a big unknown in terms of surveillance and response.

7. While there is a high risk of the spread of diseases and drug resistance, surveillance and response systems have not been fully capable of real-time and accurate information, indicating epidemic status at local levels. Several disease reporting systems are in place, but are not linked, do not reach communities, and fail to provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, thereby also limiting the efforts to improve disease control and community prevention and preparedness.

8. One way to address this is through integration of public outreach services, including community health promotion, prevention and outbreak preparedness, active case finding, screening, and, if necessary outbreak response ranging from food poisoning and dengue control to simulation exercises and control of the EIDs. Such packaging of services could make services more efficient and provide tangible staff learning opportunities. Capacity building for control of EIDs and other regional health threats can be combined. Further quality and efficiency improvement can be gained by combining services, such as for combining laboratories in regional hubs; and by improving quality control and audit of public health services, in both public and private sectors.

9. Laboratory services are complex, requiring some 20 subsystems to be in place. In Cambodia, substantial strategic planning has been done to improve laboratory services, and quality and biosafety of larger laboratories in the big provinces has been improved. However, staff constraints limit the potential for upgrading smaller laboratories in the more rural provinces. These laboratories need support in terms of staff training, referral and maintenance systems, quality assurance and audit, and medical-laboratory linkages. Addressing these system gaps will enhance benefits of past investments.

10. Hospitals are the most likely recipients for any emerging disease, and also pose a major concern in terms of spreading these and other diseases. In addition, hospitals are a source of nosocomial infections and drug resistance. Current facilities and practices in health facilities regarding infection prevention and control (IPC) are substandard, in terms of IPC management, staff capacity, facilities (isolation ward, sanitary ware, laundry, medical wears), hygiene practice standards, and practices (handwashing, visitors).

11. Regional cooperation currently consists mainly in the form of ad hoc information exchange and sometimes joint outbreak response, without standard operating procedures and regularity of reporting. Cross-border cooperation is gaining momentum but needs to be integrated as part of regular CDC. In previous projects, knowledge management activities have been quite prominent and have generated technology transfer, staff capacity, leverage, competition and commitment, and monitoring progress; but their potential, e.g. developing disease control strategies, early warning of outbreaks, and joint diseases control, is yet to be fully developed. Regional workshops on health security need to focus more on agreements for action, and follow-up. The regional cooperation unit may need to be strengthened.

12. The proposed Greater Mekong Subregion Health Security Project (the Project) is designed to support regional cooperation and national capacity building for prevention and

control of EIDs and other diseases of regional importance including malaria, dengue, TB HIV/AIDS, cholera and nosocomial and drug-resistant infections.

13. The Project builds on the achievements and lessons learned of the Governments of the Greater Mekong Subregion (GMS) and partners in enhancing GMS health security and reducing the burden of communicable diseases. ADB is currently supporting the CDC2 extension in Cambodia, Lao PDR and Viet Nam. Other major partners in the field of CDC are WHO, other UN agencies, and the US government.

14. The project will assist with implementation of the Government's drive towards universal health coverage, with complementary public health security. The countries give priority to disease prevention and control in poor border districts with multiple risks of communicable diseases and weaker public health system.

15. The Project aims to expand beyond core APSED capacities to improve strategic areas that have received less attention, in particular to reach communities and hard to each groups in these border areas, cooperation and linkages, and improving quality and biosafety of services. The Project will help develop disease prevention and control, especially in poor border districts.

16. The impact will be GMS public health security strengthened. The outcome will be improved GMS health system performance, with regard to health security. The proposed project locations are provinces and districts along the borders and economic corridors. Selection of project provinces is based on (i) economic status of the province; (ii) health and health services statistics; (iii) regional risks and priority clusters; and (iv) existing support from other partners. In Cambodia, the project will cover 13 provinces; in Lao PDR, 12 provinces; in Myanmar, 6 states and regions; and in Viet Nam, 36 provinces. The project outputs will be: (i) improved GMS cooperation and CDC in border areas; (ii) strengthened national diseases surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

(i) **Strengthened regional, cross-border, and inter-sectoral CDC.** Output 1 will: (a) strengthen regional, cross-border and inter-sectoral cooperation for the control of epidemics including EIDs, dengue and other important regional diseases, and (b) increase access to CDC for at risk youth, migrants and ethnic groups in border areas by providing outreach services using outbreak response teams**.**

(ii) **Strengthened national disease surveillance and outbreak response.** Output 2 will enhance the current surveillance and response system by: (a) expanding web-based reporting for improved surveillance and response capacities, and (b) improved community preparedness and syndromic reporting at village level.

(iii) **Improved laboratory services and hospital infection prevention and control**. Output 3 will: (a) improve quantity and biosafety of laboratory services; (b) scale up where appropriate for monitoring hospital based infection and drug resistance, and (c) improve hospital hygiene and management of highly infectious diseases.

17. **Cost estimates and financing.** In Cambodia, the Project is estimated to cost $22.8 million, to be financed by an ADB loan of $21 million and $1.8 million in Government counterpart funds. About $5.0 million of the project is reserved for regional and cross-border cooperation and CDC in border areas directly targeting MEV, who will also benefit from general improvement of health services provided they use these services. Provincial administrations will encourage ethnic groups to use services.

18. **Project implementation.** The Ministry of Health (MOH) will be the executing agency (EA), responsible for in-country implementation and coordination among countries. In Cambodia, the EA will be represented by the Health Sector Support Program (HSSP) Department of Planning and Health Information Systems, headed by the Secretary of State, who reports to the health sector steering committee for the HSSP chaired by the Minister of Health[7].

19. The Communicable Diseases Control Department (CDCD) in MOH is the coordinating implementing agency (IA). The Director CDCD is the Project Manager. The existing CDC2 Project Management Unit (PMU) in the coordinating IA will be continued for day-to-day project implementation. The PMU will have a project director and focal points for all project activities and administration, including for gender and social safeguards. The Chief Technical Advisor (CTA) and Gender and Social Safeguards Specialist will be engaged with special responsibility for Component 1. Linkages will be established with community-based organizations and partners as needed. The PMU and provincial health departments will support: (i) annual operational planning, coordination and budgeting, (ii) project implementation activities, (iii) proper procurement, financial management, (iv) adherence to safeguards, and (v) monitoring and reporting. The 13 provincial health departments will also serve as IAs. At provincial or township level, the provincial / township health department (P/THD) will be the designated project implementation unit (PIU). There are up to 3 positions in each PIU to be financially supported by the Project in each province/township, depending on the workload. This includes a provincial project coordinator, a technical officer and an account assistant.

20. The Regional Steering Committee (RSC) established under CDC1 will give guidance in Project implementation, policy dialogue, and building of regional capacity and cooperation for CDC, facilitating country decisions on the use of pooled funds for regional activities. It will be chaired by the minister or vice-minister of the host country and will consist of leading representatives from the national SCs, project directors, and ADB and WHO representatives. The Regional Coordination Unit (RCU) based in MOH Vientiane will act as the secretariat for regional coordination activities and the management of regional funds. Regional project meetings will be held 6 months before the RSC meeting to follow up regional activities and organize regional events, and report these to the RSC.

21. To support regional health security, the Project will directly support Cambodia, Lao PDR, Myanmar, and Viet Nam and encourage participation of the Peoples Republic of China (PRC) and Thailand in regional and cross border activities. All country project proposals include in the scope regional cooperation and CDC in border areas, surveillance and response, and laboratory quality improvement, and hospital hygiene, but there are differences in emphasis among the 4 countries. Both MOH Cambodia and MOH Lao PDR give emphasis to reaching those not being reached with CDC in border areas. In Myanmar, the aim at this early stage is to develop model services in state laboratories and major border hospitals. In Viet Nam, the emphasis is to develop the district health center.

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7 World Bank Health Sector Support Program Phase 1 and 2 HSSP2 is still on-going but expected to be completed in 2016.

22. **Location**. The Project is to cover 3 east-west corridors and one multi-limbed north-south corridor representing 4 distinct geographical clusters of MEV issues, as shown in Appendix 1. In Cambodia, the Project is to cover 3 clusters totaling 13 provinces in the north-west (3) bordering Thailand (Banteay Meanchey, Battambang, Pailin), north-east central (5) bordering Lao PDR, Thailand and Viet Nam (Preah Vihear, Stung Treng, Rattanakiri, Mondulkiri, and Kratie), and south-east (5) bordering Viet Nam (Kampot, Kandal, Prey Veng and Svay Rieng). In the Lao PDR, 12 provinces are included in 3 clusters in the north, center and south of the country. In Myanmar 5 states and one region are included along the easter border with China, Lao PDR and Thailand. In Viet Nam, 36 provinces are included along the northern border with China and the western border with Lao PDR and Cambodia. The north-south corridor connects major industrial areas in China with industrial areas in Viet Nam, Lao PDR, Cambodia, Thailand, and Myanmar and is the important one in terms of traffic flow, while migration flows are mainly to Thailand. The central corridor comprises most EMGs, and the north-south corridor passes through few locations with high concentration of EMGs, which could be hotspots for targeting.

23. In Cambodia, all 5 provinces in the north-east have poverty rates over 30%. Within all border districts along economic corridors, hotspots and communities with high burden of communicable diseases and low CDC coverage will be selected, using reported and estimates cases. Selection criteria will also consider local commitment, presence of partners, and feasibility of having impact on these communities. The Operational Districts (ODs) will conduct a participatory assessment and planning process, and ensure that plans are included in the provincial annual operational plan, and sustained from local sources after project completion.

II. SOCIAL IMPACT ASSESSMENT

A. Legal and Institutional Framework

24. According to ADB's 2009 *Safeguard Policy Statement (SPS)*, the objectives of Indigenous People safeguards are to design and implement projects in a way that fosters full respect for Indigenous Peoples' identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by the Indigenous Peoples themselves so that they: (i) receive culturally appropriate social and economic benefits; (ii) do not suffer adverse impacts as a result of projects; and (iii) can participate actively in projects that affect them. ADB indigenous peoples policy as presented in the SPS includes the following principles:

- Screen early on to determine (i) whether Indigenous Peoples are present in, or have collective attachment to, the project area; and (ii) whether project impacts on Indigenous Peoples are likely.

- Undertake a culturally appropriate and gender-sensitive social impact assessment or use similar methods to assess potential project impacts, both positive and adverse, on Indigenous Peoples. Give full consideration to options the affected Indigenous Peoples prefer in relation to the provision of project benefits and the design of mitigation measures. Identify social and economic benefits for affected Indigenous Peoples that are culturally appropriate and gender and inter-generationally inclusive and develop measures to avoid, minimize, and/or mitigate adverse impacts on Indigenous Peoples.

- Undertake meaningful consultations with affected Indigenous Peoples communities and concerned Indigenous Peoples organizations to solicit their participation (i) in designing, implementing, and monitoring measures to avoid adverse impacts or, when avoidance is not possible, to minimize, mitigate, or compensate for such effects; and (ii) in tailoring

project benefits for affected Indigenous Peoples communities in a culturally appropriate manner. To enhance Indigenous Peoples' active participation, projects affecting them will provide for culturally appropriate and gender inclusive capacity development. Establish a culturally appropriate and gender inclusive grievance mechanism to receive and facilitate resolution of the Indigenous Peoples' concerns.

- Ascertain the consent of affected Indigenous Peoples communities to the following project activities: (i) commercial development of the cultural resources and knowledge of Indigenous Peoples; (ii) physical displacement from traditional or customary lands; and (iii) commercial development of natural resources within customary lands under use that would impact the livelihoods or the cultural, ceremonial, or spiritual uses that define the identity and community of Indigenous Peoples. For the purposes of policy application, the consent of affected Indigenous Peoples communities refers to a collective expression by the affected Indigenous Peoples communities, through individuals and/or their recognized representatives, of broad community support for such project activities. Broad community support may exist even if some individuals or groups object to the project activities.

- Avoid, to the maximum extent possible, any restricted access to and physical displacement from protected areas and natural resources. Where avoidance is not possible, ensure that the affected Indigenous Peoples communities participate in the design, implementation, and monitoring and evaluation of management arrangements for such areas and natural resources and that their benefits are equitably shared.

- Prepare an Indigenous Peoples plan (IPP) that is based on the social impact assessment with the assistance of qualified and experienced experts and that draw on indigenous knowledge and participation by the affected Indigenous Peoples communities. The IPP includes a framework for continued consultation with the affected Indigenous Peoples communities during project implementation; specifies measures to ensure that Indigenous Peoples receive culturally appropriate benefits; identifies measures to avoid, minimize, mitigate, or compensate for any adverse project impacts; and includes culturally appropriate grievance procedures, monitoring and evaluation arrangements, and a budget and time-bound actions for implementing the planned measures.

- Disclose a draft IPP, including documentation of the consultation process and the results of the social impact assessment in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected Indigenous Peoples communities and other stakeholders. The final IPP and its updates will also be disclosed to the affected Indigenous Peoples communities and other stakeholders.

- Prepare an action plan for legal recognition of customary rights to lands and territories or ancestral domains when the project involves (i) activities that are contingent on establishing legally recognized rights to lands and territories that Indigenous Peoples have traditionally owned or customarily used or occupied, or (ii) involuntary acquisition of such lands.

- Monitor implementation of the IPP using qualified and experienced experts; adopt a participatory monitoring approach, wherever possible; and assess whether the IPP's objective and desired outcome have been achieved, taking into account the baseline conditions and the results of IPP monitoring. Disclose monitoring reports.

25. The Borrower is required to prepare an Indigenous Peoples Plan to protect, and ensure benefits for, indigenous Peoples affected by the Project. According to the Indigenous Peoples Safeguards Sourcebook, "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements.*" According to the Sourcebook, *"IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, *"the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* In the same Sourcebook, it is noted that *"a stand-alone IPP may not have to be prepared when ... only positive impacts are expected from the project."* ADB clarified that given the scale and complexity of this regional project, the potential for not achieving certain intended positive impact on indigenous peoples justifies in category B and warrants preparation of the IPP to help achieve intended impact on Indigenous Peoples Group.

26. The legal basis for Indigenous Peoples Group in Cambodia is provided in the National Constitution (Article 31) and the National Policy on the Development of Indigenous Peoples. The lead government agency in regard to Indigenous Peoples in Cambodia is the Ministry of Rural Development. There are also explicit roles of different government agencies to implement the National Policy on the Development of IP[8]. MOH is responsible for ensuring EMGs have equal access to health services, among others through engaging ethnic minority staff, increasing qualified staff in remote health centers and health posts, and providing health equity funds for the poor, many of whom are IP.

27. The National strategic Development Plan (NSDP) 2014-2018 focuses on the employment, equity, human resources development, and agriculture and infrastructure development. All Cambodians including IP are ensured of benefits from these 4 components of the rectangular strategy, which aims to reduce poverty of Cambodians about 1% a year. But in order to realize this goal, the key health issues need to be addressed.

28. The EGDP proposes that MOH mainstreams the IP dimensions in all project operations. The IP development strategy aims to (i) enhance equal opportunity for IP, (ii) target vulnerable groups among IP and non-IP, and (iii) promote IP dimensions in all project activities. It proposes to maximize benefits for vulnerable groups in border areas who are likely to be at increased risk of infectious diseases. These vulnerable groups include migrants and mobile people, isolated and poor ethnic minorities, and other vulnerable groups such as youth and pregnant women. The EGDP is aligned with national legislation and ADB's SPS.

B. Baseline Information

29. The countries show strong economic growth due to foreign investment in economic zones, plantations, and services, causing rapid industrialization (table 1). The population shifts (mostly internal migrants) in search of employment including IP, which in turn contributes to urbanization. It also shows a young population in Cambodia and Lao PDR. About 5-10% of external migrants are below the age of 18 years. While per capita income has been increasing rapidly, poverty is still common, in particular among ethnic minorities. While child mortality has declined, child malnutrition remains high, and so does the prevalence of major communicable diseases, while health sector coverage of the population is not yet universal.

[8] National policy on Indigenous Peoples Development, 2009, Cambodia

Table 1: Key Demographic, Economic and Social Indicators in the GMS

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Economic growth rate %	7.0	6.5	8	6.0
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Population below 15 years	31.1	34.7	24.5	23.2
Median age in years	24.5	19.3	28.5	29.6
Sex ratio (% m/f)	95	99	94	112
Population growth rate (%)	1.8	1.9	0.8	1.0
Population density per square kilometer	85	29	79	279
Urban population (%)	20.5	37.6	33.6	33.0
Urban growth rate (%)	2.7	4.9	2.5	3.0
Per capita income in US$	1008	1589	1184	1868
People earning below $1.25 per day (%)	19	23	26	13
Unemployed as % of labour force	0.3	1.4	3.4	2.0
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	NA	1.184	11
Tourist arrivals (1,000)	4.200	2.500	2.000	7.500
Mobile phones subscribers/100 persons	134	66	13	131
Internet users estimate (% population)	6	13	1	44
Primary/Secondary GER f/m	81/89	76/82	79/78	89/87
Child mortality general population	42.5	41.9	62.4	21.7
Child malnutrition in main population %	28.3	33.9	28.0	16.9
HIV prevalence in main population %	0.6	0.3	0.7	0.5
HIV prevalence among sex workers %	4.6	1.3	18.4	3.0
TB incidence main population /100,000	390	189	369	140
Malaria cases confirmed total	21,309	46,202	333,871	17,128
Malaria deaths confirmed / 100,000	1.7	4.4	5.4	0.1
Full Immunization main population %	85	49	98	95
Contraceptive prevalence rate (%)	51	50	46	78

Sources: UN agencies ; *Viet Nam Economic and Development Strategy Handbook, 2004 ; ** anecdotal reports, e.g., one study reports under age Hmong sex workers for tourists in Sapa ; *** e.g., one study for Lao migrants returning from Thailand ; **** BWHO National Survey of Tuberculosis Prevalence 2010 ; */* SEAJTM Prevalence of Tuberculosis in Migrants 1996 ; HIV data from UNAIDS 2008 report ; HIV data from UNAIDS 2014 report ; WHO and World Bank indicators ; SEAJTM Prevalence of Tuberculosis in Migrants 1996.

30. Indigenous and vulnerable ethnic minority groups comprise only about 4-5% of the population in Cambodia[9]. These EMGs are a very mixed group, but typically live in the highlands and mountains. In Cambodia, indigenous EMGs mainly live in the north eastern provinces (Rattanakiri, Mondukiri, Stung Treng, and Kratie provinces), with some small groups living elsewhere in the north-west and scattered throughout the country. They are called « upland Khmer « although many do not live in the highlands and are not related to Khmer (the term Khmer is being promoted to mean all citizens of Cambodia). IP related to the Khmer include the Mon-Khmer who mostly live in the north-east. Few ethnic groups are related to polynesian Cham (mostly eastern provinces) and Burmese (Pailin province). Most EMGs are fully assimilated in Khmer society in terms of culture and language, and no longer consider themselves as minority,

9 If all Chinese and Vietnamese minorities are included, the total minorities is estimated at 10%.

which would exclude them from the EGDP as per ADB definition. This also explains the range of estimates of IP varying from 1% to 5%. This was reenforced during the civil war, when both indigenous and exogenous ethnic minorities were being targeted. People today are also hesitant to identify themselves as belonging to an EMG as it is considered a lower social status in the hierarchical and status-conscious Cambodian society.

31. The IP found in Ratanakiri, Mondulkiri, Stung Treng, and Kratie represent about 66%, 71%, 7%, and 8%, respectively, of the total population in these provinces. The most populous ethnic groups are the Phong located in Mondulkiri, Stung Treng, and Ratanakri, the Tampuon located in Rattanakiri and Mondulkiri, the Kuy located in Preah Viher, Kampong Thom and Stung Treng and the Jarai located in Rattanakiri.[10] The five provinces in the north-east: Preah Vihear, Stung Treng, Rattanakiri, Mondulkiri, and Kratie, all have poverty rates over 30%.

32. Specific information on ethnic groups is largely lacking from more recent government documentation. For example, the intercensal population survey 2013 lacks information on ethnic minorities. The Government has a deliberate policy of braking down ethnic differences in order to integrate the population.[11] Reports on health statistics appear to be unreliable, presenting both over- and under-estimates. However, the Demographic and Health Survey of 2014 provides information by province, and provinces with a high proportion of IP have worse social and health statistics (table 2). Ethnic minorities in the north-eastern provinces have higher rates of infectious diseases such as malaria, tuberculosis, diarrheal diseases, and acute respiratory infections; and have less food security due to lower productivity linked to climate, land quality and farm inputs. They also have less access to education and health services. Data gaps will be filled through collection of statistics in health services and a participatory assessment during the first month of project implementation. This will help set the project baseline including for IP. This is discussed further in section VI.

Table 2: Key social indicators by province

	Banteay Meanchey	**Battambang/ Pailin**	**Mondulkiri/ Rattanakiri**	**Kratie**	**Prey Veng**	**National**
No education % for all age 6 and above	19.6	16.5	33.9	20.1	22.1	18.9
Handwashing place observed %	98.3	97.7	41.9	87.9	60.1	84.7
Has birth registration for all children below 5 years of age%	72.2	70.5	39.7	45.3	79.2	73.3
Seek health care for illness or injury %	96.1	91.2	86.1	94.5	98.3	95.1
Cost of care for illness or injury US$	58	40	56	55	70	34
Subsidy received for health care US$	4.4	7.3	5.0	5.4	2.5	5.7

National Institute of Statistics, 2014. *Demographic and Health Survey*
Note: Mondulkiri. Rattanakiri and Kratie have high proportion of ethnic minorities.

C. Stakeholders and Consultations

33. In MOH, IP issues are referred to in general planning. As the government aims to mainstream IP, there is no specific policy, strategy, plan or designated unit for IP. The

[10] *Indigenous Peoples / Ethnic Minorities and Poverty Reduction, Cambodia*, Asian Development Bank, 2002
[11] National Institute of Statistics. Ministry of Planning. Intercensal Population Survey. Phnom Penh.

Department of Planning and Health Information Systems (DPHIS) is tasked with ensuring adequate services for IP in view of achieving Universal Health Coverage (UHC), which will among others require improving the monitoring system and planning special investments. Each village or group of villages has a village health group (village health volunteers) responsible for assisting with the implementation of health activities, reporting diseases, and planning village health improvements.

34. There are several organizations involved in the wellbeing of IP, including the military, religious and grass-root organizations, NGOs, and Government services. The lead government agency in regard to IP is the Cambodia Ministry of Rural Development. It is mandated to identify IP groups based on their identity based on legal documents with the Ministry of Interior and the Ministry of Land Management, Urban Planning and Construction for communal land title. The Ministry of Women Affairs, through its branches, is engaged in advocacy for gender equality among IP in rural areas. The military operates an extensive network of health services for their personnel and dependents in border areas, including in remote rural areas with security problems. The military medical personnel sometimes provide health services for local IP. The Buddhist organization operates basic health services throughout the country. Chinese, Vietnamese, Muslim and Christian facilities provide services for their respective communities. The Ministry of Interior and the Ministry of Labour provide comprehensive provide training on legal aspects.

35. In Cambodia, while the population of indigenous groups is estimated to be roughly 5%, the proportion of migrants, mobile populations and other vulnerable minorities especially in proposed project areas, is not known. The presence of national or international associations or interest groups for specific ethnic groups (EGs) may not extend to the most disadvantaged groups, thus EG migrants may be less likely to benefit from the wide range of rights, benefits and protections. One problem is that of educated IP migrating to Phnom Penh or abroad. The impact of this process on the IP transition is not known. However, this new leadership could play an important role in policy making and planning.

36. The consultation process relied in part on knowledge gained from the CDC2 project, the ongoing project with model healthy village development in the north-eastern provinces. In September to November 2016, consultants visited Banteay Meanchey, Svey Rieng, Kratie, Stung Treng and Thbong Khmum provinces. The first two provinces have large economic zones with busy border crossings, casinos, industrial development, and large migrant populations. The next two provinces have a large population of EMGs. Thbong Khmum province was split from Kamponcham province in 2013 as it is also developing rapidly on the border with Viet Nam. The consultation and participation process undertaken during the preparation of this EGDP involved discussion with goverment officials, health staff, patients, community representatives and partners as summarized in Appendix 2.

D. Vulnerabilities, Risks, and Project Effects

37. IP and other EMGs in GMS border areas can no longer be viewed simply in terms of disadvantaged due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises, but also growing numbers of national and international cross-border migrants. EMGs are beginning this process of integration from a very disadvantaged position. Migrants, EMGs and other vulnerable groups (MEVs) such a youth and

pregnant women need special attention in any health administration, but this is often not happening, in part because health plans are disease-focused. See Appendix 1 for more background of MEVs in the GMS.

38. EMG populations living near regional economic corridors bear a disproportionate burden of the health costs of the rapid social and economic changes created by these developments. Relocation and/or resettlement of EMGs have been supported by governments and donors in CLMV for various reasons. In some provinces, movements of highland EMGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas.[12]

39. When highland-dwelling EMGs move to lower altitudes, they are exposed to malaria, to which they have little acquired resistance, so in the early phase of relocation to lower altitudes, there have been high mortality rates from malaria, as well as morbidity resulting from exposure to other water-borne and environmentally-related infectious diseases.

40. EMG populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.

41. Some EMGs may use health services, when they are available, only as a last resort. This may be because of lack of experience but also reflects anxiety about modern health services and expense of accessing them. Shifting cultivation practices also limit the opportunities to access the health service for some EMGs, especially women. EMGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel ashamed and reluctant to access services, and numerous reports of belittling treatment of EMGs by government health workers were shared informally during the field research. Programs aiming to promote behavior change (e.g. building and using latrines, drinking boiled water, removing disease vector breeding sites, hygienic management of animals, hand-washing, using bed nets, and acceptance of vaccination) are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EMG villages.

42. Provision of free health insurances has enabled poor EMGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered by the health cards. An International Organization for Migration (IOM) program on the Thai-Cambodia border found 127 cases of TB when screening deportees, while

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[12] Gebert, R. 1995. *Socio-economic baseline survey*. Muang Sing: GTZ Integrated Food Security Programme. Cohen, P.T. 2000a. "Lue across borders: pilgrimage and the Muang Sing reliquary in Northern Lao PDR. In G.Evans, C. Hutton and Kuah-Khun Eng (eds.) *Where China Meets Southeast Asia: Social and Cultural Change in the Border Region*. Singapore: Institute of Southeast Asian Studies. Cohen, P.T., 2000. "Resettlement, opium and labour dependence: Akha-Tai relations in Northern Laos", *Development and Change*, 31:179-200. Romagny, L. and Daviau, S. 2003. *Synthesis of Reports on Resettlement inLong District, Luang Namtha province, Lao PDR*. Action Contre La Faim mission in Lao PDR. Lyttleton, C. 2005. "Market-bound: relocation and disjunction in northwest Lao PDR". In Toyota, M., Jatrana, S., and Yeoh, B., 2003 (eds.) *Migration and Health in Asia.* Routledge. Alton, C. and Houmphanh Rattanavong, 2004. *Service Delivery and Resettlement: Options for Development Planning*, unpublished report, UNDP: Lao PDR, Vientiane. McCaskill D. and K. Kampe (eds.) 1997. *Development or Domestication: Indigenous Peoples of Southeast Asia* Chiang Mai: Silkworm Press.

in one study about 3% of migrants returning from Thailand to Lao PDR were testing positive for HIV. A major problem is that these returning migrants do not get pre-screening nor do they have access to treatment at home, so they have to try to return to Thailand to continue treatment. Default rate is high, leading to drug resistance.

43. Although EMGs are more likely to have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EMGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The disparities are highlighted in country specific data showing that provinces with high infant and child mortality rates also have high concentrations of EMGs. Surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by health centers and hospitals. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive.

44. The Project does not impose any vulnerabilities or risks or negative project effect on the EMGs in the project area. The only risk there may be is that EMGs are excluded from the benefits of the Project. Hence the EGDP aims to ensure that the project design, implementation, and monitoring maximizes benefits for EMGs.

E. People's Perceptions

45. Based on 10 years of ADB-supported project experience, the proposed project interventions are much appreciated. The problem is on the supply side rather than the demand side, in that MOH lacks the means to reach remote EMGs and migrants, and may be unable to assign staff to these places. Earlier on, MOH was contracting out services to NGOs. Some of these NGOs managed to engage with EMG villages. However, this function was handed over to Operational Districts (ODs). One drawback of results-based budgeting is that it often focuses on the low hanging fruits to get the results, and subsequently plans inadequately for IPP.

46. As summarized in Appendix 2, EMG village health groups indicated that common health problems are respiratory and diarrheal infections, dengue, infections, fever, cough, and problems of pregnancy and accidents that require referral. They are willing to collaborate but for time constraints if the interventions are not controversial and accepted in the community. They do not want one time promises, but continuity of engagement. Village health groups already participate in CDC in terms of planning model healthy village development, disease reporting and community preparedness, facilitating immunization and case finding, and referring people. The proposed project interventions did not raise any objections. However, community-based interventions require thorough preparation to achieve the desired results.

F. Proposed Measures

47. Each project implementation unit established at provincial level will support project border districts, through a consultation process with village health groups, community based organizations and other representative groups, to (i) identify migrants and ethnic groups along borders and economic corridors, (ii) identify gaps in communicable disease control; and (iii) plan activities including screening, diagnostics, disease control, and referral to established health facilities. Village or facility CDC plans will be included in provincial annual plans and budgets. This should help achieve benefits for migrants and ethnic groups in this project. Progress should be routinely reported to MOH.

III. INFORMATION, DISCLOSURE, CONSULTATION AND PARTICIPATION

48. Key questions concerning EMGs (and migrants) in project design, apart from general health status, include (i) their understanding of communicable diseases, causes, treatment, and prevention; (ii) EMG's (and migrant's) use of services and their perceptions of acceptability, availability, quality and affordability of government and other health services; and (iii) community organization for health services and participation in the project cycle.

49. National and international Social Safeguard Specialists conducted an assessment of social impact, including review of documents, field visits, stakeholder meetings, workshops, and assessment and disclosure of social impacts and mitigating measures from 28 October to 6 November 2015. They met with MOH Departments, WHO, IOM, World Bank, UNOPS, UNAIDS, and the Gender Group. In one of the workshops, social safeguard requirements were presented to the Government. The team visited Banthey Meanchey and Svey Rieng provinces, and conducted interviews with provincial officials, health staff, patients, sex workers, and community members and their representatives. Respondents were asked about their circumstances, views on health services, and health priorities. As there are no negative effects expected from the Project, the focus was on understanding the conditions and how the EMGs could be better assisted through the project design. This is summarized in the IPP assessment in Appendix 3. The 13 provinces will further engage affected EMGs in local assessment and planning and disclose project plans, including this EGDP, to affected groups following completion. The EA will ensure that the IPP is endorsed and translated into Laos and disclosed on their website. The IPP will also be summarized in local languages and made available to EMG communities in an appropriate form and manner. The disclosure will provide sufficient information to ensure that all community members (women and men of all EMGs) are made to understand the roles, responsibilities, and processes.

50. As summarized in Appendix 3, patients and other locals were generally satisfied with the health services. They particularly praised the attitude of health staff, trying to assist in sometime difficult conditions. Emergency services were singled out as a priority for improvement. The main change noted by the patients and other locals was the improvement in medicines. Local health staff noted the need for more in-service training and outreach services. Government officials emphasized that everyone has access to free health services including all ethnic groups and migrants. However, they also noted a lack of qualified staff in local health facilities, and that certain EMGs were hard to reach and did not make much use of public health services. Out of pocket payment was not considered an issue for the poor as the health facility provided services for free, or could provide waver for poor people.

51. Among the risks noted were: (i) lack of interest of targeted EMGs; (ii) weak provincial effort in participatory planning, implementation, and monitoring; (iii) lack of effort reaching isolated EMGs, migrant camps, and hotspots; and (iii) insufficient technical and financial backstopping of MOH. For migrants an additional issue is that it may be difficult for migrants to access health services due to unregistered migration and employment conditions; and for health staff to access and inspect labor camps, factories and casinos, which requires collaboration with MOL and business owners. These risks need to be mitigated as part of the IPP.

52. In view of these risks of insufficient focus on ensuring project benefits for IP as per EGDP, each level in the health system has clear arrangements between the officer in charge, the focal point, consultants, and any third parties for planning, implementation and monitoring of the EGDP as part of overall project implementation. Each level will ensure consultation of

potential beneficiaries or their representatives on a quarterly basis and at each stage of the process. Progress will be reported to beneficiaries and shared on websites of RCU and ADB.

IV. BENEFICIAL MEASURES

53. Direct beneficiaries in Component 1 will include prioritized EMGs[13], migrants, laborers in camps, youth, national and provincial preventive medicine officers, district health center staff, commune health station staff and village health workers. It is expected that in the 13 targeted provinces in Cambodia the project will reach about 3.7m IP. Migrants, youth, pregnant women, and remote EMGs will receive additional screening and referral for treatment as needed. Project implementation units in provinces will conduct results-based, participatory planning to ensure strong commitment from all stakeholders, and prepare annual plans with activities and targets to be financed from project funds. It is expected that the provision of motorcycles (under Component 1) and vehicles (under Component 2) will increase mobility of provincial teams to reach out to these communities. Component 1 will also support regional, cross-border, and inter-sectoral cooperation for joint planning to extend services to the target groups, and joint activities. Monitoring and supporting this component will be critical and the main assignment of the CTAs, and the gender and social safeguard experts.

54. Component 2 will help improve community preparedness, timely detection, investigation, risk analysis, risk communication, and containment of emerging and other diseases of regional significance, such as malaria, dengue, cholera, TB and HIV/AIDS. Direct beneficiaries in Component 2 include health staff, and community health workers, who will improve outbreak reporting and response and community preparedness that is appropriate for EMG communities.

55. Component 3 will improve diagnostic capacity by improving laboratory quality, and also reduce the risk of spread of dangerous infections through better laboratory biosafety, hospital infection control, and better case management of infectious diseases. Direct beneficiaries in Component 3 include laboratory staff and hospital staff who work in EMG areas.

V. MITIGATION MEASURES

56. The purpose of this EGDP is to (i) outline the potential positive and negative impacts of the project on ethnic groups; (ii) specify actions to address these impacts; and (iii) help mitigate negative impacts and enhance benefits to IP and other ethnic minority communities. During project preparation, IP and ethnic minority communities and their representatives were consulted using key informant and focus group discussions (consultation will be continued during project implementation). To increase support for IP, other EMGs and achieve positive outcomes for IP and EMGs in the project, project management units at central (CPMU) and provincial levels (PPMU) will ensure full implementation of the EGDP. To facilitate this process, key features of this EGDP are mirrored in the project DMF, loan assurances, and PAM and aligned with the existing national policy commitments to ethnic group development in the four project countries. These include participatory assessment and planning with IP and EMGs,

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[13] Component 1 targets people in border districts, including migrants and mobile populations, vulnerable women and infants, ethnic groups, and in general, poor and people living in remote areas. These populations suffer from a high burden of illnesses and common infections such as malaria, tuberculosis, dysentery, diarrhoea, typhoid fever, acute respiratory infections, measles, and parasitic infections. Poverty and economic integration also pushes and pulls these people into professions and habits with high risk of HIV/AIDS and drug resistance. Without appropriate care these diseases result in high mortality, disability, and malnutrition, impact on learning and productivity. In addition, these marginalized high risk people that are not in touch with the public health system also pose a risk for the unnoticed spread of these diseases that may result in outbreaks.

outreach to migrants, and disease control campaigns, as well as improved disease reporting and outbreak response, and better access to diagnostic services and hospital treatment of infections.

57. The actions in the EGDP (Appendix 3) support integration of IP and EMG needs and interests into Project outputs, and ensure effective participation and access to Project benefits. Measures have been identified to enhance and ensure equitable sharing of project benefits. No negative project impacts were identified that would require mitigation measures, however lack of participation and weak implementation threatens the desired positive impact.

VI. CAPACITY BUILDING

58. MOH has extensive experience with donor funded projects including CDC1 and CDC2 which have shown a slow but steady improvement in addressing IP and EMG issues but not migrant issues. The Health Sector Program (HSP) 3 will be supported by a new program support led by the World Bank. The Project will be implemented under the umbrella of HSP3, which has provisions for general capacity building such as in monitoring, procurement and financial management. With the aims of UHC, DPHIS is considering to improve the health information system to get better information of the health problems of IP, other EMGs and migrants, and develop legislation to address their health problems. This will need capacity building in MOH and cooperation with MOL, ILO and IOM. The EGDP activities are mainstreamed into project implementation activities which will be implemented by the district and provincial health management and service teams. In order to ensure the EGDP is disseminated and that each level understands the actions and activities proposed under the EGDP and the grievance procedures; and that all understand their corresponding role and responsibilities; pre-start up training for provincial and district managers is recommended.

59. The Project will assist with training and capacity building of MOH/PMU and PIUs, including for implementation of the EGDP, through training and field visits. This will be supported by the CTA and the gender and social safeguards specialist. It will be critical for MOH to attract competent mid-career consultants to provide effective capacity building. Training will also be provided for infection prevention and control nurses and field epidemiologists, with some orientation towards ethnic minority and migrant concerns. Key features of the EGDP, such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and PAM.

VII. INSTITUTIONAL ARRANGEMENTS

60. DPHIS will represent MOH as the EA and will be responsible for overall direction to ensure implementation of the EGDP. The CDCD is responsible for Components 1 and 2, while DHS is responsible for Component 3. The PMU will be responsible for coordinating implementation of the EGDP through the PHOs and ODs. The PMU will have focal points for gender and social safeguards. The Chief Technical Advisor (CTA) and Gender and Social Safeguards Specialist will be engaged with special responsibility for Component 1. Linkages will be established with community-based organizations and partners as needed.

61. Concerned MOH Departments (CDCD, DHS), PHDs and NIPH will be the IAs responsible for EGDP implementation within their location/field. Each IA will nominate focal points for ethnic groups and migrant safeguards. These focal points will be provided with sufficient means to ensure that EGDP related priorities are being mainstreamed and prioritized where possible.

VIII. GRIEVANCE REDRESS MECHANISM

62. Local stakeholders' opinions and concerns will be incorporated in project planning, implementation, and monitoring. Quarterly meetings and consultation with representatives of project beneficiaries including IP and other vulnerable groups will be held. People will be informed on progress and encouraged to raise any concerns. The project representatives at various levels (commune, district, province and central level) will be responsible for reporting any grievances up to the appropriate level. Any complaint will be assessed and negotiated into a solution between the project representative (focal point or IA) and local authorities within a period of 1.5 months, and then fed back to the communities as part of the participatory planning process. If the conflict is not solved amicably, it will be taken to the next level, up to the PMU or MOH Steering Committee under the MOH, each within a period of 1.5 months. Any issue should be resolved within 6 months. The particular activities will be carried out after such conflict is resolved satisfactorily. In cases where affected households (AHs) do not have the writing skills or are unable to express their grievances verbally, AHs are allowed to seek assistance from any recognized local group, NGO, family member, village heads or community chiefs to have their complaints or grievances written for them. Throughout the grievance redress process, the responsible committee will ensure that the concerned AHs are provided with copies of complaints and decisions or resolutions reached. All formal complaints and responses will be made public through the website of the regional cooperation unit, and the ADB website.

IX. MONITORING, REPORTING, AND EVALUATION

63. Monitoring, reporting and evaluation of the project for the EGDP will follow the overall project arrangements. PMU and PHDs, in consultation with beneficiaries, will ensure that appropriate EGDP sensitive indicators are collected at community and health facility levels with reference to the targets and indicators in Appendix 3. PMU will prepare comprehensive quarterly reports based on agreed indicators. The reports will be submitted to ADB within the next quarter. The beneficiaries will also be informed about the project progress. Social Monitoring reports discussing progress in implementing the EGDP will be disclosed on ADB's website

64. Project evaluation will be carried out in three phases: (i) Project inception: capacity building, participatory assessment and planning, identification of sites, planning implementation details; (ii) Mid-term evaluation: assessment of progress of IPO implementation and adjustments, after 1.5 years; and (iii) End-of-Project evaluation and impact assessment after 5 years. The inception report, mid-term evaluation and project evaluation will be made available on internet. Each PHD will carry out assessment of all training activities, and baseline and end-of-project data collection for assessing trends in the use of CDC services by IP, EMGs in border areas under Component 1. No survey will be done: community and health facility records will be used to assess trends. Project evaluation will include an assessment of the effectiveness of EGDP, in terms of enhancing positive impacts. The evaluation will also assess the participation of stakeholders in project implementation. Beneficiaries will be informed about progress and results through community meetings, brochures, and reports available on the website of the regional cooperation unit and the ADB, and through distribution of brochures.

X. BUDGET AND FINANCING

65. The estimated costs of CDC for vulnerable groups are budgeted under Output 1, at a cost of about $4 million for regional and cross-border meetings and workshops, mapping and participatory planning with targeted communities, and specific community campaigns and

outreach services, part of which will benefit IP and other vulnerable groups in the targeted provinces.

66. The participatory planning process to prepare the detailed project plan and EGDP for each of the targeted provinces is expected to be completed within 3 months. This will include health staff orientation, collection of health services statistics, mapping and participatory assessments of IP and other vulnerable groups, and meetings and consultations.The EGDP will be incorporated in the five year and project implementation plan and budget. About half of the budgeted amount for Output 1 is expected to directly benefit IP. IP will also benefit from related training and communication activities which are incorporated in general project training and communication activities.

Appendix 1: Information on Migrants, Ethnic and other Vulnerable Groups

The GMS has several distinct populations and hundreds of ethnic groups and languages. While some ethnic groups have been settled in the GMS for a long time, others ethnic groups migrated only recently from within the country or from neighboring countries, in particular China. Perhaps due to their relative isolation, those in the highlands and mountains typically retain their culture and customs. Many ethnic groups, either indigenous or migrants, live in border districts. They are often joined by migrants from the main ethnic group, causing land pressures.

Studies have documented that ethnic minorities are more often left behind due to lack of economic opportunity, such as lack of quality agricultural land, social exclusion, lack of credit, and lack of access to markets. On average they have less income, and are more often poor and very poor. The gaps in poverty and health indicators are actually widening. In Cambodia, the poverty rate is the highest in the north-eastern highlands at about 30%, which is mostly populated by EMGs and migrants. They have less access to health services, and have worse health indicators. EMGs have higher mortality rates and burden of communicable disease than the majority population.

Construction of highways and rural access roads in the GMS is rapidly improving regional and local connectivity, opening up new areas and creating economic corridors with industrial zones, plantations, and services that attract entrepreneurs, tourists, and migrants in search of employment. This development has been a major force for poverty reduction in the GMS, with both positive and negative impacts on health. Increasing mobility and income may increase food availability and access to health services, but also risks the spread of communicable diseases.

About one million Cambodians have migrated abroad in search of employment, study or social engagement. Cambodia also attracts migrants from China and Viet Nam including farmers, laborers for services, industries and plantations; and workers for the construction boom. These incoming migrants may sometimes be poor, have language problems, are less familiar with health services, and may not have access to subsidized care, and therefore constitute a health risk, but may not be considered as EMGs.

Integration of various ethnic groups is continuing at a fast pace, while they start from a very disadvantaged position. Resettlement causes rapid social transition and increased exposure to malnutrition and diseases. EMGs are increasingly engaged in migrant labor due to relative poverty in the face of reduced access to land, increased consumption, and rising costs of living. Studies show that migrants often live and work in poor conditions and adopt new lifestyles. They are more at risk of communicable diseases related to behavior, habitat, and lack of access to services like TB, HIV/AIDS, malaria, dengue, and food and water-borne diseases. They are also prone to accidents, drug addiction and malnutrition. However, there is a paucity of data about their health conditions. EMGs are also more often illegal migrants, which makes them more at risk of labor exploitation, coercion and trafficking. Youth and young women are especially at risk of abuse. From 6% to 10% of migrants are under-age.

Providing effective CDC for MEVs will not only help improve health and health security, but will contribute towards child protection, better learning in school, economic productivity, and poverty reduction, all high on the Government's list of priorities. In the GMS, public and private health services are reaching the general population, which is the easier part to do. However, those not being reached by any formal health service, migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs) will continue to be at risk of, and spread infections, including

possibly more drug resistant infections. As the health status improves, the impact of those not reached by the health system becomes relatively larger, and it will become critical for the government to reach MEVs to achieve universal health coverage and public health security.

Among the reasons why public and private health services have made less effort in reaching these marginal groups are living conditions and services in these areas, language problems, market failure, government regulations limiting compensation, and in general lack of trained people, many of whom migrate after education. Hence, special arrangements are needed to reach these people, often requiring a more multi-sectoral and partnership approach.

A WHO SEARO report divides mobile and migrant populations broadly in three groups: (i) affiliated to an employer, including semi-mobile employees and seasonal farm workers; (ii) affiliated with the government, including military, security personnel, and border guards; and (iii) non-affiliated, including ad hoc laborers, new settlers, highly mobile labourers and short-term migrants.[14] While all these groups would need to be targeted in terms of relevant information on prevention of diseases such as malaria, HIV/AID, tuberculosis, and other conditions, the first two groups are organized and therefore, in principle, easier to access. However, experience shows that it is also difficult to access organized groups of migrants working in plantations, casinos, and factories. While the Government has laws and policies in place to reach these people usually through the Ministry of Labor, this is not sufficient in terms of quality and quantity of inspection and migrant access to services. Hence, special arrangements are needed, with special agreements between those in charge.

For non-affiliated, often illegal migrants including ethnic minorities and minors, it is even more difficult to encourage them to use public services. Grass-root organizations and NGOs should play a major role in this field. Cambodia has many NGOs. In view of limited capacity after the war, the Government started contracting NGOs to manage and deliver health services, including in remote areas. However, within the last plan period, the Government decided to use health management contracts between the central level and the provincial and district governments. The Government may want to continue piloting alternative options to reach MEVs based on solid economic and social impact studies.

[14] WHO SEARO. *Vector control and personal protection of migrant and mobile populations in the GMS: A matrix guidance on the best options and methodologies*. New Delhi. 2015

Table 1: Geographical Clusters Along Economic Corridors[15]

Cluster and Corridor	Main Ethnic Groups	Ethnic minority characteristics	Implications
Cluster 1: Northern corridor: Vietnam North, Lao North, Myanmar-east, Myanmar-east, Thailand-north-east	Large ethnic minority populations, in particular originating from China, mainly Sino-Tibetan and Hmong but also Mon-Khmer	Relatively isolated, self-sustaining highland groups with high burden of HIV, respiratory infections and other common infections, at risk of epidemics through trade, less accessing health services	Some border districts are hard to reach based on government conditions, but these highly remote people may also be less at risk of epidemics. Focus on accessible hotspots for outreach services, community workers.
Cluster 2: Central corridor: Vietnam Central, Lao-south-central, Cambodia north-east, Thailand north-east, Myanmar-central	Large ethnic minority populations, including large indigenous Mon-Khmer and related groups and migrants from northern areas	Relatively isolated, traditional, poor and less educated highland groups and migrant workers, with high burden of common diseases, at risk of epidemics of malaria and dengue and less accessing health services	Border districts may be more accessible but face political problems. Provide appropriate health services for EMG including access to suitable community workers and free health services.
Cluster 3: Southern corridor: Viet Nam-south, Cambodia south-east to north-west, Thailand east to West, Myanmar-south	Largely inhabited by non-ethnic minorities including Kinh, Khmer, Thai and Burmese. Has large migrant and Muslim populations	Largely integrated populations, better educated, mainly living in lowlands, industrial zones, high burden of dengue, diarrheal diseases, more timely reporting of diseases and accessing services	No need for special services for ethnic minorities. Needs special care for illegal migrants by providing them information and access to free health services.
North-South Corridor: China-south to major cities in the GMS	Mainly passes through non-ethnic minority populations except when passing through cluster 1 corridor	Mostly migrant ethnic groups providing unskilled labor and other services along the economic corridors	No need for special services for ethnic minorities. Needs BCC and services for migrant workers in hotspots, factories, casinos and labor camps.

Note: the corridors referred to here are not officially recognized entities.

[15] This information is based on the crossborder cooperation work of the ADB-financed RCU and is necessarily a crude summary of the situation, but nonetheless informative

Table 2: Targeted Provinces/States/Region and Neigboring Provinces

Cambodia	13	Pailin, Battambang, Banthey Meanchay, Preah Vihar, Stung Treng, Rattanakiri, Mondulkiri, Kratie, Kandal, Tbong Khmum, Prey Veng, Svey Rieng, and Kampot Provinces
Lao PDR	12	Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu and Champasack Provinces
Myanmar	6	Shan North, Shan East, Kaya, Kayin, and Mon States, and Tanintharyi Region
Viet Nam	36	Quang Ninh, Lang Son, Cao Bang, Ha Giang, Lao Cai, Lai Chau, Dien Bien, Son La, Thanh Hoa, Nghe An, Ha Tinh, Quan Binh, Quan Tri, Thua Thien, Quan Nam, Kon Tum, Gia Lai, Dak Lak, Lam Dong, Dak Nong, Binh Phuoc, Tay Ninh, Long An, Donh Thap, An Giang, Kien Giang, Bac Lieu, Sok Trang, Tra Vinh, Ben Tre, Ba Ria, Thai Binh, Hai Phong, Yen Bai, Tuyen Quang and Bac Kan Provinces
China	1	Yunnan Province
Thailand	12	Mae Hong Son, Chiang Mai, Chang Rai, Phayao, Buen Khan, Nhakon Phanom, Udon-Ratchatani, Sa Kaew, Tak, Kanchanaburi, Ratchaburi and Phetshaburi Provinces

Appendix 2: EGDP Consultations

(October-November 2016)

Topic	Questions	Responses	Proposed action
Ministry of Health*			
Health Plans	Are policies for indigenous peoples groups and migrants adequate	All people have access to health care. Health services for IP and migrants are the same as for other people. Not enough legislation for MOH supervision of the workplace.	MOH to work with MOI and MRD to improve legislation
	Are national plans addressing needs of indigenous people and migrants	The Government gives priority to poor districts where many IP and migrants live. Through poverty reduction, health and education programs, IP (it is treated as the other people) receive considerable support. No specific plans for migrants health	MOH to address this. Project can assist with improving provincial annual plans including health services.
	Are there legal barriers	MOH has insufficient authority to inspect workplaces for migrants and non-migrants	MOH to address this with MOI, MRD and local authorities.
	What are planning issues for indigenous people groups and migrants in regional CDC	Not enough understanding of issues of IP, lack of information of conditions an health problems of migrants, and no migrant health policy	DPHIS to improve information collection
	Is investment in CDC addressing the needs of indigenous peoples	IP live in remote places where there is less access to health services and other public services, needs more effort	The project will make more funds available to addressing the IP needs in terms of health.
	What could be negative impact of a regional CDC project on Indigenous peoples and migrants	Promising services that don't materialize	The project should be well managed in terms of health services accessibility.
	Are Government and partners active in regional CDC	Government participates in regional events but cross-border work needs to be stepped up	The project will make funds available for cross border work
	What would be major constraints for CDC in border areas	The main problem is accessibility, especially during rainy season. Funding is also insufficient to expand CDC to reach the targeted group. A third problem is posting health staff to rural areas	The project will make funds available for outreach services

Health Status	Is the specific health status of indigenous people groups and migrants known	Data are not collected by indigenous people group, some small studies suggest that IP suffer more from usual infections like malnutrition, pregnancy complications, pneumonia, diarrheal diseases and tuberculosis	DPHIS to improve data collection system for universal health coverage
	What explains the poor health status of indigenous people groups and migrants	The main problem is poverty. IP are increasingly informed and ready to use health services as well as traditional health care	Target the poor communities in the project area
	Are indigenous people groups and migrants more prone to epidemics	Hard to say, migrants probably, remote indigenous people groups are self-sufficient and isolated but some may engage in cross-border trade	DPHIS to improve data collection system
Health Services	What are the problems of providing health services for indigenous people groups and migrants	Main problem of resources: access, staff, and funds for operations.	The project can link communities with services, but not scale up services in the project areas.
	Are health services affordable for indigenous people groups and migrants	Travel cost is high. Poor IP have special card for free health care but often still need to pay out of pocket due to lack of medicines	No project subsidy will one provided for the poor, only information, screening, and referral
Provincial Health Departments			
Health Plans	Are IP and migrants specifically referred to in plans	Reference is made to both groups but there are no specific plans for IP in terms of health. Migrants health is an issue under consideration	The project will help to improve plans in terms of health sector
Health Status	Occurrence of epidemics	Mainly food poisoning and dengue, some zoonotic cases	The project will improve the surveillance system
	What are the specific health problems of IP and migrants	IP have same old diseases as Khmer, but maybe more because of poverty and poor hygiene. Migrants are more at risk of HIV/AIDS	The project will help assess health problems
Health Services	What are the major hurdles for IP groups and migrants to access services	For IP probably high cost of travel, for migrants perhaps company restrictions.	The project can’t address this, only indirectly through legislation, but the government fund should ne increased to subsidize it.

	For those who can't pay out of pocket, are there arrangements	Yes free health care card, but may still have some out of pocket payment	The project can facilitate accessing health cards
Health Monito - ring system	Are health and health services data split by IP groups and migrants	No	DPHIS is considering this
	Are there any monitoring system for IP and migrants health status.	No	DPHIS is considering this
Health Center Staff			
Health Plans	Are you aware of any special arrangements for IP and migrants	No, but many migrants in factory workers don't use public health services. They go to factory clinic supported by its owners.	MOH to address this issue
Health Status	What do you see as the major health problems of IP groups and migrants	Common infections, high blood pressure, diabetes, TB and HIV and complications of delivery	The project will help collect information on health problems
	Do you think HIV and TB are higher or lower among IP groups and migrants	Don't know, but HIV higher among sex workers, who may be migrants from Viet Nam, China or upcountry. TB perhaps higher in old people.	As above
Health Services	Are IP groups and migrants using these health services as others	Factory workers have less access to health services. There are no remote IP groups here, all have access	MOH to address legal access issues
	Are there specific access problems in the provision of health services to IP groups and migrants	All people have access to health services. Foreigners have to pay. IP and poor have subsidy for health service.	The project to help examine out of pocket payment
	Are there language problems	Yes, sometimes, but they need to through the focal points who appointed by communities.	The project should consider on.
	Are there affordability problems	No, people can pay for medicine and the very poor got subsidy.	As above
	Any other problems?	Lack of ambulance for emergencies, lack of staff for 24 hour services and some medicines.	The project will provide ambulances and some more staff as identified.
Village Headmen			

Health Plans	Are you involved in discussions to improve health services	Attends village health group meetings. The village health volunteers normally involved in the meetings.	The village health group and some selected community people will be engaged in planning
	Do you think plans are appropriate for the local community	Health services are improving, still insufficient resources for health center	MOH is preparing for a new HSP3 to support this
Health Status	What do you see are the major health problems in your community	Delivery, road accidents, and common health problems	The project will provide an ambulance for emergencies
	Did you have any major epidemics	Usual common diseases, Dengue and malaria	The project will improve reporting, outbreak response, and community preparedness
	Are TB and HIV major health problems?	Yes, but only a few cases	The project will help screen and refer suspected cases
	Are there specific groups more at risk	Road accidents common among young people, pregnancy complications	The project will provide an ambulance
Health Servic es	What are the good parts of the health services	Improved staff and medicines	The project can address it.
	What parts of the health services would you like to see improved	Ambulance and more staff	As above
	Are health services affordable for the poor	Still need to pay extra for specific medicines, some people can't afford	The project will examine and report this matter
		Patients	
Health Status	What is the reason for your admission	Most of patients need to pay, except the very poor patients.	MOH should consider on this
Health Servic es	Do you find the hospital clean, can you get clean water and toilet	Most of them are clean including the health centers and posts at commune an village levels, but few is not clean.	MOH should address it.
	From how far did you travel	The health center and posts, the people can go within 30 mn bui walk, but for hospital is far.	MOH should consider on.
	Are you happy with the quality of care	Yes, most of them provide quality of care at the moment in terms of their level.	As above

	Are health services affordable	Yes, at commune and village levels, but not for provincial level.	As above.
Female and Male Community Members			
Health Status	What are main health problems in your community	TB and Malaria for IP groups (confirmed by communities), but there not enough information in place, the data collection to be done.	The project should address it with MOH.
Health Servic es	Are health services adequate	Not for IP farmers and its communities, mainly accessibilities.	The project should be addressed it ini its targeted provinces.
	What is availability and attitude of staff	More than 50% are OK in terms of capacity and attitudes, but the remaining needs to be improved/	The project needs to be addressed it.
	Are medicines available	Not 100% available, but some are OK.	The project should identify and fill the gap in its target areas.
	Other issues	IP believes and traditions.	MOH should provice more training to IP and migrants in the targeted areas.
Partners**			
Health Plans	What are planning issues for IP groups and migrants in regional CDC	Lack of information, no specific targeting, difficult to access IP in remote areas and to legal issues to reach migrants in factories and other entertainment places.	MOH/DPHIS will examine this and propose legislation and investment
	Is investment in CDC addressing the needs of IP groups and migrants	Insufficient policy and funds	As above
	Are there legal issues for IP groups and migrants	MOH can access factories and casinos for outbreak invitation but not routine inspection, MOI has a more narrow agenda	As above
	What are major gaps	MOH inspection of workplaces towards seeking for the gaps.	As above
Health Status	What is the HIV and TB status among IP groups and migrants	HIV likely higher among migrants because of lifestyle but no data and information available. TB is higher in poor people, diabetic, prisoners, not know what is status in IP	As above

	Is the surveillance system reaching to IP groups and migrants	Yes but factories and casinos need to report to do self-reporting to provincial health office and MOH for investigation	CDCD is considering how to improve the surveillance system in workplaces
Health Services	How is to access to health services for indigenous people groups and migrants	IP have same rights and free health care but access in remote areas less. Factory workers need permission to access services	MOH/DPHIS will examine this and propose legislation and investment with MOI and MRD.
	What is the government capacity in providing services to indigenous people groups and migrants	Problems of staff availability in rural areas. Factories are usually in locations with good health services, migrants can access if permitted during working hours	MOH/DPHIS will examine this and propose legislation and investment with MRD/
	What works better in reaching indigenous people groups and migrants	For remote areas, it might be better to contract out services to NGOs, or provide additional resources to provide health services	MOH has not agreed to do contracting out for this project

The indigenous people will be considered as the target group, but ethnic minority group. There are legal documents for indigenous peoples, but not for ethnic minority groups *DPHIS, CDCD, DHS, NIPH, TB and HIV/AIDS programs

** IOM, WHO, USAID

Appendix 3: Indigenous People Plan

Project Outputs	Sub-outputs	Indigenous People Design Features/Activities	Performance Targets/Indicators
Output 1: improved GMS cooperation and CDC in border areas	1.1. Improved regional, cross- border and inter- sector cooperation 1.2 Enhanced knowledge management and community of practice (COP) 1.3 Increased access to CDC in border areas, in particular for vulnerable groups such as migrants, HIV positive youth, pregnant women, and isolated ethnic minorities.	Enhance participation, capacity building and decision making opportunities for representatives of IP in regional, cross-border, and inter-sectoral events. Use workshops for IP advocacy and increasing IP awareness among workshop participants and stakeholders/governments. Ensure full participation of IP staff for outreach activities using IP-sensitive education and care procedures. Proactively target IP at increased risk of infectious diseases with CDC activities in border areas.	Participation of IP representatives in all these events (baseline unknown). Workshop materials clearly demonstrate mainstreaming of IP issues and promotion of IP-sensitive strategies. Participation of IP staff in outreach activities. Decreased prevalence of infections among IP in border areas based on health statistics.
Output 2: strengthened national disease surveillance and outbreak response systems	2.1 Strengthened surveillance 2.2. Strengthened response	Collect, analyze and report IP-disaggregated data. Ensure participation of IP staff in any outbreak response teams. Increase participation of IP in field epidemiology training.	IP disaggregated reporting for CDC project activities in each country. In districts with over 20% IP, each outbreak response team has at least one IP staff. Of participants in field epidemiology training, at least 5% are IP in Cambodia, 30% in Lao PDR, 30% in Myanmar, and 10% in Viet Nam.

Output 3: improved laboratory services and hospital infection prevention and control	3.1 Improved laboratory quality and biosafety 3.2 Improved infection prevention and control in hospitals	Ensure representative IP participation in laboratory training programs for districts with large IP population. Ensure representative participation of IP in scholarships for hospital infection prevention and control. Ensure IP sensitive facilities in isolation wards	Representative participation of IP laboratory management and quality assurance training programs Representative participation of IP in hospital infection and control training. All repaired isolation wards provide arrangements for IP
Project Management	3.1 Ensure Integration of project activities in regular services 3.2 Improve efficiency and governance.	All implementation plans for specific project activities and annual operational plans (AOPs) supported provinces address gender and IP dimensions of project activities All implementing agencies have an IP focal point All quarterly reports report on progress in IP iissues At least 50% of consultants have experience working with IP.	Proportion of project implementation plans and AOPs that address IP dimensions adequately. Proportion of active focal points in implementing agencies (based on participation in events. Proportion of quarterly reports that report on IP issues. Proportion of consultants with IP experience.

Ethnic Group Development Plan, Lao PDR

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS

(as of 11 May 2015)

Currency unit	–	kip (KN)
KN1.00	=	$0.000123
$1.00	=	KN8,096

NOTES

(i) The fiscal year (FY) of the Government of Lao People's Democratic Republic and its agencies ends on 31 December. "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

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ACRONYMS

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
AOP	annual operational plan
APSED	Asia-Pacific Strategy for Emerging Diseases
CDC	communicable diseases control
CDC1	First GMS Regional Communicable Diseases Control Project
CDC2	Second GMS Regional Communicable Diseases Control Project
CLMV	Cambodia, Lao PDR, Myanmar and Viet Nam
CNMPE	National Center for Malaria, Parasitology and Entomology
CTA	chief technical adviser
DCDC	Department of Communicable Diseases Control
DMF	design and monitoring framework
DPIC	Department of Planning and International Cooperation
EGDP	ethnic group development plan
EHF	Ebola hemorrhagic fever
EID	emerging infectious diseases
EMG	ethnic minority group
GAP	gender action plan
GMS	Greater Mekong Subregion
GSS	gender and social safeguards specialist
HIV	human immunodeficiency virus
IHR	international health regulations
IPC	infection prevention and control
Lao PDR	Lao People's Democratic Republic
LECS	Lao Economic and Consumption Survey
LNF	Lao National Front
LSIS	Lao Social Indicator Survey
LWU	Lao Women's Union
MDG	Millennium Development Goal
MEV	Migrants and mobile people, ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
MOLSW	Ministry of Labor and Social Welfare
MMR	maternal mortality ratio
MNCH	maternal, neonatal and child health
MOH	Ministry of Health
NCAW	National Commission for the Advancement of Women
NCLE	National Center for Laboratory and Epidemiology
NESDP	National Economic and Social Development Plan
NGO	nongovernmental organization
PAM	project administration manual
PCR	project completion report
PHC	primary health care
PMU	project management unit
PPMS	project performance management system
RCU	regional coordination unit
RSC	regional steering committee
SPS	safeguard policy statement
VHV	village health volunteer
WHO	World Health Organization

EXECUTIVE SUMMARY

This Ethnic Group Development Plan (EGDP) of the Ministry of Health, the Lao People's Democratic Republic (Lao PDR) summarizes the analysis, strategy, and plan for addressing ethnic group concerns/issues for the Greater Mekong Subregion Health Security Project (the project) in accordance with the Government's relevant laws and policies and the Safeguard Policy Statement (SPS) of the Asian Development Bank (ADB) for ADB investment.[1]

The 49 ethnic minority groups (EMGs) recognized by the Government make up about 34% of the total population[2] and more so in the targeted project provinces. Many EMGs are fully mainstreamed in Lao society. For practical purposes, the EMDP focused on indigenous people[3] that have higher mortality rates and CDC burden and worse health indicators than the general population. These are mostly poor indigenous people, with lack of access to services, displacement, or rights issues. The EMDP focuses on the first group, including remote ethnic groups, and internal and external migrants, many of whom are also poor indigenous people. The challenges of control of infectious diseases of regional relevance in these two subgroups are not only a priority but strategically quite apart involving different stakeholders.

The proposed GMS Health Security Project (the project) for Cambodia, the Lao PDR, Myanmar and Viet Nam aims to improve regional public health security by strengthening health security systems and CDC in border areas, in particular for migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs). Three components or outputs[4] are proposed: (i) improved regional cooperation and CDC in border areas; (ii) strengthened national disease surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

In support of the 2005 International Health Regulations (IHR) of the World Health Organization (WHO) and the 2010 Asia Pacific Strategy for Emerging Diseases (APSED), the project is designed to support regional cooperation and national capacity building for prevention and control of emerging infectious diseases (EID) and other diseases of regional importance such as malaria, dengue, cholera, tuberculosis, HIV/AIDS, and drug-resistant infections.

The project will cover a total of 12 provinces in the Lao PDR, in addition to 13 provinces in Cambodia, 36 provinces in Viet Nam, and 5 states and one region in Myanmar. In Lao, about 1.4 million people live in targeted project provinces, of whom just under 1 million are EMGs. The targeted provinces in the Lao PDR are Bokeo, Luang Namtha, Oudomxay, Phongsali, Houaphanh, Xiengkhouang, Bolikhamxai, Khammouane, Saravane, Sekong, Attapeu, and Champasak. Most of the targeted provinces in the Lao PDR have a predominant ethnic minority population.

According to ADB's 2009 Safeguard Policy Statement (SPS), the Borrower is required to ensure benefits for EMGs affected by the project. According to the Indigenous Peoples Safeguards Sourcebook[5]: "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through*

[1] DB. 2009. Social Safeguards Statement. Manila.
[2] The Government of Lao PDR doesn't use the term "*indigenous peoples*" but instead uses "*ethnic minority*".
[3] The term "indigenous" is considered inappropriate by some governments as this implies backwardness and excludes recent migrants, so the term "ethnic minority group" (EMG) is preferred. In Lao use the "Ethnic Groups" and will not use the words" minority or Indigenous".
[4] Government uses the term 'components' and ADB uses 'outputs', therefore both terms are used in this IPP.
[5] ADB. 2013. Indigenous Peoples Safeguards: A Planning and Implementation Good Practice Sourcebook (Draft Working Document).

information disclosure, consultation, and informed participation following all policy principles and safeguard requirements." According to the Sourcebook*, "IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* As per the ADB SPS, *"if [ethnic groups] are the sole or the overwhelming majority of direct project beneficiaries and when only positive impacts are identified, the elements of an [EGDP] could be included in the overall project design in lieu of preparing a separate [EGDP]."* While the project is expected to have positive impacts on IPs, they are not the sole or overwhelming majority of direct project beneficiaries. Furthermore, given the scale and complexity of this regional project, the potential for not achieving certain intended positive impact on ethnic monitories justifies a category B and warrants preparation of this EGDP to help achieve intended impact on EMGs.

This EGDP for the Lao PDR summarizes the findings of the assessment and consultation process. The Lao Government prefers the term EMG rather than indigenous people, as many EMGs are not indigenous but in fact are recent migrants from neighboring countries, in particular from Myanmar and from China (Yunnan), Myanmar, and Viet Nam.

Only positive project impact on EMGs is foreseen. Sufficient legislation is in place to address the needs of EMGs, except migrants and displaced people. MOH gives high priority to services for poor and isolated EMGs. However, the current health system often doesn't reach these groups, as for example evident in low vaccination rates. The major concern is that proposed project benefits for EMGs do not fully materialize. Implementation of EGDPs in earlier, similar projects for communicable diseases and model healthy village development was mostly satisfactory in terms of effort and improving over time. However, project implementation may have shortcomings in terms of (i) project relevance and appropriateness for certain EMGs, (ii) project effort and efficiency and (iii) sustainability of interventions.

In particular, for Output 1, CDC in border areas, activities such as community engagement for disease prevention and case finding, training, campaigns, and outreach services should be appropriate for the particular EMG. Surveillance and response systems should also be appropriate given limited local capacity. IPs should be facilitated to access screening and manage infections. Sustainability of interaction of communities and health services will depend on appropriateness of staff and affordability of services, as well as on integration of IP needs in provincial annual plans and budgets. Inclusivity in the central and provincial planning and monitoring processes along with special efforts to reach certain IPs and other vulnerable groups will be critical success factors.

For this project, MOH has committed to provide the necessary leadership and inputs to fully implement the EGDP. MOH aims to maximize project benefits for vulnerable groups likely to be at increased risk of infectious diseases in border areas. Vulnerable groups include migrants and mobile people, ethnic minorities, and other vulnerable groups including youth and poor women. In alignment with national policy and context, MOH proposes to mainstream IP concerns in all project activities. The EGDP is to (i) enhance equal opportunity, (ii) target vulnerable groups, and (iii) promote IP in alignment with priorities.

The Government is facing several challenges in implementing the EMDP such as MOH capacity, provincial priorities, staff shortage in remote health centers and health posts, and financial and logistic constraints. MOH is aware of its constraints to reach isolated villages and migrants. MOH has experience and mechanisms in place to work with other agencies and grassroots

organizations for social mobilization and village health development. MOH is encouraging partners to help finance these investments.

MOH will use a participatory approach in project implementation. EMG engagement and services, along with other activities to be supported by the project will all be included in provincial and district annual operational plans and budgets, and in staff training and project management. The PMU and implementing provinces will have a focal point for implementing the EGDP to ensure that IP issues are being addressed. MOH will also engage a chief technical adviser and a gender and social safeguards expert to assist in this process. The PMU will initiate a participatory planning and budgeting process for EMGs and prepare specific plans within 6 months of the start of the project. The PMU will also put monitoring, reporting and grievance systems in place. The PMU will seek to include MEV disaggregated indicators, and report on progress of implementing the EGDP in every quarterly and annual project report, and on the project website. Key features of the EGDP are mirrored in the project design and monitoring framework, loan covenants, and project administration manual.

I. PROJECT DESCRIPTION

1. GMS leaders are committed to enhance regional health security following outbreaks of emerging infectious diseases (EIDs), notably severe acute respiratory syndrome (SARS) in 2003, and Highly Pathogenic Avian Influenza (HPAI) in 2004. Recent outbreaks of Ebola Hemorrhagic Fever (EHF) in West Africa and Middle-East Respiratory Syndrome (MERS) in South Korea show respectively, how EIDs can get out of control with major human impact, and how a relatively small outbreak in a hospital can have major economic impact. New zoonosis poses a constant threat in the region.

2. Misuse of antibiotics for bacterial infections is causing drug resistance, while new antibiotics are few and expensive. Nosocomial infections in hospitals are increasing due to poor infection prevention and control (IPC). Common infections like dengue and cholera show genetic adaptation. Climate change including global warming and frequent flooding may also increase the disease burden of infectious diseases. While the incidence of HIV/AIDS, tuberculosis and malaria have declined following major investments, drug resistant types are also considered EIDs and major threats for the control of these diseases. Childhood infections preventable through immunizations are resurging due to weak vaccination systems. Continued investment will be needed to keep communicable diseases under control.

3. The overarching drivers for GMS control of emerging and re-emerging infectious diseases (EIDs) are the International Health Regulations (IHR, 2005) and the Asia Pacific Strategy for Emerging Diseases (APSED, 2010) and related disease control and health system building strategies of the World Health Organization (WHO). The IHR and APSED strategic areas guide efforts to improve public health security, including surveillance and outbreak response, risk analysis and communication, community preparedness, laboratory services, hospital infection control, and regional cooperation. Other WHO global and regional strategies also guide control efforts, such as for the control of HIV/AIDS, malaria, tuberculosis, dengue, and neglected tropical diseases; strengthening of laboratory services, infection control in hospitals, and the control of fake drugs.

4. The term health security[6] refers to a public health goal of prevention of major epidemics or other disasters with major impact on health and the economy, and is concerned with the health of populations, in contrast to universal health coverage, which is concerned with the right of every individual to affordable, quality health care. Investment in the control of emerging diseases has strong public goods, market failure and equity rationale, in addition to potential economic and political consequences of a major epidemic or pandemic.

5. MOH and WHO have conducted evaluation of APSED implementation in 2015. Lao has not yet achieved IHR and APSED targets. Core functions owned by MOH are well in place, but other functions depending more on collaboration with other countries, sectors, partners, community, and the private sector are less advanced. There is major progress in the control of malaria, less progress in the control of HIV/AIDS, tuberculosis, and dengue, and major emerging concerns of nosocomial infections and multiple drug resistance.

6. Overall, public health security systems for APSED and other significant diseases need to become more mainstreamed, standardized, reliable, and financially sustainable. Second, in view of the increase in communication, urbanization and industrialization, the traditional dependence

[6] Health security is achieved through a set of activities, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations

on a single public health system no longer holds, and MOH will need to strengthen its capacity for collaboration with other sectors. Progress in APSED is affected by health system limitations, but these are not clearly identified. Key areas are IT connectivity, basic staff capacity and administrative and management capacity. In general, the private sector is a big unknown in terms of surveillance and response.

7. While there is a high risk of the spread of diseases and drug resistance, surveillance and response systems have not been fully capable of real-time and accurate information, indicating epidemic status at local levels. Several disease reporting systems are in place, but are not linked, do not reach communities, and fail to provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, thereby also limiting the efforts to improve disease control and community prevention and preparedness.

8. One way to address this is through integration of public outreach services, including community health promotion, prevention and outbreak preparedness, active case finding, screening, and, if necessary outbreak response ranging from food poisoning and dengue control to simulation exercises and control of the EIDs. Such packaging of services could make services more efficient and provide tangible staff learning opportunities. Capacity building for control of EIDs and other regional health threats can be combined. Further quality and efficiency improvement can be gained by combining services, such as for combining laboratories in regional hubs; and by improving quality control and audit of public health services, in both public and private sectors.

9. Laboratory services are complex, requiring some 20 subsystems to be in place. In Lao PDR, insufficient effort has gone into strategic planning, human resource development, referral and maintenance systems, quality assurance and audit, and medical-laboratory linkages. Addressing these system gaps will enhance benefits of past investments.

10. Hospitals are the most likely recipients for any emerging disease, and also pose a major concern in terms of spreading these and other diseases. In addition, hospitals are a source of nosocomial infections and drug resistance. Current facilities and practices in health facilities regarding infection prevention and control (IPC) are substandard, in terms of IPC management, staff capacity, facilities (isolation ward, sanitary ware, laundry, medical wears), hygiene practice standards, and practices (handwashing, visitors).

11. Regional cooperation currently consists mainly in the form of ad hoc information exchange and sometimes joint outbreak response, without standard operating procedures and regularity of reporting. Cross-border cooperation is gaining momentum but needs to be integrated as part of regular CDC. In previous projects, knowledge management activities have been quite prominent and have generated technology transfer, staff capacity, leverage, competition and commitment, and monitoring progress; but their potential, e.g. developing disease control strategies, early warning of outbreaks, and joint diseases control, is yet to be fully developed. Regional workshops on health security need to focus more on agreements for action, and follow-up. The regional cooperation unit may need to be strengthened.

12. The proposed Greater Mekong Subregion Health Security Project (the project) is designed to support regional cooperation and national capacity building for prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance

including malaria, dengue, tuberculosis, HIV/AIDS, cholera and nosocomial and drug-resistant infections.

13. The project builds on the achievements and lessons learned of the Governments of the Greater Mekong Subregion (GMS) and partners in enhancing GMS health security and reducing the burden of communicable diseases. MOH Lao PDR is currently running the extension of the Second GMS Regional Communicable Diseases Control (CDC2) Project with support of ADB, and is also implementing the Health Governance Program (HGP) with support of ADB and the World Bank, and health system development with support of Lux Development. Other major partners in the field of CDC are WHO and other UN agencies.

14. The project will assist with implementation of the Government's drive towards Universal Health Coverage, with complementary Public Health Security. MOH Lao PDR is giving priority to strategic investment for poor border districts with multiple risks of communicable diseases and weaker public health system, especially along borders with China and Viet Nam.

15. The project aims to expand beyond core APSED capacities to improve strategic areas that have received less attention, in particular to reach communities and hard to each groups in border areas, cooperation and linkages, and improving quality and biosafety of services. The project will help develop disease prevention and control, especially in poor border districts.

16. The impact will be GMS public health security strengthened. The outcome will be improved GMS health system performance, with regard to health security. The proposed project locations are provinces and districts along the borders and economic corridors. Selection of project provinces is based on (i) economic status of the province; (ii) health and health services statistics; (iii) regional risks and priority clusters; and (iv) existing support from other partners. In Cambodia, the project will cover 13 provinces; in Lao PDR, 12 provinces; in Myanmar, 6 states and regions; and in Viet Nam, 36 provinces. The project outputs will be: (i) improved GMS cooperation and CDC in border areas; (ii) strengthened national diseases surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

(i) **Strengthened regional, cross-border, and inter-sectoral CDC.** Output 1 will: (a) strengthen regional, cross-border and inter-sectoral cooperation for the control of epidemics including EIDs, Dengue and other important regional diseases, and (b) increase access to CDC for at risk youth, migrants and ethnic groups in border areas by providing outreach services using outbreak response teams.

(ii) **Strengthened national disease surveillance and outbreak response.** Output 2 will enhance the current surveillance and response system by: (a) expanding web-based reporting for improved surveillance and response capacities, and (b) improved community preparedness and syndromic reporting at village level.

(iii) **Improved laboratory services and hospital infection prevention and control**. Output 3 will: (a) improve quantity and biosafety of laboratory services; (b) scale up where appropriate for monitoring hospital based infection and drug resistance, and (c) improve hospital hygiene and management of highly infectious diseases.

17. **Cost Estimates and Financing** in the Lao PDR, the project is estimated to cost $12.6 million, to be financed by an ADB grant of $8 million, an AFB loan of $4 million and $0.6 million in Government counterpart funds. About $3 million of the project is reserved for regional and cross-

border cooperation and CDC in border areas directly targeting migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs), who will also benefit from general improvement of health services provided they use these services. Targeted outreach activities will encourage ethnic groups to use services.

18. **Project Implementation**. The Ministries of Health (MOH) will be the executing agencies (EAs), responsible for in-country implementation and coordination among countries. In the Lao PDR, the EA is represented by the Department of Planning and International Cooperation (DPIC) in MOH, with the Director General of DPIC as the Project Director, who reports to the MOH Steering Committee chaired by the Minister of Health.

19. In the Lao PDR, a deputy project director in DPIC will assist the project director in day-to-day project coordination and management, including administration. The existing CDC2 project management unit (PMU) will continue with project administration and coordination. The Department of Communicable Disease Control (DCDC), the National Center for Malariology, Parasitology and Entomology (CNMPE), the National Center for Laboratory and Epidemiology (NCLE) and 12 provincial health departments will also serve as IAs. Within each project management unit (PMU), a gender and social safeguards specialist (GSS) will be engaged to help plan, provide capacity building for, and monitor GAP implementation. The PMU will support: (i) annual operational planning, coordination and budgeting, (ii) project implementation activities, (iii) proper procurement, financial management, (iv) adherence to safeguards, and (v) monitoring and reporting. At provincial level, the provincial health office (PHO) will be the designated implementing agency (IA).

20. A regional steering committee (RSC) will guide regional coordination and activities. The regional coordination unit of the GMS Health Security Project based on MOH Vientiane will continue supporting regional events and information exchanges. The Project supports: (i) comprehensive provincial health annual operational plans to improve targeting, quality and access; and (ii) proper procurement procedures and financial management. Three east-west corridors and one multi-limbed north-south corridor represent 4 distinct geographical clusters of MEV issues, as shown in Appendix 1, Table 1. The north-south corridor connects major industrial areas in China with similar production areas in Viet Nam, Lao PDR, Cambodia, Thailand, and Myanmar.

21. **Scope**. To support regional health security, the project will directly support Cambodia, Lao PDR, Myanmar, and Viet Nam and encourage participation of the People's Republic of China (PRC) and Thailand in regional and cross border activities. All country project proposals include in the scope regional cooperation and CDC in border areas, surveillance and response, and laboratory quality improvement, and hospital hygiene, but there are differences in emphasis among the 4 countries. Both MOH Cambodia and MOH Lao PDR give emphasis to reaching those not being reached with CDC in border areas. In Myanmar, the aim at this early stage is to develop model services in state laboratories and major border hospitals. In Viet Nam, the emphasis is to develop the district health center. In Lao, major emphasis is given to improving access and capacity development of the health system.

22. **Location**: The project will cover 3 clusters totaling 12 provinces in the north (6), central (2) and south (4) as shown in Appendix 1. Specifically, the 12 provinces are: Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu and Champasack.

II. SOCIAL IMPACT ASSESSMENT

A. Legal and Institutional Framework

23. According to ADB's 2009 *Safeguard Policy Statement*, the objectives are to design and implement projects in a way that fosters full respect for Indigenous Peoples' identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by the Indigenous Peoples themselves so that they: (i) receive culturally appropriate social and economic benefits; (ii) do not suffer adverse impacts as a result of projects; and (iii) can participate actively in projects that affect them. ADB indigenous peoples' policy as presented in the SPS includes the following principles:

- Screen early on to determine (i) whether Indigenous Peoples are present in, or have collective attachment to, the project area; and (ii) whether project impacts on Indigenous Peoples are likely.

- Undertake a culturally appropriate and gender-sensitive social impact assessment or use similar methods to assess potential project impacts, both positive and adverse, on Indigenous Peoples. Give full consideration to options the affected Indigenous Peoples prefer in relation to the provision of project benefits and the design of mitigation measures. Identify social and economic benefits for affected Indigenous Peoples that are culturally appropriate and gender and inter-generationally inclusive and develop measures to avoid, minimize, and/or mitigate adverse impacts on Indigenous Peoples.

- Undertake meaningful consultations with affected Indigenous Peoples communities and concerned Indigenous Peoples organizations to solicit their participation (i) in designing, implementing, and monitoring measures to avoid adverse impacts or, when avoidance is not possible, to minimize, mitigate, or compensate for such effects; and (ii) in tailoring project benefits for affected Indigenous Peoples communities in a culturally appropriate manner. To enhance Indigenous Peoples' active participation, projects affecting them will provide for culturally appropriate and gender inclusive capacity development. Establish a culturally appropriate and gender inclusive grievance mechanism to receive and facilitate resolution of the Indigenous Peoples' concerns.

- Ascertain the consent of affected Indigenous Peoples communities to the following project activities: (i) commercial development of the cultural resources and knowledge of Indigenous Peoples; (ii) physical displacement from traditional or customary lands; and (iii) commercial development of natural resources within customary lands under use that would impact the livelihoods or the cultural, ceremonial, or spiritual uses that define the identity and community of Indigenous Peoples. For the purposes of policy application, the consent of affected Indigenous Peoples communities refers to a collective expression by the affected Indigenous Peoples communities, through individuals and/or their recognized representatives, of broad community support for such project activities. Broad community support may exist even if some individuals or groups object to the project activities.

- Avoid, to the maximum extent possible, any restricted access to and physical displacement from protected areas and natural resources. Where avoidance is not possible, ensure that the affected Indigenous Peoples communities participate in the design, implementation, and monitoring and evaluation of management arrangements for such areas and natural resources and that their benefits are equitably shared.

- Prepare an Ethnic Group Development Plan (EGDP) that is based on the social impact assessment with the assistance of qualified and experienced experts and that draw on indigenous knowledge and participation by the affected Indigenous Peoples communities. The EGDP includes a framework for continued consultation with the affected Indigenous Peoples communities during project implementation; specifies measures to ensure that Indigenous Peoples receive culturally appropriate benefits; identifies measures to avoid, minimize, mitigate, or compensate for any adverse project impacts; and includes culturally appropriate grievance procedures, monitoring and evaluation arrangements, and a budget and time-bound actions for implementing the planned measures.

- Disclose a draft EGDP, including documentation of the consultation process and the results of the social impact assessment in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected Indigenous Peoples communities and other stakeholders. The final EGDP and its updates will also be disclosed to the affected Indigenous Peoples communities and other stakeholders.

- Prepare an action plan for legal recognition of customary rights to lands and territories or ancestral domains when the project involves (i) activities that are contingent on establishing legally recognized rights to lands and territories that Indigenous Peoples have traditionally owned or customarily used or occupied, or (ii) involuntary acquisition of such lands.

- Monitor implementation of the EGDP using qualified and experienced experts; adopt a participatory monitoring approach, wherever possible; and assess whether the EGDP's objective and desired outcome have been achieved, taking into account the baseline conditions and the results of EGDP monitoring. Disclose monitoring reports.

24. The Borrower is required to prepare an EGDP to protect, and ensure benefits for ethnic minorities affected by the project. According to the Indigenous People's Safeguards Sourcebook, "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook*, "IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* In the same Sourcebook, it is noted that *"a stand-alone [EGDP] may not have to be prepared when ... only positive impacts are expected from the project."* ADB clarified that given the scale and complexity of this regional project, the potential for not achieving certain intended positive impact on ethnic monitories justifies a category B and warrants preparation of the EGDP to help achieve intended impact on EMG.

25. Government strategies relating to EMGs are outlined in three major policies: Lao Constitution 2003, Decree of the National Assembly of the Lao PDR n°213/NA, dated 24 November 2008 regarding promulgation of the amended the called names and the number of the ethnics in the Lao PDR, and the Guiding Notification of the Lao Front for National Construction, dated 4 February 2009.

26. The 7th National Economic and Social Development Plan (NESDP),[7] which runs from 2011 until 2015, calls for authorities to integrate smaller villages, particularly in the more remote areas, to facilitate administration and allow better provision of services. This relocation can have significant effects on EG communities as they move to areas of lower altitude and flat land, which entail different livelihood and farming systems. The NESDP calls for the authorities to:

(i) Integrate small scattered villages to be merged and reorganized to become bigger villages and establish new communities (small town) to become a model in rural and remote areas with 1–2 towns per province.
(ii) Resettle displaced people by developing permanent new agricultural lands and living facilities, completely halt (and reverse) deforestation, and stop shifting cultivation.
(iii) Continue village grouping (kumban) as an anti-poverty and rural/human resource development approach.

B. Baseline Information

27. Key demographic, economic and social indicators of the 4 targeted GMS countries are in Table 1. Several indicators regarding the specific health status of minority ethnic groups are lacking. Data gaps will be filled through a participatory assessment during the early stages of project implementation, to identify gaps in health security and plan for a package of activities including screening, diagnostics, disease control, and referral to established programs. This is discussed further in section VI. Proposed Measures.

Table 1: Key Demographic, Economic and Social Indicators in the GMS

Indicator (latest available, 2013-2015)	Cambodi	Lao PDR	Myanmar	Viet Nam
Economic growth rate %	7.0	6.5	8.0	6.0
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Population below 15 years	31.1	34.7	24.5	23.2
Median age in years	24.5	19.3	28.5	29.6
Sex ratio (% m/f)	95	99	94	112
Population growth rate (%)	1.8	1.9	0.8	1.0
Population density per square kilometer	85	29	79	279
Urban population (%)	20.5	37.6	33.6	33.0
Urban growth rate (%)	2.7	4.9	2.5	3.0
Per capita income in US$	1008	1589	1184	1868
People earning below $1.25 per day (%)	19	23	26	13
Unemployed as % of labor force	0.3	1.4	3.4	2.0
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	NA	1.184	11
Tourist arrivals (1,000)	4.200	2.500	2.000	7.500
Mobile phone subscribers/100 persons	134	66	12.8	131
Internet users estimate (% population)	6	13	1	44
Primary/Secondary GER f/m	81/89	76/82	79/78	89/87
Child mortality general population	42.5	41.9	62.4	21.7

[7] Ministry of Planning and Investment. 2011. *National Economic and Social Development Plan, 2011-2015: Targets for 2015.* Vientiane.

Indicator (latest available, 2013-2015)	Cambodi	Lao PDR	Myanmar	Viet Nam
Child malnutrition in main population %	28.3	33.9	28.0	16.9
HIV prevalence in main population %	0.6	0.3	0.7	0.5
HIV prevalence among sex workers %	4.6	1.3	18.4*/**	3
TB incidence main population /100,000	390	189	369	140
Malaria cases confirmed total	21,309	46,202	333,871	17,128
Malaria deaths confirmed / 100,000	1.7	4.4	5.4	0.1
Full Immunization main population %	85	49	98	95
Contraceptive prevalence rate (%)	51	50	46	78

Sources: UN agencies ; *Viet Nam Economic and Development Strategy Handbook, 2004 ; ** anecdotal reports, e.g., one study reports under age Hmong sex workers for tourists in Sapa ; *** e.g., one study for Lao migrants returning from Thailand ; **** BWHO National Survey of Tuberculosis Prevalence 2010 ; */* SEAJTM Prevalence of Tuberculosis in Migrants 1996 ; HIV data from UNAIDS 2008 report ; HIV data from UNAIDS 2014 report ; WHO and World Bank indicators ; SEAJTM Prevalence of Tuberculosis in Migrants 1996.

28. While the GMS has been politically stable, all countries experienced rapid economic growth and major poverty reduction due to rapid expansion of the industrial and services sectors including tourism, even though some two third of people continue to depend on agriculture as a livelihood. This development was brought about with increased connectivity and foreign investment partly concentrated in economic zones. It has also contributed to rapid urbanization and major internal and external migration. The population in the GMS is relatively young, with 23%-35% of the population below the age of 15, the so-called demographic dividend. However, 13% to 26% of people in these 4 countries are very poor, living on less than $1.25 per person per day. While child mortality has declined substantially, child malnutrition is still high, and so is the prevalence of major communicable diseases, while health sector coverage of the population is not yet universal.

29. In Lao PDR, there are 49 EMGs that are officially recognized by the government and make up about 34% of the total population of Laos.[8] They are categorized according to four ethno-linguistic families.[9] The Tai-Kadai family includes Lao, Lue, Phoutay, and other lowland groups, and account for 67% of the national population. The Mon-Khmer family includes groups such as the Khmu, Khuan, and Samtao that account for 23% of the population. The Hmong, Yao, and other Hmong-Tien groups account for 7%, and the Sino-Tibetan groups account for 3% of the national population. The categorization of the four main ethno-linguistic families in three predominant habitats is now being discouraged.[10]

30. The Lao Tai and other Tai Kadai traditionally live in the lowland, valley floor regions of the country that historically have cultivated paddy, practiced Buddhism, and are integrated into the national economy. These correspond to the Lao-Tai group and represent approximately 65% of the population. The Mon-Khmer traditionally dominate the middle hills and for the most part practice swidden agriculture (rain fed upland hill rice, maize), many raise cattle, most are reliant on forest products, and to some extent are isolated from the dominant lowland culture. Many groups exhibit varying degrees of assimilation and adaptation to Tai-Lao culture. These groups are the original inhabitants of Southeast Asia. The Sino-Tibetan Burma and Hmong-Lewmien)

[8] 2014 estimates from the Department of Planning and International Cooperation, Ministry of Health.

[9] The actual number of ethnic groups may be as high as 236 depending on the level of classification used in regards to groups and subgroups within the main ethno-linguistic families (Chamberlain et. al.1996).

[10] The VI Ordinary Session of the National Assembly, via Decision No. 213/NA, dated 24 November 2008, noted that the Lao PDR has 49 ethnic groups, with sub-groups and classified into 4 linguistic families such as: Lao-Tai linguistic family contents 8 ethnic groups, Mon-Khmer linguistic family content 32 ethnic groups, Hmong-Iu-Mien linguistic family contents 2 ethnic groups and Chine-Tibet linguistic family contents 7 ethnic groups. The national assembly also agreed to delete the 3 major ethnic terms “Lao Loum”, “Lao Theung” and “Lao Soung”.

groups live in the highland areas practicing swidden agriculture growing mainly hill rice, maize, and traditionally, many have grown opium. Many of these groups are recent arrivals from Southern China and Viet Nam. The distribution of EMGs is shown in Table 2.

Table 2: Distribution of Ethnic Groups by Province in the Lao PDR

Province	Total Pop	% EMG	2014 EMG Popn	% and No. of Lao-Tai		% and No. of Mon-Khmer		% and No. of Sino Tibeto-Burma		% and No.of Hmong-Lewmien		% and No. Other	
Oudomxai	329,110	76.9%	253,177	20.6%	54,280	60.9%	150,964	5.7%	10,466	12.3%	35,300	0.0%	156
Phongsali	180,996	80.4%	175,209	18.5%	25,195	20.7%	31,340	53.6%	78,721	6.1%	8,811	0.0%	0
Luang Namtha	181,000	72.2%	123,975	26.5%	34,632	34.2%	35,852	31.2%	43,309	6.8%	9,175	0.0%	0
Bokeo	182,198	67.4%	111,294	37.1%	39,137	28.4%	43,766	18.7%	11,302	15.1%	16,074	0.1%	268
Xiengkhouang	264,466	51.3%	123,540	48.1%	56,325	10.1%	14,027	0.1%	120	41.2%	58,115	0.0%	0
Luangpabang	472,618	70.7%	302,364	30.0%	79,866	51.4%	151,169	0.2%	419	17.6%	52,343	0.1%	313
Houaphan	340,828	44.4%	150,346	55.7%	66,282	20.3%	28,812	0.0%	38	23.1%	34,628	0.0%	13
Sayabouly	408,504	27.2%	106,959	73.6%	58,727	15.8%	27,685	0.1%	206	9.0%	13,307	0.0%	115
Xaisomboun	81,801	67.1%	54,824	32.0%	13,871	19.1%	8,158	0.1%	67	47.7%	32,202	0.3%	158
Vientiane Prov	446,270	30.8%	143,460	70.7%	60,680	16.8%	31,956	0.1%	91	11.5%	19,667	0.0%	22
Bolikhamxai	294,707	25.7%	76,420	74.6%	42,182	8.8%	9,067	0.1%	68	14.5%	16,252	0.7%	1,007
Khammouane	434,190	15.5%	64,896	76.4%	41,230	21.9%	21,600	0.1%	176	0.0%	12	0.7%	370
Savannakhet	1,004,646	29.2%	222,757	69.5%	114,952	29.2%	105,742	0.0%	0	0.0%	0	0.2%	348
Champassak	727,821	13.4%	100,164	85.1%	57,206	13.4%	41,925	0.0%	0	0.0%	0	0.2%	401
Saravan	403,575	46.9%	151,431	49.6%	47,751	48.9%	101,865	0.0%	0	0.0%	0	0.6%	1,529
Sekong	115,165	85.3%	98,765	10.0%	11,958	89.3%	86,082	0.0%	0	0.0%	0	0.1%	80
Attapeu	148,984	65.3%	87,857	29.2%	25,180	69.8%	61,590	0.0%	0	0.0%	0	0.1%	77
Vte Capital	903,747	3.7%	40,090	95.0%	36,710	1.4%	601	0.2%	72	2.3%	2,080	0.1%	38
Total	6,909,583	34.2%	2,364,017	59.3%	874,206	26.8%	951,603	4.6%	145,055	8.2%	298,326	0.2%	5,395

Sources of data: Population and EMG estimated for 2014 by DPIC, MOH

31. Several studies of the World Bank, UN, and other agencies have documented that ethnic minorities have on average less income, are move often poor and very poor, have less access to health services, and have worse health indicators. The gaps in poverty and health indicators are actually widening. The poverty rate is highest in the northern mountains, and the mountains along the border with Vie N; and among the Mon-Khmer (42.3%) and Hmong-Lewmien (39.8%) groups. The large Lao-Tai group have substantially lower poverty incidence than the other ethnic groups (15.4%). The Mon-Khmer have poverty incidence more than two and a half times the rate of the Lao-Tai and have seen a relatively slow decline in poverty incidence compared to the Lao-Tai (lowland dwellers).[11]

32. EMGs have higher mortality rates, and burden of communicable disease than the majority population. Increasing mobility and affluence will further increase the risk of communicable diseases, and some ethnic groups are ill informed about these risks, or may have customs which obstruct prevention of diseases. In certain traditional communities, for example, there are fears that vaccination of children will lead to infertility. Tracking recent outbreaks of polio, it was found that some Hmong communities have extremely low vaccination coverage. Similarly, it was found that EMG migrants have higher levels of HIV and TB infections. EMG use

[11] ADB. 2015. *Two Decades of Rising Inequality and Declining Poverty in the Lao PDR*. Manila. UNDP. Most increase in wealth is in urban areas and along economic corridors, while more rural parts of Lao benefit less. With increasing connectivity, education and economic participation, poverty among EMGs will reduce, inequality among ethnic groups will reduce, but inequality between income groups will increase further.

of health services is mostly lower including for vaccination. Political conflict, geographical and social isolation, language barriers, traditional customs, and poverty have contributed to the disparities between EMGs and majority ethnic groups and need to be taken into consideration when preparing project interventions.

C. Stakeholders and Consultations

33. In MOH, EG issues are referred to in general plans. As the government aims to mainstream EMGs, there is no specific policy, strategy, plan or designated unit for EMGs. The Department of Planning and International Cooperation (DPIC), and Health Information Management Systems (HIMS) is tasked with ensuring adequate services for EMGs in view of achieving Universal Health Coverage (UHC), which will among others require improving the monitoring system and planning special investments. Each village or group of village has a village health group responsible for assisting with the implementation of health activities, reporting diseases, and planning village health improvements.

34. There are several organizations that are involved in the wellbeing of EMGs, including the military, religious and grass-roots organizations, NGOs, and Government services. The lead government agency in regard to EMGs is the Department of Ethnic Affairs (DEA), under the Lao Front for National Construction (LFNC). This organization is the mass organization which establish from central to village level. It is mandated to the Lao Women's Union (LWU) and the Lao Youth Union (LYU) are also set up from central to village level. The military operated an extensive network of health services for their personnel and dependents in border areas, including in remote rural areas with security problems. The military medical personnel sometimes provide health services for local EMGs. For example, the Ministry of National Defense has their own hospital named 103 Hospital, and the Ministry of Public Security also has their hospital named 109 Hospital. Both facilities provide services for their own forces and general patients as well in respective communities.

35. In Lao PDR, the proportion of migrants that belong to EMGs is not known, but probably small. EMG migrants may be less able to benefit from the comprehensive labor code which aims to ensure a wide range of rights, benefits and protections, because they are more likely to lack permanent addresses and formal documentation. Further, the presence of national or international associations or interest groups for specific EMGs may not extend to the most disadvantaged groups. One problem is that of educated EMGs migrating to Vientiane Capital and other secondary towns. The impact of this process on the EMG transition is not known.

36. The consultation process has covered stakeholders including government officials, health staff, and representatives of mass organizations and communities; and also relies on information gained from the CDC2 project, the ongoing project with model healthy village development in the 12 provinces. In addition, consultants visited stakeholders in Bokeo province (other team visit Luangnamtha province), the Bokeo borders with major tourism industry, casinos, and large migrant populations. EMGs in these locations are mainly from abroad (Thailand, China, Burma). The consultation and participation process undertaken during preparation of this EGDP is discussed further in Section C. Information, Disclosure, Consultation and Participation.

D. Vulnerabilities, Risks, and Project Effects

37. The Indigenous Peoples safeguards are triggered if a project directly or indirectly affects the dignity, human rights, livelihood systems, or culture of Indigenous Peoples or affects the territories or natural or cultural resources that Indigenous Peoples own, use, occupy, or claim as

an ancestral domain or asset. The term Indigenous Peoples is used in a generic sense to refer to a distinct, vulnerable, social and cultural group possessing the following characteristics in varying degrees: (i) self-identification as members of a distinct indigenous cultural group and recognition of this identity by others; (ii) collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories; (iii) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and (iv) a distinct language, often different from the official language of the country or region. In considering these characteristics, national legislation, customary law, and any international conventions to which the country is a party will be taken into account. A group that has lost collective attachment to geographically distinct habitats or ancestral territories in the project area because of forced severance remains eligible for coverage under this policy.

38. EMGs in GMS border areas can no longer be thought of simply in terms of disadvantage due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. EMGs are beginning this process of integration from a very disadvantaged position. Migrants, EMGs and other vulnerable groups (MEVs) such a youth and pregnant women need special attention in any health administration, but this is often not happening, in part because health plans are disease-focused. See Appendix 1 for more background of MEVs in the GMS.

39. EMG populations living near regional economic corridors bear a disproportion burden of the health costs of the rapid social and economic changes created by these developments. Relocation and/or resettlement of EMGs have been supported by governments and donors in CLMV for various reasons. In some provinces, movements of highland EMGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas.[12]

40. When highland-dwelling EMGs move to lower altitudes, they are exposed to malaria, to which they have little acquired resistance, so in the early phase of relocation to lower altitudes, there have been high mortality rates from malaria, as well as morbidity resulting from exposure to other water-born and environmentally-related infectious diseases.

41. EMG populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.

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[12] Gebert, R. 1995. *Socio-economic baseline survey*. Muang Sing: GTZ Integrated Food Security Programme. Cohen, P.T. 2000a. "Lue across borders: pilgrimage and the Muang Sing reliquary in Northern Lao PDR. In G. Evans, C. Hutton and Kuah-Khun Eng (eds.) *Where China Meets Southeast Asia: Social and Cultural Change in the Border Region*. Singapore: Institute of Southeast Asian Studies. Cohen, P.T., 2000. "Resettlement, opium and labor dependence: Akha-Tai relations in Northern Laos", *Development and Change*, 31:179-200. Romagny, L. and Daviau, S. 2003. *Synthesis of Reports on Resettlement in Long District, Luang Namtha province, Lao PDR*. Action Contre La Lyttleton, C. 2005. "Market-bound: relocation and disjunction in northwest Lao PDR". In Toyota, M., Jatrana, S., and Yeoh, B., 2003 (eds.) *Migration and Health in Asia.* Routledge. Alton, C. and Houmphanh Rattanavong, 2004. *Service Delivery and Resettlement: Options for Development Planning*, unpublished report, UNDP: Lao PDR, Vientiane. McCaskill D. and K. Kampe (eds.) 1997. *Development or Domestication: Indigenous Peoples of Southeast Asia* Chiang Mai: Silkworm Press.

42. Some EMGs may use health services, when they are available, only as a last resort. This may be because of lack of experience but also reflects anxiety about modern health services and expense of accessing them. Shifting cultivation practices also limit the opportunities to access the health service for some EMGs, especially women. EMGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel ashamed and reluctant to access services, and numerous reports of belittling treatment of EMGs by government health workers were shared informally during the field research. Programs aiming to promote behavior change (e.g. building and using latrines, drinking boiled water, removing disease vector breeding sites, hygienic management of animals, hand-washing, using bed nets, and acceptance of vaccination) are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EMG villages.

43. Provision of free health insurance through the health equity fund has enabled poor EMGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered by the health cards.

44. Although EMGs are more likely to have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EMGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The disparities are highlighted in country specific data showing that provinces with high infant and child mortality rates also have high concentrations of EMGs. Surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by health centers and hospitals. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive.

45. The Project does not impose any vulnerabilities or risks or negative project effect on the EMGs in the project area. The only risk there may be is that EMGs are excluded from the benefits of the project. Hence the EGDP aims to ensure that the project design, implementation, and monitoring maximizes benefits for EMGs.

E. People's Perceptions

46. Based on 10 years of ADB-supported project experience, the proposed project interventions are much appreciated. The problem is on the supply side rather than the demand side, in that MOH lacks the means to reach remote EMGs and migrants, and may be unable to assign staff to these places.

47. As summarized in Appendix 2, patients and other locals were generally satisfied with the health services. Major issues in health centers are staff absenteeism, a shortage of medicines, high transportation costs, and additional charges for health care. Emergency Services was singled out as a priority for improvement. The main change noted by the patients and other locals was the improvement in medicines. Local health staff noted the need for more in-service training and outreach services. Government officials emphasized that the poor should have access to free health services including all ethnic groups and migrants, but that there were financing constraints. They also noted a lack of qualified staff in local health facilities, and that certain

EMGs were hard to reach and didn't make much use of public health services. Out of pocket payment was a major issue for the poor.

48. EMG village health groups indicated that common health problems are respiratory and diarrheal infections, dengue, infections, fever, cough, and problems of pregnancy and accidents that require referral. They are willing to collaborate but for time constraints if the interventions are not controversial and accepted in the community. They don't want one time promises, but continuity of engagement. Village health groups already participate in CDC in terms of planning model healthy village development, disease reporting and community preparedness, facilitating immunization and case finding, and referring people. The proposed project interventions didn't raise any objections, but evidently the focus is on expecting improvement in curative services.

F. Proposed Measures

49. Each provincial level will support project border districts, through a consultation process with village health groups, community based organizations and other representative groups, to (i) identify migrants and ethnic groups along borders and economic corridors, (ii) identify gaps in communicable disease control; and (iii) plan activities including screening, diagnostics, disease control, and referral to established health facilities. Village or facility CDC plans will be included in provincial annual plans and budgets. This should help achieve benefits for migrants and ethnic groups in this project. Progress should be routinely reported to MOH.

III. INFORMATION, CONSULTATION, DISCLOSURE, AND PARTICIPATION

50. The national and international social safeguard specialists conducted a joint assessment of social impact, including review of documents, field visits, stakeholder meetings, workshops, and assessment and disclosure of social impacts and mitigating measures from 17 to 25 October 2015. They met with MOH departments, other ministries, mass organizations, partners and communities. Discussions were held with community representatives and EMGs. The project and its potential for EMGs was discussed at a regional workshop, in accordance with ADB's SPS 2009.

51. Key questions concerning EMGs in project design, apart from general health status, include (i) EMG's understanding of communicable diseases, causes, treatment, and prevention; (ii) EMG's use of services and their perceptions of acceptability, availability, quality and affordability of government and other health services; and (iii) community organization for health services and participation in the project cycle. As the project has no negative impact on EMGs, so the focus is on how to ensure positive impacts for EMGs.

52. As summarized above (People's Perceptions) and in Appendix 2, patients and other locals noted scope for improvement in rural health centers and affordability of health services. Local health staff requested more in-service training and outreach services. Government officials emphasized that everyone has access to free health services including all ethnic groups and migrants. However, they also noted a lack of qualified staff in local health facilities, and that certain EMGs were hard to reach and didn't make much use of public health services.

The EA will ensure that the EGDP is endorsed and translated into Laos and disclosed on their website. The EGDP is also to be summarized in local languages and made available to EMGs in an appropriate form and manner. The disclosure will provide sufficient information to ensure that all community members (women and men of all EGs) are made to understand the roles, responsibilities, and processes of the VAC in regards to dispute resolution, the involvement of

the LNF, and also of the additional avenues available should local mediation fail. ADB will disclose the endorsed EGDP on their web site upon receipt.

53. The provincial and district health authorities will disclose the EGDP contents to community representatives benefiting from the project. The project will finance outreach activities during which relevant portions of the EGDP will be disclosed and local safeguards experts hired by the project will support disclosure of the EGDP to beneficiaries.

54. The planning of activities to benefit EMGs will use a participatory planning approach to prepare the budgeted district plans for EMGs within 6 months from the start of the project. Quarterly meetings will be held with EMGs to discuss activities, monitor progress, and resolve any issues. Special attention will be given to obtaining the views of women and migrants of EMGs. These participatory evaluations have been specified in the EGDP.

55. Among the risks noted were: (i) lack of interest of targeted EMGs; (ii) weak provincial effort in participatory planning, implementation, and monitoring; (iii) lack of effort reaching isolated EMGs, migrant camps, and hotspots; and (iii) insufficient technical and financial backstopping of MOH. For migrants an additional issue is that it may be difficult for migrants to access health services due to unregistered migration and employment conditions; and for health staff to access and inspect labor camps, factories and casinos, which require collaboration with the Ministry of Labor and Social Welfare (MOLSW) and business owners. The Project design will support the development and harmonization of strategies where appropriate. The project will support implementation through CDC activities in border areas, as per output 1.

56. In view of these risks of insufficient focus on ensuring project benefits for IPs as per EGDP, each level in the health system has clear arrangements between the officer in charge, the focal point, consultants, and any third parties for planning, implementation and monitoring of the EMGP as part of overall project implementation. Each level will ensure consultation of potential beneficiaries or their representatives on a quarterly basis and at each stage of the process. Progress will be reported to beneficiaries and shared on websites of RCU and ADB.

IV. BENEFICIAL MEASURES

57. Direct beneficiaries in Component 1 will include prioritized EMGs[13], migrants, laborers in camps, youth, national and provincial preventive medicine officers, district health center staff, commune health station staff and village health workers. It is expected that in Lao in the 36 targeted districts, the project will reach about 1m? EMGs. Migrants, youth, pregnant women, and remote EMGs will receive additional screening and referral for treatment as needed. Project implementation units in provinces will conduct results-based, participatory planning to ensure strong commitment from all stakeholders, and prepare annual plans with activities and targets to be financed from project funds. It is expected that the provision of a vehicle and motorcycle (under Component 2) will increase mobility of provincial teams to reach out to these communities. Component 1 will also support regional, cross-border, and inter-sectoral

[13] Component 1 targets people in border districts, including migrants and mobile populations, vulnerable women and infants, ethnic groups, and in general, poor and people living in remote areas. These populations suffer from a high burden of illnesses and common infections such as malaria, tuberculosis, dysentery, diarrhoea, typhoid fever, acute respiratory infections, measles, and parasitic infections. Poverty and economic integration also pushes and pulls these people into professions and habits with high risk of HIV/AIDS and drug resistance. Without appropriate care these diseases result in high mortality, disability, and malnutrition, impact on learning and productivity. In addition, these marginalized high risk people that are not in touch with the public health system also pose a risk for the unnoticed spread of these diseases that may result in outbreaks.

cooperation for joint planning to extend services to the target groups, and joint activities. Monitoring and supporting this component will be critical and the main assignment of the CTA, gender and social safeguard experts.

58. Component 2 will help improve community preparedness, timely detection, investigation, risk analysis, risk communication, and containment of emerging and other diseases of regional significance, such as malaria, dengue, cholera, tuberculosis and HIV/AIDS. Direct beneficiaries in Component 2 include health staff, and community health workers, who will improve outbreak reporting and response and community preparedness that is appropriate for EMG communities.

59. Component 3 will improve diagnostic capacity by improving laboratory quality, and also reduce the risk of spread of dangerous infections through better laboratory biosafety, hospital infection control, and better case management of infectious diseases. Direct beneficiaries in Component 3 include laboratory and hospital staff, many of whom belong to EMGs, and will work in EMG areas.

V. MITIGATION MEASURES

60. The purpose of the EGDP is to (i) outline the potential positive and negative impacts of the project on ethnic groups; (ii) specify actions to address these impacts; and (iii) help mitigate negative impacts and enhance benefits to EMG communities. To increase support for EMGs in the project, the project management unit (PMU) at central level and provincial level PMU will ensure full implementation of the EGDP. To facilitate this process, key features of this EGDP are mirrored in the project DMF, loan assurances, and PAM and aligned with the existing national policy commitments to ethnic group development in the four project countries. These include participatory assessment and planning with EMGs, outreach to migrants, and disease control campaigns, as well as improved disease reporting and outbreak response, and better access to diagnostic services and hospital treatment of infections.

61. The actions in the EGDP (Appendix 3) support integration of EMG needs and interests into project outputs, and ensure effective participation and access to project benefits. The assessment and participatory planning will help enhance benefits for EMGs. No negative project impacts were identified that would require mitigation measures, however lack of participation and weak implementation threatens the desired positive impact.

VI. CAPACITY BUILDING

62. The EGDP activities are mainstreamed into project implementation activities which will be implemented by the district and provincial health management and service teams. In order to ensure the EGDP is disseminated and that each level understands the actions and activities proposed under the EGDP and the grievance procedures; and that all understand their corresponding role and responsibilities, pre-start up training for provincial and district managers is recommended. The project will assist with training and capacity building of MOH/PMU and PIUs, including for implementation of the EGDP, through training and field visits. This will be supported by the CTA and the gender and social safeguards specialist. It will be critical for MOH to attract competent mid-career consultants to provide effective capacity building. Training will also be provided for infection prevention and control nurses and field epidemiologists, with some orientation towards ethnic minority and migrant concerns. Key features of the EGDP, such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and PAM.

VII. INSTITUTIONAL ARRANGEMENTS

63. As the lead agency, the Department of Planning and International Cooperation will be responsible to the Minister of Health for quality, effectiveness, efficiency of implementation within funds allocated. Provincial Health Office (PHOs) will be the provincial implementing agencies. Each PHO will nominate focal points for project coordination and administration, project planning and monitoring. PHOs and lower levels will be provided with training to implement project activities.

64. The MOH project director and provincial health officers have responsibility to ensure that the EGDP is implemented. MOH and provincial health departments will appoint a focal point for social safeguards. Safeguard oversight will be provided through the Project Management Unit (PMU) with guidance from the CTA and GSS.

65. The Regional Steering Committee (RSC) established under CDC1 will give guidance in Project implementation, policy dialogue, and building of regional capacity and cooperation for CDC, facilitating country decisions on the use of pooled funds for regional activities. It will be chaired by the minister or vice-minister of the host country and will consist of leading representatives from the national SCs, project directors, and ADB and WHO representatives. The Regional Coordination Unit (RCU) will act as the secretariat for regional coordination activities and the management of regional funds. Regional project meetings will be held 6 months before the RSC meeting to follow up regional activities and organize regional events, and report these to the RSC.

66. Related ADB health projects have shown a steady improvement in EGDP implementation. Project Directors are committed to provide the necessary leadership and inputs to fully implement the EGDP. Key features of the EGDP such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and PAM.

VIII. GRIEVANCE REDRESS MECHANISM

67. Regular meetings and consultation will seek to minimize dissatisfaction among project-affected people. Local stakeholders' opinions and concerns will be part of the project planning and implementation. The participatory approach will encourage people to raise any concerns before conflicts may appear in the design and implementation of Project activities. The beneficiaries can address their concerns to the Project Director through their representative. The complaint will be assessed and negotiated into a solution between the project representative (focal point or IA) and local authorities, and then fed back to the communities as part of the participatory planning process. If the conflict is not solved amicably, it will be taken to the PMU or MOH Steering Committee under the MOH. The project representatives at various levels will be responsible for reporting any grievances up to the appropriate level. The particular activities will be carried out after such conflict is resolved satisfactorily.

68. Although no grievances are envisaged under the proposed GMSHSP, the ADB Safeguard Policy Statement (2009) does require a grievance redress mechanism. In the Lao PDR, the judicial system starts at the local level with the Village Administrative Committee (VAC), which is normally used for grievances against local government agencies, civil actions, and minor criminal matters. In the case of most EG communities there is a more informal but very influential Village Elders group that includes individuals with social capital and influential social position in

the community. The Village Elders should also participate in the grievance hearing and resolution at the village level.

69. The EG members may make verbal complaints at the village level. If the issue is to be referred to the district authorities, formal complaints must be put in writing and bear the village stamp to indicate that the complaint has been referred correctly through the local grassroots authorities. If the village has difficulty in submitting a formal written complaint, the Lao National Front (LNF) office at district level will provide the necessary assistance to do so. Complaints received must be documented and acted upon immediately. The VACs will be advised of the need to keep records of grievance hearings and the information needed.

70. Should issues not be resolved at the village level, an appeals process at district and provincial levels will be made available through the respective health office who will act on behalf of the project owner. The respective PHD or district health office (DHO) will be required to request the participation of the provincial or district Lao National Front (LNF) representatives at any grievance hearing. Any grievance not resolved at the local level can be referred to the Department of Planning and International Cooperation, MOH, and again, with the participation of LNF representatives. If the matter is still not resolved, the issue can be referred to the Provincial Peoples' Court.

71. Grievance resolution will be aligned with the other safeguard processes where possible. The procedural steps for filing and resolution of grievance and complaints are described in Table 4 below.

Table 2: Grievance Procedure

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to VAC/VE at village level. If unwritten the VAC/VE will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint at the district level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the district level, he/she can seek redress at provincial GRC that should decide the issue within 10 days.
Stage 4	The AP may elevate the complaint for hearing at the PMO if still unsatisfied with the decision of GRC at the provincial level. The PMO will ensure to resolve each complaint within 10 days after receiving the appeal.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, PMO = Project Management Office, VAC = Village Administrative Committee, VE = Village Elder

IX. MONITORING, REPORTING, AND EVALUATION

72. The executing agency (EA) will take action to ensure that a monitoring and evaluation system is formulated and implemented. As mentioned earlier, the EGDP contains suggested activities with indicators and targets which must be included in the Project performance management system (PPMS). The CTA and Safeguards Specialist will assist the PMO PPMS officer to ensure that all EGDP indicators are properly identified and defined and included in the PPMS. The PMO PPMS officer will receive updated reports from the provincial coordination unit and safeguard focal point, and prepare quarterly reports for the EA at central level using the design monitoring framework which is prepared and submitted to ADB on a quarterly basis.

73. Project evaluation will be carried out in three phases: (i) Project inception: capacity building, participatory assessment and planning, identification of sites, planning implementation details; (ii) Mid-term evaluation: assessment of progress of EGP implementation and adjustments, after 1.5 years; and (iii) End-of-Project evaluation and impact assessment after 5 years. The inception report, mid-term evaluation and project evaluation will be made available on internet. The PMU will carry out assessment of all training activities, and baseline and end-of-project data collection for assessing trends in the use of CDC services by EMG in border areas under Component 1. No survey will be done: community and health facility records will be used to assess trends. Project evaluation will include an assessment of the effectiveness of EGDP, in terms of enhancing positive impacts. The evaluation will also assess the participation of stakeholders in project implementation. Beneficiaries will be informed about progress and results through community meetings, brochures, and reports available on the website of the regional cooperation unit and the ADB, and through distribution of brochures.

X. BUDGET AND FINANCING

74. The total cost for output 1 including regional and cross border cooperation and CDC for MEVs is budgeted at about $3 million. About half of this budget is expected to benefit EMGs directly in the form of campaigns and outreach services. EMGs will also benefit from training, surveillance and response, and other project activities, as well as project support services, The EGDP activities are integrated into the overall arrangements and total budget of the project.

75. The participatory planning process to prepare the detailed project plan and EGDP for each of the targeted provinces is expected to be completed within 6 months. This will include health staff orientation, collection of health services statistics, mapping and participatory assessments of IPs and other vulnerable groups, and meetings and consultations. This is followed by quarterly meetings with EMGs to monitor and report progress. A budget has been set aside to finance this planning and monitoring process.

Appendix 1: Information on Migrants, Ethnic Minorities, and other Vulnerable Groups

A. Introduction

Various migrants, mobile people, ethnic minorities and other vulnerable groups (MEVs) in border areas and economic corridors work in plantations, factories and entertainment services. Depending on the type of occupation and living conditions, these women and men are exposed to various risks such as poor working conditions, higher risk of infectious diseases, and less access to services. Unskilled labor is provided by internal and external migrants but also by local people living near factories. Skilled labor is also often provided by internal or external migrants. While most migrants periodically return home, some are deported after confinement of 1-2 months as illegal laborers. Many migrants are exposed to various forms of exploitation more likely to result in illness and infections. However, there is little information on the actual health status of ethnic groups and migrants.

B. Ethnic minorities

The GMS is an increasingly interlinked geographical and economic region that shows remarkable ethnic and social diversity. Historically, it has seen successive dynasties, migrations, conflicts, and occupations, but despite this intermingling has retained distinct populations and ethnic groups. While some of the ethnic groups are original inhabitants, others migrated later from neighboring countries, either by conquest, or to lands traditionally less populated, in particular the highlands and mountains, and habitats rive with endemic diseases. These ethnic groups maintained practices and customs from their homeland, and adjusted in various ways to their new surroundings. Many of these ethnic groups in the GMS are trans-border people, and form a major part of the population in some provinces in Cambodia, Lao PDR and Viet Nam, and states in Myanmar. Remarkably, many of these ethnic groups have remained isolated and homogenous, even when adapting to new economic opportunities in agriculture, tourism, trade and migrant labor.

While there are still some traditional and less informed ethnic groups living in isolated locations, the majority of them is in one way or another exposed to developments at home and abroad, bringing both opportunities in terms of trade and labor, and risks in terms of social instability, diseases and drugs. While some ethnic groups and families have been able to make use of new economic opportunities, many have had difficulty adjusting, with sometimes serious consequences such as new poverty, malnutrition, and diseases. Insufficient effort is made to ensure that no harm is done to ethnic groups, and that they are provided with appropriate opportunities. Mobility and migration of ethnic groups should therefore be of major concern in the context of regional health security.

A remarkable feature is the low median age of populations, in particular in the Lao PDR. In addition, as shown in several UN studies, a large proportion of external migrants are below 18 years of age. These minors are especially vulnerable to all kinds of exploitation. Those returning home may have less access to health services. Child migration and its consequences is a serious child rights issue which is not receiving much attention in the health sector.

C. Migrants

Road construction in the GMS is rapidly improving regional and local connectivity, opening up new areas and creating economic corridors and employment. Settlements along these roads attract entrepreneurs and migrants. Immigration and trade agreements stimulate the flow of people and goods between countries. Tourism promotion and increased wealth add regional travel and demand for services. More recently, due to the rapid expansion of plantations and industrial zones with labor opportunities, with internal migration in areas traditionally settled by ethnic minorities, integration of various ethnic groups is continuing at a much faster pace, causing rapid transition in terms of changing social structures, labor, consumption, and exploitation.

Lao attracts migrants from China, Thailand and Viet Nam including farmers, laborers for services, industries and plantations; and workers for the construction boom. Only a small proportion of these migrants are from poor EMGs, but most migrants have language problems, are not familiar with health services, and may not have access to subsidized care. At the same time, about 1 million Laotians are working abroad, mainly in Thailand and the USA, including 30% of Lao's university graduates. It is hoped that, as economic opportunities in Lao are improving, this diaspora will slow down.

While migration overall has been a major force for poverty reduction in the region, studies show that EMGs are more often left behind due to lack of economic opportunity, such as lack of quality agricultural land, social exclusion, lack of credit, and geographical isolation with lack of access to markets. EMGs are also more often illegal migrants, for example because they lack education, and victims of mis-information about salary and labor conditions, and sometime confinement, coercion and trafficking. Studies show that illegal migrants often live in very poor living condition.

Economic developments accelerate social and economic changes are likely to have both positive and negative impacts on health. Migrant labor may increase exposure to communicable diseases related to new behavior, such as tuberculosis, HIV/AIDS, hepatitis; habitat, such as malaria and, dengue, and lack of access to services, such as for food and water-borne diseases. Lack of knowledge of diseases and access to services make them prone to spreading diseases, including EIDs. Migrant laborers are also more prone to accidents, alcoholism, drug addiction and malnutrition.

The risks will vary by age, education, gender, occupation and location. EMGs and migrants in border areas will generally have less access to services. MEVs may be less willing to access services due to lack of awareness, financial hardship, illegal labor, addiction, and lack of rights. Cross-border migrant workers with HIV or TB may not be able to continue treatment. There are two major child rights issues: youth and pregnant women are particularly at risk of exploitation and abuse and may have less access to services.

Providing effective CDC for MEVs will not only help improve health and health security, but will contribute towards child protection, better learning in school, economic productivity, and poverty reduction, all high on the Government's list of priorities.

D. Other Vulnerable Groups

Each province, state or region will have a mix of vulnerable groups, in terms of (i) personal vulnerability due to condition and exposure, and (ii) not being reached by the health system and therefore likely at increased of illness and spreading infections. Each province will need to identify its own priorities to be addressed using a participatory approach, also to generate ownership and sustainability. In some districts, migrants and ethnic minorities may not be priority, but instead unemployed youth or sex workers may be a particularly vulnerable group for infectious diseases. The Project should be able to respond to local priorities.

Within provinces/states/regions, border districts/townships along economic corridors are selected with hotspots with high burden of communicable diseases and low CDC coverage in MEVs. Selection criteria will also consider local commitment, presence of partners, and cost-effectiveness of reaching and having impact on these MEVs. The focal points in the provincial health department and preventive medicine centers will need to facilitate the selection process after initial orientation. Plans will need to be included in provincial annual operational plans, approved at higher level, and investment sustained from local sources in subsequent years.

E. Health Services

In the GMS, public and private health services are reaching a large part of the population. The Government focuses on providing services to the general public. However, those not being reached by any formal health service, migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs) will continue to be at risk of, and spread infections, including possibly more drug resistant infections. As the health status improves, the impact of those not reached by the health system, marginal groups such as migrants and ethnic groups, becomes relatively larger, and it will become more cost-effective for the government to develop ways to reach these groups, at a higher unit cost.

Among the reasons why both formal public and private health services have made less effort in reaching these marginal groups are living conditions and services in these areas, language problems, market failure, government regulations limiting adequate compensation, and in general lack of trained people, many of whom migrate after education. Hence, special arrangements are needed to reach these people, often requiring a more multi-sectoral and partnership approach.

Access to the public health system is less than satisfactory in mountainous border districts. The population in these districts includes ethnic groups and migrants from other districts, and mobile people working cross-border. While these people have a higher disease burden and may sustain the spread of infections, their access to health services is less.

A WHO SEARO report divides mobile and migrant populations (MMPs) broadly in three groups:
(i) those affiliated to an employer, including semi-mobile employees and seasonal farm workers;
(i) those affiliated with the government, including military, security personnel, and border guards; (iii) non-affiliated, including ad hoc laborers, new settlers, highly mobile laborers and short-term migrants.[14]

[14] WHO SEARO. Vector control and personal protection of migrant and mobile populations in the GMS: A matrix guidance on the best options and methodologies. New Delhi. 2015

While all these groups would need to be targeted in terms of relevant information on prevention of diseases such as malaria, HIV/AID, tuberculosis, and other conditions, the first 2 groups are organized and therefore, in principle, easier to access. However, experience shows that it is also difficult to access organized groups of migrants working in plantations, casinos, and factories. While the Governments has laws and policies in place to reach these people usually through the MOLSW, this is not sufficient in terms of quality and quantity of inspection and migrant access to services. Hence, special arrangements are needed, with special agreements between those in charge. For non-affiliated, often illegal migrants including ethnic minorities and minors, it is even more difficult to encourage them to use public services. Grassroots organizations and NGOs should play a major role in this field. Viet Nam has so far shown less recognition of the potential roles of NGOs in this regard.

F. Location

The selected provinces/states/region can be grouped in 3 clusters of broad economic corridors with certain characteristics, as shown in Table 1.

Table 1: Geographical Clusters Along Economic Corridors[15]

Cluster and Corridor	Main Ethnic Groups	Ethnic minority characteristics	Implications
Cluster 1: Northern corridor: Vietnam North, Lao North, Myanmar-east, Myanmar-east, Thailand-north-east	Large ethnic minority populations, in particular originating from China, mainly Sino-Tibetan and Hmong but also Mon-Khmer	Relatively isolated, self-sustaining highland groups with high burden of HIV, respiratory infections and other common infections, at risk of epidemics through trade, less accessing health services	Some border districts are hard to reach based on government conditions, but these highly remote people may also be less at risk of epidemics. Focus on accessible hotspots for outreach services, community workers.
Cluster 2: Central corridor: Vietnam Central, Lao-south- central, Cambodia north-east, Thailand north-east, Myanmar-central	Large ethnic minority populations, including large indigenous Mon-Khmer and related groups and migrants from northern areas	Relatively isolated, traditional, poor and less educated highland groups and migrant workers, with high burden of common diseases, at risk of epidemics of malaria and dengue and less accessing health services	Border districts may be more accessible but face political problems. Provide appropriate health services for EMG including access to suitable community workers and free health services.

[15] This information is based on the crossborder cooperation work of the ADB-financed RCU and is necessarily a crude summary of the situation, but nonetheless informative

Cluster and Corridor	Main Ethnic Groups	Ethnic minority characteristics	Implications
Cluster 3: Southern corridor: Viet Nam-south, Cambodia south-east to north-west, Thailand east to West, Myanmar-south	Largely inhabited by non-ethnic minorities including Kinh, Khmer, Thai and Burmese. Has large migrant and Muslim populations	Largely integrated populations, better educated, mainly living in lowlands, industrial zones, high burden of dengue, diarrheal diseases, more timely reporting of diseases and accessing services	No need for special services for ethnic minorities. Needs special care for illegal migrants by providing them information and access to free health services.
North-South Corridor: China-south to major cities in the GMS	Mainly passes through non-ethnic minority populations except when passing through cluster 1 corridor	Mostly migrant ethnic groups providing unskilled labor and other services along the economic corridors	No need for special services for ethnic minorities. Needs BCC and services for migrant workers in hotspots, factories, casinos and labor camps.

Note: the corridors referred to here are not officially recognized entities.

Primary targeted provinces/states/region in CLMV countries and neighboring states and provinces in China and Thailand are in Table 2.

Table 2: Targeted Project Provinces/States/Region

Participating countries	Number of targeted project provinces, states/region	Targeted project provinces/states/region
Cambodia	13	Pailin, Battambang, Banthey Meanchay, Preah Vihar, Stung Treng, Rattanakiri, Mondulkiri, Kratie, Kandal, Tbong Khmum, Prey Veng, Svey Rieng, Kampot
Lao PDR	12	Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu, Champasack
Myanmar	6	Shan North, Shan East, Kaya, Kayin, Mon, Tanintharyi
Viet Nam	36	Quang Ninh, Lang Son, Cao Bang, Ha Giang, Lao Cai, Lai Chau, Dien Bien, Son La, Thanh Hoa, Nghe An, Ha Tinh, Quan Binh, Quan Tri, Thua Thien, Quan Nam, Kon Tum, Gia Lai, Dak Lak, Lam Dong, Dak Nong, Binh Phuoc, Tay Ninh, Long An, Donh Thap, An Giang, Kien Giang, Bac Lieu, Sok Trang, Tra Vinh, Ben Tre, Ba Ria, Thai Binh, Hai Phong, Yen Bai, Tuyen Quang and Bac Kan

Neighboring countries	Number of neighboring provinces	Neighboring provinces
China	1	Yunnan
Thailand	12	Mae Hong Son, Chiang Mai, Chang Rai, Phayao, Buen Khan, Nhakon Phanom, Udon-Ratchatani, Sa Kaew, Tak, Kanchanaburi, Ratchaburi, Phetshaburi

G. Conclusion

In summary, most EMGs in GMS border areas can no longer be thought of simply in terms of disadvantage due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change.

This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. In most cases, EMGs are beginning this process of integration from a very disadvantaged position.

Although EMGs are more likely have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EMGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The reason is that governments do not want to emphasis ethnic differences. Country specific data show that provinces with high infant and child mortality rates also have high concentrations of EMGs. Surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by health centers and hospitals. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive. While national surveys collecting information on vulnerable people may have some utility in terms of advocacy and monitoring, information also needs to be locally collected to identify vulnerable groups, and target appropriate interventions using a participatory planning cycle process.

Appendix 2: Ethnic Group Development Plan Consultations, October 2015

Topic	Questions	Responses	Proposed action
Ministry of Health*			
Health Plans	Are policies for ethnic groups and migrants adequate?	In 12 provinces has equity fund for poor ethnic group not cover of migrants in border area in 2017 HOH equity fund will cover all provinces	Cooperate with MOH and MOLSW to improve health service for ethnic & migrant
	Are national plans addressing needs of ethnic groups and migrants?	Yes, national plans almost mentioned on ethnic groups and less for migrants; the government prioritized to develop villages of high proportion of EMGs.	
	Are there legal barriers?	There are no legal barriers of EMGs and migrants follow government rules and procedures.	
	What are planning issues for ethnic groups and migrants in regional CDC?	The planning is covering of ethnic groups and migrants in remote area.	MOH in cooperated with NGOs that working in these areas
	Is investment in CDC addressing the needs of ethnic groups?	Few paras in this current CDC, MOH will improve services to remote areas cover of ethnic minority	MOH in cooperated with NGOs that working in these areas
	What could be negative impact of a regional CDC project on ethnic groups and migrants?	Alignment national program into regional CDC and make sure of sustainable after project complete.	MOH to develop a regional CDC program
	Are Government and partners active in regional CDC?	Yes, government and partners in region is working together at policy and planning level. At provincial level has cross-border CDC cooperation not at national level. These plans do not specifically address regional concerns related to EMGs and migrants, but do make some recommendations.	
	What would be major constraints for CDC in border areas?	The main constraint in each border areas is security problems between countries. In some border did not have a local health officer neither office for working	Some local border has no health office

Topic	Questions	Responses	Proposed action
Health Status	Is the specific health status of ethnic groups and migrants known?	MOLSW and NA responsible for EMGs and migrants workers it is not including of health indicators. Some migrants HIV/AIDS indicators collected by CHAS based on survey not surveillance.	MOH does not have a regularly system for collection of migrants health, however MOLSW have some report of migrant worker
	What explains the poor health status of ethnic groups and migrants	No clear system for evidence of poor health status of EMGs as in each health facilities in remote areas. Also no survey or surveillance of their health problem and how they search for treatment as the difficulty of access to health service. Migrants labors have the same problem as MOLSW have limited regulation and supervision of migrant labor	MOLSW developed the labor law in 2009 and it will review and adopted to ASEAN labor law in 2020
O	Are ethnic groups and migrants more prone to epidemics?	It depends on their exposure determined by occupation and living conditions, health status, knowledge, and timely reporting but specific risk profiles are lacking	CDC should make a survey of extract from their regularly surveillance
Health Services	What are the problems of providing health services for ethnic groups and migrants?	In additional problem of communication and trust of health service. In timber area or remote area construction may have their own health service	
	Are health services affordable for ethnic groups and migrants?	Health services have equity fund for poor ethnic existing in remote health facilities in whole country.	This needs to be further investigated through interviews of patients
Department of Planning & Cooperation			
Health Plans	Are EMGs and migrants specifically referred to?	Sure that EMGs is primarily target gaps in health plan same as gender, however the general direction of health service should be available to the general public, irrespective of ethnic	Health plan should include migrants
Health Status	Occurrence of epidemics	There have not been a major cases of emerging infectious diseases	

Topic	Questions	Responses	Proposed action
	What are the specific health problems of EMGs and migrants?	EMGs often have hygiene and poverty related diseases like diarrheal diseases, pneumonia, tuberculosis and malnutrition. Prevalence of sexually transmitted diseases may be higher in migrants but they usually go to a private clinic.	The project should assist with health promotion and safe sex in communities, and link people to health
Health Services	What are the major hurdles for ethnic groups and migrants to access services?	Some ethnic groups prefer traditional medicine. If they live far away, travel time and transport costs are problems. Migrants may be reluctant to access public health services, or may not get permission	
	For those who can't pay out of pocket, are there arrangements?	Yes, in all public hospital have user fee for health care service for people who can afford to pay.	To be investigated if this works adequately
Health Monito- ring	Are health and health services data split by ethnic groups and migrants?	Yes, in the registration book at each health facility have one column for ethnic group, unfortunately that not in the national health statistic. Migrant not existing in the registration book	The project may assist national health statistic to keep the record
Health Staff			
Health Plans	Are you aware of any special arrangements for EMGs and migrants?	Not known	To be investigated
Health Status	What do you see as the major health problems of ethnic groups and migrants?	EMGs who are living in remote area are poor and limited knowledge of hygienic and practice of traditional believing many of them are suffered from common infections. Migrants almost using of their camp care service few of them are using of health facilities service.	Health problems to be identified by the IA outreach team using a participatory approach with target groups
	Do you think HIV and TB are higher or lower among ethnic groups and migrants?	TB is higher in among of ethnic groups, HIV higher in migrant worker. As TB common found in poor, malnutrition and elderly.	This requires a more formal study, beyond the scope of this Project

Topic	Questions	Responses	Proposed action
Health Services	Are ethnic groups and migrants using these health services as others?	In each province have different ethnic groups either in the big city, they are using health services except some remote area in border district was hard to access to the health facilities service. Very rare for migrant to use health service at facility as it has their own camp service.	
	Are there specific access problems in the provision of health services to ethnic groups and migrants?	Sure that it has, but no record of identify of hard accessible problem; almost with the road and transportation for ethnic groups. Migrants has camp service for each timber except for illegal timber that hard to find service	
	Are there language problems?	Yes, some ethnic could not communicate with national language.	
	Are there affordability problems?	Many of them could not pay of user fee that hospital collect for treatment service; almost for surgery and some expensive	WHO report in 2009 on out of pocket
	Any other problems?	Some ethnic group has a barrier of culture to use of health care service at health facility	Almost for birth delivery
Ethnic Community Representatives			
Health Plans	Are you involved in discussions to improve health services?	Some provinces such as LNT, PSL, ODX, XK, SK and ATP that we visited were involved in the community meeting for improving of their health service	Lacking of follow up from province to central on their plan
	Do you think plans are appropriate for the local community	In the root level the plan was appropriate unfortunately that very few selected to include in the national health plans. It means that some activities were drop out and no money. Data collection during our field trip.	
Health Status	What do you see are the major health problems in your community?	All disease that they found the major health problems but none of them mentioned hygiene	Just for ethnic community near by the health facility
	Did you have any major epidemics?	Seasonal cough and diarrhea	As above
	Are TB and HIV major health problems?	TB and HIV have free treatment at all health facilities	

Topic	Questions	Responses	Proposed action
	Are there specific groups more at risk?	Ethnic group in remote area that hard to access, and migrants that work at illegal timber	
Health Services	What are the good parts of the health services?	The health staff at remote health facilities that courage to work over there ever that not	
	What parts of the health services would you like to see improved?	Staff quality and supplies equipment for running health services both in health facility and outreach	
	Are health services affordable for the poor?	No, too expensive for the villagers that qualify as not poor, as it has equity for poor	To be investigated
Ethnic Patients			
Health Status	What is the reason for your admission?	High fever, diarrhea, cough chronic, vomit	They could not tell with diagnosis
Health Services	Do you find the hospital clean, can you get clean water and toilet?	Province and district hospital are clean not at health center because some time no water and toilet cannot use without water	
	From how far did you travel?	From some ethnic group took almost a day to access HC, some nearby informed	
	Are you happy with the quality of care?	Yes, some staff is our ethnic group so we can communicate with them	
	Are health services affordable?	Some time we paid for the fee and some time we bought additional medicine that hospital does not have	
Female and Male Ethnic Members			
Health Status	What are main health problems in your community?	Cough, diarrhea, high fever with vomit and malnutrition	
Health Services	Are health services adequate	For small sick is OK but not for serious sick must go to higher hospital	They need some transport
	What is availability and attitude of staff?	The staff living near to their health service and they are helpful	
	Are medicines available?	Basic treatment mostly available	
	Other issues?	Improve emergency services	

Topic	Questions	Responses	Proposed action
Partners*			
Health Plans	What are planning issues for ethnic groups and migrants in regional CDC?	Lacking of data information on EMGs and migrant in health statistic and very rare to use at MOH level. Some partner such as LuxDev, have some few case study at the project sites only. Migrants information may be existing in some INGOs that worked in their project area only and not a systematic regular collection	The Government to conduct a survey for the migration health policy. The project can help to collect some data in target area
	Is investment in CDC addressing the needs of ethnic groups and migrants?	EMG is including ethnic in city, provinces, districts and remote area are serviced through general health system all population could access to the health facilities. Migrant based on the Labor law for health access, except illegal migrant labor need to registered	Clear information need from survey or surveillance
	Are there legal issues for ethnic groups and migrants?	Yes, for ethnic group not special for migrants	To be investigated by MOH in preparation of the Migration Health Policy
	What are major gaps?	- Lack of data information to analysis - no specific issue for migrants in health plans - Developing a comprehensive multi-sectoral program endorsed by all stakeholders including the private sector for regulation and implementation	As above
Health Status	What is the HIV and TB status among ethnic groups and migrants?	Based on data information from the Global Fund project there are no conclusion data on the status of EMGs and migrants. CHAS and NTB made some survey on TB/HIV infection in migrant's worker, it seems that the prevalence is high but could not compare data of reach percentage	This requires a special survey, which is beyond the scope of the project

Topic	Questions	Responses	Proposed action
	Is the surveillance system reaching ethnic groups and migrants?	Yes, the surveillance system reaching ethnic groups for some diseases and outbreaks are reaching all community. Migrants hard to get a clear data information	The project will strengthen the surveillance system
Health Services	How is access to health services for ethnic groups and migrants?	All population including ethnic and migrant are fully accessible to health services except some ethnic in remote that hard to access almost during the rainy season. Some illegal migrants may not access to health service	
	What is the government capacity in providing services to ethnic groups and migrants?	The government capacity is limited to provide service to ethnic group in remote area, however government try to put some GOL for improving service with distributed some qualify staff to remote province and districts. Migrants still need to improve policy and it strategy plan	
	What works better in reaching ethnic groups and migrants?	Government health service in cooperation with INGOs to improve working condition. The government should support the INGOs to reach the remote ethnic groups and migrants as many INGOs are working with ethnic group and migrants than the public	

Note: The national social safeguards specialist visited project provinces in October 2015. From 21 to 24 October 2015, the international Gender and Social Safeguards Specialists visited Bokeo and Luang Namtha provinces located in North–West of Lao PDR. Bokeo province shares borders with Myanmar and Thailand (through the Friendship Bridge No.4 in Huoyxai, the Bokeo capital). Luang Namtha shares borders with Myanmar and China (Yunnan).

Appendix 3: Ethnic Group Development Plan

Project Outputs	Sub-outputs	Ethnic Groups' Design Features/Activities	Performance Targets/Indicators
Output 1: improved GMS cooperation and CDC in border areas	1.1. Improved regional, cross-border and inter-sector cooperation 1.2 Enhanced knowledge management and community of practice (COP) 1.3 Increased access to CDC in border areas, in particular for vulnerable groups such as migrants, HIV positive youth, pregnant women, and isolated ethnic minorities.	Enhance participation, capacity building and decision making opportunities for representatives of IP in regional, cross-border, and inter-sectoral events. Use workshops for EG advocacy and increasing EG awareness among workshop participants and stakeholders/governments. Ensure full participation of EG staff for outreach activities using IP-sensitive education and care procedures. Proactively target EG at increased risk of infectious diseases with CDC activities in border areas.	Participation of EG representatives in all these events (baseline unknown). Workshop materials clearly demonstrate mainstreaming of EG issues and promotion of EG-sensitive strategies. Participation of IP staff in outreach activities. Decreased prevalence of infections among IPs in border areas based on health statistics.
Output 2: strengthened national disease surveillance and outbreak response systems	2.1 Strengthened surveillance 2.2. Strengthened response	Collect, analyze and report EG-disaggregated data. Ensure participation of EG staff in any outbreak response teams. Increase participation of IPs in field epidemiology training.	EG disaggregated reporting for CDC project activities in each country. In districts with over 20% EGs, each outbreak response team has at least one EG staff. Of participants in field epidemiology training, at least 5% are EGs in Cambodia, 30% in Lao PDR, 30% in Myanmar, and 10% in Viet Nam.

Project Outputs	Sub-outputs	Ethnic Groups' Design Features/Activities	Performance Targets/Indicators
Output 3: improved laboratory services and hospital infection prevention and control	3.1 Improved laboratory quality and biosafety 3.2 Improved infection prevention and control in hospitals	Ensure representative EG participation in laboratory training programs for districts with large EG population. Ensure representative participation of EGs in scholarships for hospital infection prevention and control. Ensure EG sensitive facilities in isolation wards	Representative participation of IPs laboratory management and quality assurance training programs Representative participation of EGs in hospital infection and control training. All repaired isolation wards provide arrangements for EGs
Project Management	3.1 Ensure Integration of project activities in regular services 3.2 Improve efficiency and governance.	All implementation plans for specific project activities and annual operational plans (AOPs) supported provinces address gender and EG dimensions of project activities All implementing agencies have an EG focal point All quarterly reports report on progress in EG issues At least 50% of consultants have experience working with EGs.	Proportion of project implementation plans and AOPs that address IP dimensions adequately. Proportion of active focal points in implementing agencies (based on participation in events. Proportion of quarterly reports that report on EG issues. Proportion of consultants with EG experience.

Ethnic Group Development Plan, Myanmar

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS
(as of 7 April 2016)

Currency unit	–	kyat (MMK)
MMK1.00	=	$0.00085
$1.00	=	MMK1,170

NOTES

(i) The fiscal year (FY) of the Government of Myanmar and its agencies ends on 31 March. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 March 2017.

(ii) In this report, "$" refers to US dollars.

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ACRONYMS

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
AOP	annual operational plan
APSED	Asia-Pacific Strategy for Emerging Diseases
CBO	community-based organization
CDC	communicable diseases control
CDC1	First GMS Regional Communicable Diseases Control Project
CDC2	Second GMS Regional Communicable Diseases Control Project
CLMV	Cambodia, Lao PDR, Myanmar and Viet Nam
CTA	chief technical adviser
DMF	design and monitoring framework
DMS	Department of Medical Services
DPH	Department of Public Health
EGDP	ethnic group development plan
EID	emerging infectious diseases
EMG	ethnic minority group
GAP	gender action plan
GMS	Greater Mekong Subregion
GSS	gender and social safeguards specialist
HIV	human immunodeficiency virus
IHR	international health regulations
ILO	International Labor Organization
IOM	International Organization of Migration
MEV	migrants, ethnic and other vulnerable groups
MOH	Ministry of Health
MOLES	Ministry of Labor, Employment, and Social Security
NGO	nongovernmental organization
NHL	national health laboratory
PAM	project administration manual
PDR	People’s Democratic Republic (Lao-)
PMU	project management unit
RCU	regional cooperation unit
RSC	regional steering committee
SPS	safeguard policy statement
S/RHO	state/region health office
S/RMU	state/region management unit
UNAIDS	United Nations Joint Program for the Control of HIV/AIDS
UNDP	United Nations Development Program
UHC	universal health coverage
WHO	World Health Organization

EXECUTIVE SUMMARY

This Ethnic Group Development Plan (EGDP) of the Ministry of Health, Myanmar, presents the Myanmar-specific ethnic group analysis, strategy, and plan for the Greater Mekong Subregion (GMS) Health Security Project (the Project) based on the Government's laws and the Safeguard Policy Statement (SPS) of the Asian Development Bank (ADB) for ADB financed projects.[1]

Ethnic minority groups (EMGs)[2] are the majority population in all of Myanmar's States.[3] Most EMGs are fully mainstreamed in Myanmar society. For practical purpose, the EMDP focuses on indigenous people[4] that have higher mortality rates and CDC burden and worse health indicators than the general population. These are mostly poor indigenous people, with lack of access to services, displacement, or rights issues. The EMDP focuses on the first group, including remote ethnic groups, and internal and external migrants, many of whom are also poor indigenous people. The challenges of control of infectious diseases of regional relevance in these two subgroups are not only a priority but strategically quite apart involving different stakeholders.

The proposed GMS Health Security Project for Cambodia, the Lao PDR, Myanmar and Viet Nam aims to improve regional public health security by strengthening health security systems and Communicable Diseases Control (CDC) in border areas, particularly for migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs). Three components or outputs[5] are proposed: (i) improved regional cooperation and CDC in border areas; (ii) strengthened national disease surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control (IPC).

In support of the 2005 International Health Regulations (IHR) of the World Health Organization (WHO) and the 2010 Asia Pacific Strategy for Emerging Diseases (APSED), the Project is designed to support regional cooperation and national capacity building for prevention and control of emerging infectious diseases (EID) and other diseases of regional importance such as malaria, dengue, cholera, tuberculosis, HIV/AIDS, and drug-resistant infections.

The project will cover a total of 5 states and 1 region in Myanmar, as well as 13 provinces in Cambodia, 12 provinces in the Lao PDR, and 36 provinces in Viet Nam. In Myanmar, approximately 2 million people (two thirds of those living in the target project area) is classified as EMGs, living in diverse socio-economic settings with different customs and languages. The targeted states and region[6] are Shan North, Shan East, Kayah, Kayin, and Mon States, and Tanintharyi region bordering China, Laos, and Thailand. Tanintharyi region has a high poverty rate of over 30% and a high concentration of migrant workers. All states have substantial populations of EMGs.

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[1] As described in the ADB Safeguard Policy Statement (2009).

[2] In Myanmar, the term *ethnic group* is more commonly used instead of *ethnic minority group* or *indigenous people.*

[3] The Government of Myanmar doesn't use the term "*indigenous peoples*" but "*race*" or "*ethnic minority*".

[4] The term "indigenous" is considered inappropriate by some governments as this implies backwardness and excludes recent migrants, so the term "ethnic minority group" (EMG) is preferred. In Lao use the "Ethnic Groups" and will not use the words "minority or Indigenous".

[5] Government uses the term 'components' and ADB uses 'outputs', therefore both terms are used in this EGDP

[6] Administratively, Shan North and Shan East are parts of the Shan State, one of 15 States, Regions and Territory the makes up the Union. The capital city of the 'Shan State' is Taunggyi, where the Chief Minister and the Shan State Government have their offices. Kengtung (Eastern Shan) and Lashio (Northern Shan), the targeted project areas are within the Shan State.

According to ADB's 2009 Safeguard Policy Statement (SPS), the Borrower is required to ensure benefits for EMGs affected by the Project. According to the Indigenous Peoples Safeguards Sourcebook[7]: "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook, *"IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* As per the ADB SPS, *"if [ethnic groups] are the sole or the overwhelming majority of direct project beneficiaries and when only positive impacts are identified, the elements of an EGDP could be included in the overall project design in lieu of preparing a separate EGDP."*

While the project is expected to have positive impacts on poor EMGs, they are not the exclusive targeted project beneficiaries. The project aims for improving regional health security, not primarily improving the health of EMGs. Given the scale and complexity of this regional project, the potential for not achieving certain intended positive impact on EMGs where this is required justifies a category B and warrants preparation of this EGDP.

Sufficient legislation is in place to address the needs of EMGs, except possibly for migrants and displaced people. MOH gives high priority to services for border areas, the poor and isolated EMGs. However, implementation may fall short of intended project benefits for EMGs because of (i) project relevance and appropriateness for certain ethnic groups, (ii) project efficiency and (iii) sustainability of interventions. In particular, for Component 1, CDC in border areas, interventions such as disease control campaigns and outreach health services should be appropriate for EMGs. Villages are highly appreciative of local health staff, but funding constraints affect the expansion of communicable diseases control (CDC) and surveillance.

MOH has committed to provide the necessary leadership and inputs for the Project to fully implement the EGDP. MOH aims to maximize project benefits by targeting MEVs likely to be at increased risk of infectious diseases in border areas. In alignment with national policy and context, MOH proposes to mainstream EMG concerns in all Project activities. The EGDP is to (i) enhance equal opportunity, (ii) target vulnerable groups, and (iii) promote IP in alignment with priorities.

The Government is facing several challenges in implementing the EMDP such as MOH capacity, provincial priorities, security problems, staff shortage in remote health centers and health posts, and financial and logistic constraints. MOH is aware of its constraints to reach isolated villages and migrants. MOH has experience and mechanisms in place to work with other agencies and grassroots organizations for social mobilization and village health development. MOH is encouraging partners to help finance these investments.

MOH will use a participatory approach in project implementation. EMG engagement and services, along with other activities to be supported by the project will all be included in provincial and district annual operational plans and budgets, and in staff training and project management. The PMU and implementing provinces will have a focal point for implementing the EGDP to ensure that EMG issues are being addressed. MOH will also engage a chief technical adviser and a gender and social safeguards expert to assist in this process. The PMU will initiate

[7] ADB. 2013. Indigenous Peoples Safeguards: A Planning and Implementation Good Practice Sourcebook (Draft Working Document).

a participatory planning and budgeting process for EMGs and prepare specific plans within 6 months of the start of the Project. The PMU will also put monitoring, reporting and grievance systems in place. The PMU will seek to include MEV disaggregated indicators, and report on progress of implementing the EGDP in every quarterly and annual project report, and on the project website. Key features of the EGDP are mirrored in the project design and monitoring framework, loan covenants, and project administration manual.

I. DESCRIPTION OF THE PROJECT

1. GMS leaders are committed to enhance regional health security following outbreaks of emerging infectious diseases (EIDs), notably severe acute respiratory syndrome (SARS) in 2003, and Avian Influenza in 2004. Recent outbreaks of Ebola Hemorrhagic Fever (EHF) in West Africa and Middle-East Respiratory Syndrome (MERS) in South Korea show respectively, how EIDs can get out of control with major human impact, and how a relatively small outbreak in a hospital can also have major economic impact. New zoonosis diseases also pose a constant threat in the region.

2. The misuse of antibiotics for bacterial infections is causing drug resistance, while new antibiotics are few and expensive. Nosocomial infections in hospitals are increasing due to poor infection prevention and control (IPC). Common infections like dengue and cholera show genetic adaptation. While climate change including global warming and frequent flooding may also further increase the disease burden of infectious diseases. While the incidence of HIV/AIDS, tuberculosis and malaria have declined following major investments, drug resistant strains, such as those for malaria and TB, are also considered EIDs and major threats for the control of these diseases. Preventable childhood infections are resurging due to weak vaccination systems, further requiring continued investment will be needed to keep communicable diseases under control.

3. The overarching drivers for GMS control of emerging and re-emerging infectious diseases (EIDs) are the International Health Regulations (IHR, 2005) and the Asia Pacific Strategy for Emerging Diseases (APSED, 2010) and related disease control and health system building strategies of the World Health Organization (WHO). The IHR and APSED strategic areas guide efforts to improve public health security, including surveillance and outbreak response, risk analysis and communication, community preparedness, laboratory services, hospital infection control, and regional cooperation. Other WHO global and regional strategies also guide control efforts, such as for the control of HIV/AIDS, malaria, tuberculosis, dengue, and neglected tropical diseases; strengthening of laboratory services, infection control in hospitals, and the control of fake drugs.

4. The term health security[8] refers to a public health goal of prevention of major epidemics or other disasters with major impact on health and the economy, and is concerned with the health of populations. This is in line with the concept of universal health coverage, which is concerned with the right of every individual to affordable, quality health care. Investment in the control of emerging diseases has a strong public good and equity rationale, also considering the potential economic and political consequences of a major epidemic or pandemic.

5. MOH and WHO conducted an evaluation of APSED implementation in 2015. Myanmar has not yet achieved IHR and APSED targets. Core functions owned by MOH are well in place, but other functions depending more on collaboration with other countries, sectors, partners, community, and the private sector are less advanced. There is major progress in the control of malaria, less progress in the control of HIV/AIDS, Tuberculosis (TB), and Dengue, and major emerging concerns of nosocomial infections and multiple drug resistance.

6. Overall, public health security systems for APSED and other significant diseases need to become more mainstreamed, standardized, reliable, and financially sustainable. Second, in view of the increase in communication, urbanization and industrialization, the traditional

[8] According to WHO, health security is achieved through a set of activities, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations.

dependence on a single public health system no longer holds, and MOH will need to strengthen its capacity for collaboration with other sectors. Progress in APSED is affected by health system limitations, but these are not clearly identified. Key areas are information technology (IT) connectivity, basic staff capacity and administrative and management capacity. In general, the private sector is a big unknown in terms of surveillance and response.

7. While there is a high risk of the spread of diseases and drug resistance, surveillance and response systems have not been fully capable of real-time and accurate information, indicating epidemic status at local levels. Several disease reporting systems are in place, but are not linked, do not reach communities, and fail to provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, further limiting the efforts to improve disease control and community prevention and preparedness.

8. One way to address this is through integration of public outreach services, including community health promotion, prevention and outbreak preparedness, active case finding, screening, and, if necessary outbreak response ranging from food poisoning and dengue control to simulation exercises and control of the EIDs. Such packaging of services could make services more efficient and provide tangible staff learning opportunities. Capacity building for control of EIDs and other regional health threats can be combined. Further quality and efficiency improvement can be gained by combining services, such as for combining laboratories in regional hubs; and by improving quality control and audit of public health services, in both public and private sectors.

9. Laboratory services are complex, requiring some 20 subsystems to be in place. In Myanmar, insufficient effort has gone into strategic planning, human resource development, referral and maintenance systems, quality assurance and audit, and medical-laboratory linkages. Addressing these system gaps will enhance benefits of past investments.

10. Hospitals are the most likely recipients for any emerging disease, and also pose a major concern in terms of spreading these and other diseases. In addition, hospitals are a source of nosocomial infections and drug resistance. Current facilities and practices in health facilities regarding infection prevention and control (IPC) are substandard, in terms of IPC management, staff capacity, facilities (isolation ward, sanitary ware, laundry, medical wears), hygiene practice standards, and practices (handwashing, visitors).

11. Regional cooperation currently consists mainly in the form of ad hoc information exchange and sometimes joint outbreak response, without standard operating procedures and regularity of reporting. Cross-border cooperation is gaining momentum but needs to be integrated as part of regular CDC. In previous projects, knowledge management activities have been quite prominent and have generated technology transfer, staff capacity, leverage, competition and commitment, and monitoring progress; but their potential, e.g. developing disease control strategies, early warning of outbreaks, and joint diseases control, is yet to be fully developed. Regional workshops on health security need to focus more on agreements for action, and follow-up. The regional cooperation unit may need to be strengthened.

12. The proposed Greater Mekong Subregion Health Security Project (the Project) is designed to support regional cooperation and national capacity building for prevention and control of EIDs and other diseases of regional importance, including malaria, dengue, TB, HIV/AIDS, cholera and nosocomial and drug-resistant infections.

13. The Project builds on the achievements and lessons learned of the Governments of the Greater Mekong Subregion (GMS) and partners in enhancing GMS health security and reducing the burden of communicable diseases. ADB is currently supporting the CDC2 extension in Cambodia, Lao PDR and Viet Nam. Other major partners in the field of CDC are WHO, other UN agencies, and USA.

14. The project will assist with implementation of the Government's drive towards Universal Health Coverage and also support government goals to advance Public Health Security. The countries give priority to disease prevention and control in poor border districts with multiple risks of communicable diseases and weaker public health system.

15. The Project aims to expand beyond core APSED capacities to improve strategic areas that have received less attention, in particular to reach communities and hard to each groups in border areas, cooperation and linkages, and improving quality and biosafety of services.
The Project will help develop disease prevention and control, especially in poor border districts.

16. The impact will be GMS public health security strengthened. The outcome will be improved GMS health system performance, with regard to health security. The proposed project locations are provinces and districts along the borders and economic corridors. Selection of project provinces is based on (i) economic status of the province; (ii) health and health services statistics; (iii) regional risks and priority clusters; and (iv) existing support from other partners. In Cambodia, the project will cover 13 provinces; in Lao PDR, 12 provinces; in Myanmar, 6 states and regions; and in Viet Nam, 36 provinces. The project outputs will be: (i) improved GMS cooperation and CDC in border areas; (ii) strengthened national diseases surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

(i) **Strengthened regional, cross-border, and inter-sectoral CDC.** This component will (i) strengthen regional, cross-border and inter-sectoral cooperation for the control of epidemics including EIDs, Dengue and other important regional diseases; and, (ii) increase access to CDC for at risk youth, migrants and ethnic groups in border areas by providing outreach services using outbreak response teams.

(ii) **Strengthened national disease surveillance and outbreak response**. This component will extent the current surveillance and response system by expanding web-based reporting, improve surveillance and response capacities, and improving community preparedness and syndromic reporting at village level.

(iii) **Improved laboratory services and hospital infection prevention and control**. This component will improve quantity and biosafety of laboratory services, scale up where appropriate for monitoring hospital based infection and drug resistance, and improve hospital hygiene and management of highly infectious diseases.

17. **Cost estimates and financing**. In Myanmar, the Project is estimated to cost $12.6 million, to be financed by an ADB loan of $12 million and $0.6 million in Government counterpart funds. About $4.0 million of the project is reserved for regional and cross-border cooperation and CDC in border areas directly targeting MEV, who will also benefit from general improvement of health services, provided they use these services. Provincial administrations will encourage ethnic groups to use services.

18. **Project implementation**. The Ministries of Health (MOH) in each country will be the executing agencies (EAs), responsible for in-country implementation and coordination among countries. In Myanmar, the EA is represented by the Department of Public Health and the Department of Medical Services (for consideration of the Minister of Health). The MOH steering committee chaired by the Minister of Health will direct and monitor the project implementation. MOH will appoint a senior government officer as project director.

19. The project management unit (PMU) will be established in the MOH to support: (i) annual operational planning, coordination and budgeting, (ii) project implementation activities, (iii) proper procurement, financial management, (iv) adherence to safeguards, and (v) monitoring and reporting. A deputy project director will assist the project director in day- to-day project coordination and management, including administration. The National Health Laboratory (NHL) and the 12 townships health departments will be IAs. Within each project management unit (PMU), a gender and social safeguards specialist (GSSS) will be engaged to help plan, provide capacity building for, and monitor GAP implementation. At provincial or township level, the provincial / township health department (P/THD) will be the designated project implementation units (PIUs). There are up to 3 positions in each PIU to be financially supported by the Project in each province/township, depending on the workload. This includes a provincial project coordinator, a technical officer and an account assistant.

20. The Regional Steering Committee (RSC) established under CDC1 will give guidance in Project implementation, policy dialogue, and building of regional capacity and cooperation for CDC, facilitating country decisions on the use of pooled funds for regional activities. It will be chaired by the minister or vice-minister of the host country and will consist of leading representatives from the national SCs, project directors, and ADB and WHO representatives. The Regional Coordination Unit (RCU) will act as the secretariat for regional coordination activities and the management of regional funds. Regional project meetings will be held 6 months before the RSC meeting to follow up regional activities and organize regional events, and report these to the RSC.

21. To support regional health security, the Project will directly support Cambodia, Lao PDR, Myanmar, and Viet Nam and encourage participation of the Peoples Republic of China (PRC) and Thailand in regional and cross border activities. All country project proposals include regional cooperation and CDC in border areas, surveillance and response, and laboratory quality improvement, and hospital hygiene, but there are differences in emphasis among the 4 countries. Both MOH Cambodia and MOH Lao PDR give emphasis to reaching those not currently being reached for CDC in border areas. In Myanmar, the aim at this early stage is to develop model services in state laboratories and major border hospitals.

22. **Location**. The Project is to cover 3 east-west corridors and one multi-limbed north- south corridor representing 4 distinct geographical clusters of MEV issues, as shown in Appendix 1. In Myanmar, it includes Shan North, Shan East, Kayah, Kayin, and Mon States, and Tanintharyi region bordering China, the Lao PDR, and Thailand. In Cambodia, 13 provinces are included in 3 clusters in the north-west, north-east, and south-east. In the Lao PDR, 12 provinces are included in 3 clusters in the north, center and south of the country. In Viet Nam, 36 provinces are included along the northern border with China and the western border with the Lao PDR and Cambodia. The north-south corridor connects major industrial areas in China with industrial areas in Viet Nam, Lao PDR, Cambodia, Thailand, and Myanmar and is the important one in terms of traffic flow, while migration flows are mainly to Thailand. The central corridor comprises most EMGs, and the north-south corridor passes through few locations with high concentration of EMGs, which could be hotspots for targeting.

23. In Myanmar, all 5 states have substantial populations of EMGs. The Government has identified 135 EMGs. Tanintharyi region has a high poverty rate of over 30%. Within all border districts along economic corridors, hotspots and communities with high burden of communicable diseases and low CDC coverage will be selected, using reported and estimates cases. Selection criteria will also consider local commitment, presence of partners, and feasibility of having impact on these communities. The project districts will conduct a participatory assessment and planning process, and ensure that plans are included in the provincial annual operational plan, and sustained from local sources after project completion.

II. SOCIAL IMPACT ASSESSEMENT

A. Legal and Institutional Framework

24. According to ADB's 2009 *Safeguard Policy Statement (SPS)*, the objectives of [MGs' safeguards are to design and implement projects in a way that fosters full respect for EMGs' identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by the EMGs themselves so that they: (i) receive culturally appropriate social and economic benefits; (ii) do not suffer adverse impacts as a result of projects; and (iii) can participate actively in projects that affect them. ADB policy for EMGs as presented in the SPS includes the following principles:

- Screen early on to determine (i) whether [EGs] are present in, or have collective attachment to, the project area; and (ii) whether project impacts on EMGs are likely.

- Undertake a culturally appropriate and gender-sensitive social impact assessment or use similar methods to assess potential project impacts, both positive and adverse, on EMGs. Give full consideration to options the affected [EGs] prefer in relation to the provision of project benefits and the design of mitigation measures. Identify social and economic benefits for affected EMGs that are culturally appropriate and gender and inter-generationally inclusive and develop measures to avoid, minimize, and/or mitigate adverse impacts on EMGs.

- Undertake meaningful consultations with affected EMGs and concerned EMG organizations to solicit their participation (i) in designing, implementing, and monitoring measures to avoid adverse impacts or, when avoidance is not possible, to minimize, mitigate, or compensate for such effects; and (ii) in tailoring project benefits for affected [EGs] in a culturally appropriate manner. To enhance EMGs' active participation, projects affecting them will provide for culturally appropriate and gender inclusive capacity development. Establish a culturally appropriate and gender inclusive grievance mechanism to receive and facilitate resolution of the EMGs' concerns.

- Ascertain the consent of affected [EGs] to the following project activities: (i) commercial development of the cultural resources and knowledge of EMGs; (ii) physical displacement from traditional or customary lands; and (iii) commercial development of natural resources within customary lands under use that would impact the livelihoods or the cultural, ceremonial, or spiritual uses that define the identity and community of EMGs For the purposes of policy application, the consent of affected EMGs]refers to a collective expression by the affected EMGs , through individuals and/or their recognized representatives, of broad community support for such project activities. Broad community support may exist even if some individuals or groups object to the project activities.

- Avoid, to the maximum extent possible, any restricted access to and physical displacement from protected areas and natural resources. Where avoidance is not possible, ensure that the affected [EGs] participate in the design, implementation, and monitoring and evaluation of management arrangements for such areas and natural resources and that their benefits are equitably shared.

- Prepare an EGDP that is based on the social impact assessment with the assistance of qualified and experienced experts and that draw on indigenous knowledge and participation by the affected EMGs. The EGDP includes a framework for continued consultation with the affected [EMGs] during project implementation; specifies measures to ensure that EMGs receive culturally appropriate benefits; identifies measures to avoid, minimize, mitigate, or compensate for any adverse project impacts; and includes culturally appropriate grievance procedures, monitoring and evaluation arrangements, and a budget and time-bound actions for implementing the planned measures.

- Disclose a draft EGDP, including documentation of the consultation process and the results of the social impact assessment in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected EMGs and other stakeholders. The final EGDP and its updates will also be disclosed to the affected EMGs and other stakeholders.

- Prepare an action plan for legal recognition of customary rights to lands and territories or ancestral domains when the project involves (i) activities that are contingent on establishing legally recognized rights to lands and territories that EMGs have traditionally owned or customarily used or occupied, or (ii) involuntary acquisition of such lands.

- Monitor implementation of the EGDP using qualified and experienced experts; adopt a participatory monitoring approach, wherever possible; and assess whether the EGDP's objective and desired outcome have been achieved, taking into account the baseline conditions and the results of EGDP monitoring. Disclose monitoring reports.

25. The Borrower is required to prepare an EGDP to protect, and ensure benefits for ethnic minorities affected by the Project. According to the Indigenous People's Safeguards Sourcebook, "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook, *"IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* In the same Sourcebook, it is noted that *"a stand-alone may not have to be prepared when ... only positive impacts are expected from the project."* While they are not the sole or overwhelming majority of expected project beneficiaries, and given the scale and complexity of this regional project, this EGDP has been prepared to help ensure that intended positive impacts on ethnic monitories are achieved.

26. Government policy relating to EMGs identifies three essential features for EMG development:[9] (i) the 2008 Constitution prescribes rights of EGs; (ii) The 1982 Citizenship Law enables EMGs to be registered as citizens; and (iii) there are also initiatives to promote and support EMGs e.g.; ethnic national days and committees have been designated and the Ethnic

[9] The 2008 Constitution and the 1982 Citizenship Law.

Affairs Ministry has been established recently to work for ethnic groups in Myanmar. But policy and planning processes have not yet been amended by the new Government.

27. The Framework for Economic and Social Reforms (FESR) 2014[10] identifies policy priorities for the period 2012 to 2015. It acts as a bridge between the 5th Five-Year Plan (2011-12 to 2015-16) on one hand and, on the other, the reform-oriented National Comprehensive Development Plan (2011-31) and future five-year plans that will support it.

B. Baseline Information

28. Key demographic, economic and social indicators of the 4 targeted GMS countries are in Table 1. Several indicators regarding the specific health status of EMG are lacking[11]. Data gaps will be filled through a participatory assessment during the early stages of project implementation, to identify gaps in health security and plan for a package of activities including screening, diagnostics, disease control, and referral to established programs. This is discussed further in section VI. Proposed Measures.

Table 1: Key Demographic, Economic and Social Indicators in the GMS

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Economic growth rate %	7.0	6.5	8.0	6.0
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Population below 15 years	31.1	34.7	24.5	23.2
Median age in years	24.5	19.3	28.5	29.6
Sex ratio (% m/f)	95	99	94	112
Population growth rate (%)	1.8	1.9	0.8	1.0
Population density per square kilometer	85	29	79	279
Urban population (%)	20.5	37.6	33.6	33.0
Urban growth rate (%)	2.7	4.9	2.5	3.0
Per capita income in US$	1008	1589	1184	1868
People earning below $1.25 per day (%)	19	23	26	13
Unemployed as % of labor force	0.3	1.4	3.4	2.0
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	NA	1.184	11
Tourist arrivals (1,000)	4.200	2.500	2.000	7.500
Mobile phone subscribers/100 persons	134	66	12.8	131
Internet users estimate (% population)	6	13	1	44
Primary/Secondary GER f/m	81/89	76/82	79/78	89/87
Child mortality general population	42.5	41.9	62.4	21.7
Child malnutrition in main population %	28.3	33.9	28.0	16.9
HIV prevalence in main population %	0.6	0.3	0.7	0.5
HIV prevalence among sex workers %	4.6	1.3	18.4*/**	3
TB incidence main population /100,000	390	189	369	140
Malaria cases confirmed total	21,309	46,202	333,871	17,128
Malaria deaths confirmed / 100,000	1.7	4.4	5.4	0.1

[10] The 2014 National Framework for Economic and Social Reforms (FESR).
[11] This lack of information om ethnic groups was also observed by a UNFPA report.

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Full Immunization main population %	85	49	98	95
Contraceptive prevalence rate (%)	51	50	46	78

Sources: UN agencies ; *Viet Nam Economic and Development Strategy Handbook, 2004 ; ** anecdotal reports, e.g., one study reports under age Hmong sex workers for tourists in Sapa ; *** e.g., one study for Lao migrants returning from Thailand ; **** BWHO National Survey of Tuberculosis Prevalence 2010 ; */* SEAJTM Prevalence of Tuberculosis in Migrants 1996 ; HIV data from UNAIDS 2008 report ; HIV data from UNAIDS 2014 report ; WHO and World Bank indicators ; SEAJTM Prevalence of Tuberculosis in Migrants 1996.

29. While the GMS has been politically stable, all countries experienced rapid economic growth and major poverty reduction due to rapid expansion of the industrial and services sectors including tourism, even though some two third of people continue to depend on agriculture as a livelihood. This development was brought about with increased connectivity and foreign investment partly concentrated in economic zones. It has also contributed to rapid urbanization and major internal and external migration. The population in the GMS is relatively young, with 23%-35% of the population below the age of 15, the so-called demographic dividend. However, 13% to 26% of people in these 4 countries are very poor, living on less than $1.25 per person per day. While child mortality has declined substantially, child malnutrition is still high, and so is the prevalence of major communicable diseases, while health sector coverage of the population is not yet universal.

30. About one third of the population in the Lao PDR and Myanmar are EMGs. This is much less in Viet Nam at 14%, and only about 5% in Cambodia[12] These EMGs are a very mixed group, but typically live in the highlands and mountains. In Myanmar, EMGs mainly live in respective States which surrounding the central lowland area, with small groups living scattered throughout the country. Some EMGs are mainstreamed and hesitant to identify themselves as belonging to an EMG in the hierarchical and status-conscious Myanmar society.

C. Stakeholders and Consultations

31. In MOH, EG issues are referred to in general plans. As the government aims to mainstream EGs, there is no specific policy, strategy, plan or designated unit for EGs. The Department of Planning and Health Information Systems (DPHIS) is tasked with ensuring adequate services for EGs in view of achieving Universal Health Coverage (UHC), which will among others require improving the monitoring system and planning special investments. Each village or village tract has a village health group responsible for assisting with the implementation of health activities, reporting diseases, and planning village health improvements. There are many communities based ethnic groups in Mon and Kayin State. These community-based ethnic groups work for basic health care and small health care centers in their states dominantly in southern border areas of Myanmar.

32. In Myanmar, several organizations are involved in the wellbeing of EGs, including religious and grass-root organizations, NGOs, EG associations and Government services. The lead government agency on EGs is the Ministry of Ethnic Affairs which was recently established by the new Government, and mandated on 30 March 2016 by Formation of Union Government. Most EG associations are formally or informally established in their respective states and also in other areas. The military operates an extensive network of health services for their personnel and dependents in border areas, including in remote rural areas with security problems. The military medical personnel sometimes provide health services for local EGs. The Buddhist

[12] Cambodia has between 1%-10% of EMGs, depending on the definition of EMG. If all minorities are included including Chinese, Cham and Vietnamese, it reaches 10%. If only traditional EMGs are included, it may be 1%.

organizations, faith-based organizations and some social welfare organizations such as NGOs operate basic health services throughout the country. Muslim and Christian facilities provide services for their respective communities.

33. The proportion of migrants and mobile populations who belong to EGs, especially in proposed project areas, is not known. The presence of national or international associations or interest groups for specific EGs may not extend to the most disadvantaged groups, thus EG migrants may be less likely to benefit from the wide range of rights, benefits and protections. The impact of this process on the EG transition is not known as well. However, this new leadership could play an important role in policy making and planning in near future.

34. The consultation process has covered some stakeholders including Mon Women's Organization and some EG health staff in Mon State, Kayin State and Shan (east) State but also relies on information gained from the CDC2 project, the ongoing project with model healthy village development in the north-eastern provinces. Mon, Kayin and Eastern Shan States are both major borders with major industrial development, trade zone, casinos, and large migrant populations. The consultation and participation process undertaken during preparation of this EGDP is discussed further in Section C. Information, Disclosure, Consultation and Participation.

D. Vulnerabilities, Risks, and Project Effects

35. EGs in GMS border areas can no longer be thought of simply in terms of disadvantage due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. EGs are beginning this process of integration from a very disadvantaged position. Migrants, EGs and other vulnerable groups (MEVs) such a youth and pregnant women need special attention in any health administration, but this is often not happening, in part because health plans are disease-focused. See Appendix 1 for more background of MEVs in the GMS.

36. EG populations living near regional economic corridors bear a disproportion burden of the health costs of the rapid social and economic changes created by these developments. Relocation and/or resettlement of EGs have been supported by governments and donors in CLMV for various reasons. In some provinces, movements of highland EGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas.[13]

[13] Gebert, R. 1995. *Socio-economic baseline survey*. Muang Sing: GTZ Integrated Food Security Programme. Cohen, P.T. 2000a. "Lue across borders: pilgrimage and the Muang Sing reliquary in Northern Lao PDR. In G.Evans, C. Hutton and Kuah-Khun Eng (eds.) *Where China Meets Southeast Asia: Social and Cultural Change in the Border Region*. Singapore: Institute of Southeast Asian Studies. Cohen, P.T., 2000. "Resettlement, opium and labour dependence: Akha-Tai relations in Northern Laos", *Development and Change*, 31:179-200. Romagny, L. and Daviau, S. 2003. *Synthesis of Reports on Resettlement inLong District, Luang Namtha province, Lao PDR*. Action Contre La Faim mission in Lao PDR. Lyttleton, C. 2005. "Market-bound: relocation and disjunction in northwest Lao PDR". In Toyota, M., Jatrana, S., and Yeoh, B., 2003 (eds.) *Migration and Health in Asia.* Routledge. Alton, C. and Houmphanh Rattanavong, 2004. *Service Delivery and Resettlement: Options for Development Planning*, unpublished report, UNDP: Lao PDR, Vientiane. McCaskill D. and K. Kampe (eds.) 1997. *Development or Domestication: Indigenous Peoples of Southeast Asia* Chiang Mai: Silkworm Press.

37. When highland-dwelling EGs move to lower altitudes, they are exposed to malaria, to which they have little acquired resistance, so in the early phase of relocation to lower altitudes, there have been high mortality rates from malaria, as well as morbidity resulting from exposure to other water-born and environmentally-related infectious diseases.

38. EG populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.

39. Some EGs may use health services, when they are available, only as a last resort. This may be because of lack of experience but also reflects anxiety about modern health services and expense of accessing them. Traditional beliefs and practices are common especially in remote areas. Shifting cultivation practices also limit the opportunities to access the health service for some EGs, especially women and children. EGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel ashamed and reluctant to access services, and numerous reports of belittling treatment of EGs by government health workers were shared informally during the field research. Programs aiming to promote behavior change (e.g. building and using latrines, drinking boiled water, removing disease vector breeding sites, hygienic management of animals, hand-washing, using bed nets, and acceptance of vaccination) are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EG villages. However, community-based interventions, such as those focused on malaria-prevention, are being currently implemented by organizations such as Save the Children and Population Services International (PSI). In addition, the United Nations Refugee Agency (UNHCR) currently implements behavior change and communication programs to prevent the transmission of HIV among migrant populations on the Thai-Myanmar border.

40. Provision of free health insurances has enabled poor EGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered under the Government scheme.

41. Although EGs are more likely to have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The disparities are highlighted in country specific data showing that provinces with high infant and child mortality rates also have high concentrations of EGs. For example, surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by border check points, health centers and hospitals particularly Thai-Myanmar border. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive.

42. The Project does not impose any vulnerabilities or risks or negative project effect on the EGs in the project area. The only risk there may be is that EGs are excluded from the benefits of the Project. Hence the EGDP aims to ensure that the project design, implementation, and monitoring maximizes benefits for EGs.

E. People's Perceptions

43. The proposed project interventions are much appreciated. The problem is on the supply side rather than the demand side, in that MOH lacks the means to reach remote EMGs and migrants, and may be unable to assigned staff to these places.[14] NGOs are heavily engaged with EG work, but increasingly this function is being handed over to Operational Districts (ODs). One drawback of results-based budgeting is that it often focuses on the low hanging fruits to get the results, and consequently inadequately plan for EGs.

44. EG village health groups indicated that common health problems are respiratory and diarrheal infections, dengue, infections, fever, cough, and problems of pregnancy and accidents that require referral. They are willing to collaborate but for time constraints if the interventions are not controversial and accepted in the community. They don't want one time promises, but continuity of engagement. Village health groups already participate in CDC in terms of planning model healthy village development, disease reporting and community preparedness, facilitating immunization and case finding, and referring people. The proposed project interventions didn't raise any objections. However, community-based interventions require thorough preparation to achieve the desired results. EGs reside in isolated, hilly regions far from community facilities and systems, and it will be important to promote a sense of ownership of project interventions.

F. Proposed Measures

45. In preparation of project implementation, each PHD will request border Bag Packed Health Worker Team (BPHWT) to identify MEVs along economic corridors, and engage the village health group, CBO or other representative group to engage in a participatory assessment to identify gaps in health security and plan for a package of activities including screening, diagnostics, disease control, and referral to the established programs. Village or facility CDC plans will be included in Bag Packed Health Worker Team (BPHWT) annual plans and budgets, and if possible scaled up to OD or township level. This should help achieve benefits for MEVs in this project. Progress in rolling out the EGDP should be reported to MOH. Further, MOH can collaborate with EG Associations and CBOs that are working for EGs especially in health sector.

III. INFORMATION, DISCLOSURE, CONSULTATION AND PARTICIPATION

46. The national and international social safeguard specialists conducted an assessment of social impact, including review of documents, field visits, stakeholder meetings, workshops, and assessment and disclosure of social impacts and mitigating measures from 20 September 2015 to 2 October 2015 and 15-26 February 2016. They met with MOH Departments, partners, the NGO Gender Group and the Mon Women Organization. In one of the workshops, social safeguard requirements were presented to the Government. The team visited Mon, Kayin and Shan States, and conducted interviews with state officials, health staff, and community members. Tools adopted by consultants for gathering information during field visits included questionnaires, open interviews and observations. Respondents were asked about their circumstances, views on health services, and health priorities. Key questions concerning project design[15] apart from general health status, include (i) their knowledge of communicable diseases; (ii) EGs' use of services and their perceptions of health services; and (iii) community organization for health services and participation in meaningful consultation with EMGs in the project cycle.

[14] In Myanmar, this has always been a problem despite incentive programs that are in place.

[15] KAP studies, key informants interviews and FGD sessions might be assigned perhaps supporting a postgraduate project looking into these matters might yield additional information.

47. As summarized in Appendix 2, patients and other locals were generally satisfied with the health services. They particularly praised the attitude of health staff, trying to assist in often difficult conditions. Services are for the most part free of charge but sometimes not available. Local health staff requested more in-service training and outreach services. Government officials emphasized that everyone has access to free health services including all ethnic groups and migrants. However, they also noted a lack of qualified staff in local health facilities, and that certain EMGs were hard to reach and didn't make much use of public health services.

48. Among the risks noted were: (i) lack of interest of targeted EGs; (ii) weak provincial effort in participatory planning, implementation, and monitoring; (iii) lack of effort reaching isolated EGs, migrant camps, and hotspots; and (iii) insufficient technical and financial backstopping of MOH. For migrants an additional issue is that may be difficult for migrants to access health services due to unregistered migration and employment conditions; and for health staff to access and inspect labor camps, factories and casinos, which requires collaboration with MOL and business owners. The Project design will support the development and harmonization of strategies where appropriate. The project will support implementation through CDC activities in border areas, as per output 1.

IV. BENEFICIAL MEASURES

49. Direct beneficiaries in Component 1 will include prioritized EGs[16], migrants, laborers in camps, youth, local health staff, and community health workers. It is expected that in the 300 targeted districts (12 in Myanmar), the project will reach about 1 million MEVs, mostly through outreach. Migrants, youth, pregnant women, and remote EGs will receive additional screening and referral for treatment as needed. Project implementation units in provinces will conduct results-based, participatory planning to ensure strong commitment from all stakeholders, and prepare annual plans with activities and targets to be financed from project funds. It is expected that the provision of motorcycles (under Component 1) and vehicles (under Component 2) will increase mobility of provincial teams to reach out to these communities. Component 1 will also support regional, cross-border, and inter-sectoral cooperation for joint planning to extend services to the target groups, and joint activities. Monitoring and supporting this component will be critical and the main assignment of the CTAs, and the gender and social safeguard experts.

50. Component 2 will help improve community preparedness, timely detection, investigation, risk analysis, risk communication, and containment of emerging and other diseases of regional significance, such as Malaria, Dengue, Cholera, TB and HIV/AIDS. Direct beneficiaries in Component 2 include health staff, and community health workers who will improve outbreak reporting and response and community preparedness that is appropriate for EG communities.

51. Component 3 will improve diagnostic capacity by improving laboratory quality, and also reduce the risk of spread of dangerous infections through better laboratory biosafety, hospital infection control, and better case management of infectious diseases. Direct beneficiaries in

[16] Component 1 targets people in border districts, including migrants and mobile populations, vulnerable women and infants, ethnic groups, and in general, poor and people living in remote areas. These populations suffer from a high burden of illnesses and common infections such as malaria, tuberculosis, dysentery, diarrhea, typhoid fever, acute respiratory infections, measles, and parasitic infections. Poverty and economic integration also pushes and pulls these people into professions and habits with high risk of HIV/AIDS and drug resistance. Without appropriate care these diseases result in high mortality, disability, and malnutrition, impact on learning and productivity. In addition, these marginalized high risk people that are not in touch with the public health system also pose a risk for the unnoticed spread of these diseases that may result in outbreaks.

Component 3 include laboratory staff and hospital staff, many of whom belong to EGs, and will work in EG areas.

V. MITIGATION MEASURES

52. The purpose of this EGDP is to (i) outline the potential positive and negative impacts of the project on ethnic groups; (ii) specify actions to address these impacts; and (iii) help mitigate negative impacts and enhance benefits to EG communities. During project preparation EG communities and their representatives were consulted using key informant and focus group discussions (consultation will be continued during project implementation). To increase support for EGs and achieve positive outcomes for EGs in the project, project management units at central level (EEA/PMU) and state/region level (IA/PPMU) will ensure full implementation of the EGDP. To facilitate this process, key features of this EGDP are mirrored in the project DMF, loan assurances, and PAM and aligned with the existing national policy commitments to ethnic group development in the four project countries. These include participatory assessment and planning with EGs, outreach to migrants, and disease control campaigns, as well as improved disease reporting and outbreak response, and better access to diagnostic services and hospital treatment of infections.

53. The actions in the EGDP (Appendix 3) support integration of EG needs and interests into Project outputs, and ensure effective participation and access to Project benefits. The assessment and participatory planning will help enhance benefits for EGs. No negative project impacts were identified that would require mitigation measures, however lack of participation and weak implementation threatens the desired positive impact.

VI. CAPACITY BUILDING

54. MOH departments have demonstrated support for donor funded projects, but have less experience in working directly with partners. The WB has initiated a project to strengthen the health services, including capacity building of MOH in administration and financial management. Related ADB health projects have shown a steady improvement in EGDP implementation, although there is no experience with health projects in Myanmar. However, Project Directors are committed to provide the necessary leadership and inputs to fully implement the EGDP.[17]

55. The Project will assist with training and capacity building of MOH/PMU and PIUs, including for implementation of the EGDP, through training and field visits. This will be supported by the CTA and GSSS, who will particularly focus on component one with most EG issues. It will be critical for MOH to attract competent mid-career consultants to provide effective capacity building. Training will also be provided for IPC nurses and field epidemiologists, with some orientation towards ethnic minority and migrant concerns. Key features of the EFDP, such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and PAM.

VII. INSTITUTIONAL ARRANGEMENTS

56. DPH and DMS will jointly represent MOH as the EA and will be responsible for overall direction to ensure implementation of the EGDP. The PMU will be responsible for coordinating implementation of the EGDP through the IAs and S/RMUs. The PMU will have focal points for gender and social safeguards. The Chief Technical Advisor (CTA) and Gender and

[17] Capacity assessment and capacity building in terms of facilities, human resources, technical capabilities and systems is of paramount importance and this should be on-going for a sustainable outcome of the project.

Social Safeguards Specialist (GSSS) will be engaged with special responsibility for Component 1. Linkages will be established with community-based organizations and partners as needed.

57. The S/RHD and National Health Laboratory will be the IAs responsible for EGDP implementation within their location/field. Each S/RHD will nominate focal points for EMGs and migrant safeguards. These focal points will be provided with sufficient means to ensure that EGDP related priorities are being mainstreamed and prioritized where possible.[18]

VIII. GRIEVANCE REDRESS MECHANISM

58. Regular field visits, meetings and consultation will seek to engage targeted MEVs and minimize dissatisfaction among project-affected people. Local stakeholders' opinions and concerns will be part of the project planning, implementation, and monitoring. The participatory approach will encourage people to raise any concerns before conflicts may appear in the design and implementation of Project activities. The beneficiaries can address their concerns to the Project Director through their representative. The complaint will be assessed and negotiated into a solution between the project representative (focal point of IA) and local authorities, and then fed back to the communities as part of the participatory planning process. If the conflict is not solved amicably, it will be taken to the PMU or MOH Steering Committee under the MOH. The project representatives at various levels will be responsible for reporting any grievances up to the appropriate level. The particular activities will be carried out after such conflict is resolved satisfactorily.[19]

59. Although no grievances are envisaged under the proposed project the ADB Safeguard Policy Statement (2009) does require a grievance redress mechanism. In Myanmar, the judicial system starts at the local level with the village administrative committee (VAC), which is normally used for grievances against local government agencies, civil actions, and minor criminal matters. In the case of most EMG there is a more informal but very influential village elders group that includes individuals with social capital and influential social position in the community. The village elders should also participate in the grievance hearing and resolution at the village level.

60. The EMG members may make verbal complaints at the village level. If the issue is to be referred to the township authorities, formal complaints must be put in writing and bear the village stamp to indicate that the complaint has been referred correctly through the local grassroots authorities. If the village has difficulty in submitting a formal written complaint, a local organization will provide the necessary assistance to do so. Complaints received must be documented and acted upon immediately. The VACs will be advised of the need to keep records of grievance hearings and the information needed.

61. Should issues not be resolved at the village level, an appeals process will be made available through the respective health office at each level (table 2). The respective township health office will be required to request the participation of the State/Region at any grievance hearing. Any grievance not resolved at the local level can be referred to the PMU in MOH. If the issue is still not resolved, the issue can be referred to higher level.

62. Grievance resolution will be aligned with the other safeguard processes where possible. The procedural steps for filing and resolution of grievance and complaints are described in Table 4 below.

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[18] Facilities and personnel need to have the capacity to deliver effective outputs/outcomes. Therefore, Capacity Building is an essential component for all EAs, IAs and PMU at all levels. Roles of CTA and GSSS are critical.

[19] Grievances procedures should be put in place but may be culturally difficult to implement in some cases.

Table 2: Grievance Procedure

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to VAC/VE at village level. If unwritten the VAC/VE will assist to put it in writing and provide a copy to the project at district level. The head of the township health office and the VC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint at the district level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the district level, he/she can seek redress at provincial GRC that should decide the issue within 10 days.
Stage 4	The AP may elevate the complaint for hearing at the PMU if still unsatisfied with the decision of GRC at the provincial level. The PMU will ensure to resolve each complaint within 10 days after receiving the appeal.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, PMU = Project Management Unit, VAC = Village Administrative Committee, VE = Village Elder.

IX. MONITORING, REPORTING, AND EVALUATION

63. Monitoring, reporting and evaluation of the project for EGDP will follow the overall project monitoring, reporting and evaluation arrangements. PMU and S/RMUs, in consultation with beneficiaries, will ensure that appropriate EGDP sensitive indicators are collected at community and health facility levels with reference to the targets and indicators in Appendix 3. PMU will prepare comprehensive quarterly reports based on agreed indicators as shown in the DMF. The reports will be submitted to ADB within the next quarter. The project will finance outreach activities during which relevant portions of the EGDP will be disclosed and local safeguards experts hired by the project will support disclosure of the EGDP to beneficiaries. The h will also be informed via Township Health Officers and community heads on the project progress. Social Monitoring reports discussing progress in implementing the EGDP will be disclosed on RCU and ADB websites.

64. Project evaluation will be carried out in three phases: (i) Project inception: capacity building, participatory assessment and planning, identification of sites, planning implementation details; (ii) Mid-term evaluation: assessment of progress of EGDP implementation and adjustments, after 1.5 years; and (iii) End-of-Project evaluation and impact assessment after 5 years. The inception report, mid-term evaluation and project evaluation will be made available on internet. Each S/RMU will carry out assessment of all training activities, and baseline and end-of-project data collection for assessing trends in the use of CDC services by EG in border areas under Component 1. No survey will be done: community and health facility records will be used to assess trends. Project evaluation will include an assessment of the effectiveness of EGDP, in terms of enhancing positive impacts. The evaluation will also assess the participation of stakeholders in project implementation. Beneficiaries will be informed about progress and results through community meetings, brochures, and reports available on the website of the regional cooperation unit and the ADB, and through distribution of brochures.

X. BUDGET AND FINANCING

64 Estimated costs of regional cooperation and CDC in border areas is budgeted for under Component 1, at a cost of about $4 million, most of which will benefit EMG as targeted states are mainly populated by EMGs. The activities in the EGDP are integrated into the overall arrangements and total budget of the project, including for consulting services. EGDP-related training and communication activities will be incorporated into other project training and communication activities.

65. The participatory planning process to prepare the detailed project plan and EGDP for each of the targeted provinces is expected to be completed within 6 months. This will include health staff orientation, collection of health services statistics, mapping and participatory assessments of IPs and other vulnerable groups, and meetings and consultations. This is followed by quarterly meetings with EMGs to monitor and report progress. A budget has been set aside to finance this planning and monitoring process.

Appendix 1: Information on Migrants, Ethnic Minorities, and other Vulnerable Groups

The GMS has distinct populations and hundreds of ethnic groups (EGs) and languages. While some EGs have lived in the GMS for a long time, other EGs migrated only recently from within the country or from neighboring countries. Perhaps due to their relative isolation, those in the highlands and mountains typically retained their culture and customs until recently. In recent years, large numbers of migrants have been moving in and out of the highlands and mountains, and new towns have developed in border areas.

Based on the 2014 Myanmar Population and Housing Census, Myanmar had a population of 51.4 million. The country is divided in 7 regions, 7 states and the capital region Nay Pyi Taw. The populations in Yangon, Ayeyawady, Mandalay, and Sagaing regions comprise about half the population. Females outnumber males by 7%, and 25% of the population is below 15 years. The country is in a political, economic and social transition with rapid economic growth. Project target area population is as follow:

Target Population	Total	Male	Female
Laisho	323405	158512	164893
Muse	117507	60946	56561
Keng Ton	171620	87779	83841
Tachileik	148021	74827	73194
Loikaw	128401	63109	65292
Mese	6319	3402	2917
Hpa An	421575	203910	217665
Myawaddy	195624	99771	95853
Mawlamyaing	289388	139026	150362
Ye	152485	76089	76396
Dawei	125605	60044	65561
Kawthaung	116980	59507	57473
	2,196,930	1,086,922	1,110,008

Source: Myanmar Population and Housing Census, 2014.

Based on Health in Myanmar, 2014, the country has 135 national races[20] speaking over 100 languages and dialects. The major ethnic groups are Bamar (Burmese), Shan, Kachin, Kayah, Kayin, Mon, Chin, Rakhine. About 90% of the population is Buddhist. There are some less developed ethnic subgroups, in particular in the mountains in Kachin, Shan and Rakhin states. The Burmese mostly live in the central lowland of Myanmar, with Yangon as the economic hub. The second largest EG, the Shan, live on a ridged plateau in the east of the country. The other ethnic groups also live in mountainous areas along the borders of Myanmar, such as the Rakkhine and Chin in the west, the Kachin in the north, the Kayah and the Karen in the east, and the Mon in the south. The income poverty rate is slightly higher in rural areas at 29.2% compared to urban areas at 25.6%. By region, income poverty is the highest in Chin (73%), followed by Rakhine (44%), Tanintharyi (33%), Shan (33%), and Ayeyarwardy (32%). Transitionary poverty

[20] The GoM claims that there are 135 "ethnic races" in Myanmar. In March of 2016 another "non-Burmese language speaking" group in the northern Shan State was designated an ethnic group called Mone Wan (Bamar).

is substantial in Myanmar, affecting about one third of the population, as households lack support of services to cope with financial shocks like for medical services.

Studies have documented that ethnic minorities are often left behind due to lack of economic opportunity, such as lack of quality agricultural land, social exclusion, lack of credit, and lack of access to markets. On average they have less income, and are move often poor and very poor. Gaps in poverty and health indicators are actually widening. EGs have less access to health services, and have worse health indicators. Women in Myanmar have relative equality in terms of major decisions, however in property ownership and financial aspects, the roles that girls and women assume throughout their lives are still based on culturally accepted notions of male dominance. Women also have additional workload of child caring and risks of childbearing.

Integration of various EGs, sometimes through resettlement but increasingly through migration, is continuing at a fast pace, while they start from a very disadvantaged position. Integration of EGs has been troubled by conflict, and illegal practices, causing major migration to Thailand. It is estimated that there are 1.2 million refugees living in Thailand and elsewhere. Due to civil conflicts there are internally displaced populations in some areas of the country for example in Kachin, Rakhine, Shan states. They are among the poorest and most vulnerable population groups and have limited access to quality health services, and combined with language and cultural barriers for many of them, they are highly vulnerable in terms of health services. They may not be identified in local population statistics and therefore local health plans may not be able to deliver in time the quality services that accommodate the particular circumstances and needs of internally displaced groups

Construction of highways and rural access roads in the GMS is rapidly improving regional and local connectivity, opening up new areas and creating economic corridors with industrial zones, plantations, and services that attract entrepreneurs, tourists, and migrants in search of employment. This development has been a major force for poverty reduction in the GMS, with both positive and negative impacts on health. Increasing mobility and income may increase food availability and access to health services, but also risks the spread of communicable diseases.

An increasing number of migrants, ethnic minorities and other vulnerable groups (MEVs) work in plantations, factories and entertainment and services in border areas and along economic corridors. Due to changing lifestyle, poor living and working conditions, unsafe transport, and less access to health services, these women and men have increased exposure to such conditions as malaria, dengue, tuberculosis, HIV/AIDS, water and food-born infections, malnutrition and road accidents. A major problem is that these returning migrants do not get pre-screening nor do they have access to treatment at home, so they have to try to return to Thailand to continue treatment. Default rate is high, leading to drug resistance. Such data for Myanmar are not available. However, there is a lack of disaggregated information.

The 2014 census listed the total number of internal migrants as 9.4 million. The number of unregistered migrants is not known. About 1 million registered external migrants and an unknown number of illegal migrants live abroad. More than half of these are likely to be EGs, who migrate primarily because of economic opportunity.

The rapid economic transition and weak enforcement of labor laws create an environment of exploitation of migrants.[21] An International Labor Organization (ILO) survey of internal migrants

[21] ILO. The Mekong challenge – Underpaid, overworked and overlooked: The realities of young migrant workers in Thailand. 2006. Bangkok. www.ilo.org/asia/whatwedo/publications/WCMS_BK_PB_67_EN/lang--en/index.htm

found that 24% of migrants were in a situation of forced labor, which, among others, often involved long working hours and poor living and working conditions.[22] Youth and young women are especially at risk of abuse. From 6% to 10% of migrants are under-age. There is also evidence of exploitation within Myanmar, including sexual exploitation, such as in Kachin and northern Shan states, were some women are forced into prostitution or marriage inside China.[23] Prostitution and drug addiction are widespread throughout Myanmar, despite strict government laws.

A presentation at the Myanmar Health Forum: Investing in Health: The Key to Achieving a People Centered Development, on 28 July 2015, illustrated the high burden of communicable diseases in Myanmar compared to other countries in the region. Health statistics from 2012 indicate that infectious diseases are still prominent, particularly in states predominantly inhabited by EGs. Possible causes for such a high level of infectious diseases are poor preventive practices, and lack of coverage of villages. Domestic health spending in Myanmar has been extremely low until recently. This long period of low spending has caused a wasted health system, which will need many years of rebuilding.

In remote EG areas, the public health services are sometimes inadequate due to geographic, social and economic constraints. Health facilities may lack staff from these EMGs, as they are often less educated and can't access vocational training. Rural access roads are often lacking or not accessible in the rainy season. Many hard-to-reach villages are located in border areas with security problems, sometimes 3 days away from the township center by boat or walking. Language and cultural barriers and poor understanding of health care benefits are key factors preventing EGs from accessing facilities. Some EGs may use health services, when they are available, only as a last resort. This may be because of lack of experience but also reflects anxiety about modern health services and expense of accessing them. In some provinces, movements of highland EGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas.[24]

EG populations living near regional economic corridors bear a disproportion burden of the health costs of the rapid social and economic changes created by these developments and are more likely to have a higher burden of infectious diseases than mainstream populations due to factors outlined above. Some studies suggest, for example, higher level of malaria in illegal forest workers, and tuberculosis and HIV among returning migrants. However, there are no

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Human Rights Watch. From the tiger to the crocodile: Abuse of migrant workers in Thailand. 2010. Bangkok. www.hrw.org/sites/default/files/reports/thailand0210webwcover_0.pdf

[22] Source: Internal Labour Migration Survey, ILO-Yangon, 2015.

[23] Kachin Women's Association Thailand: Pushed to the brink: Conflict and human trafficking on the Kachin-China border. 2013. www.kachinwomen.com/kachinwomen/images/stories/publication/pushed_to_the_brink.pdf Burmese Women's Union. Caught between two hells: Situation of women migrants in Thailand and China. 2007. www.womenofburma.org/Report/Caught between two hells.pdf

[24] Gebert, R. 1995. *Socio-economic baseline survey*. Muang Sing: GTZ Integrated Food Security Programme. Cohen, P.T. 2000a. "Lue across borders: pilgrimage and the Muang Sing reliquary in Northern Lao PDR. In G.Evans, C. Hutton and Kuah-Khun Eng (eds.) *Where China Meets Southeast Asia: Social and Cultural Change in the Border Region*. Singapore: Institute of Southeast Asian Studies. Cohen, P.T., 2000. "Resettlement, opium and labour dependence: Akha-Tai relations in Northern Laos", *Development and Change*, 31:179-200. Romagny, L. and Daviau, S. 2003. *Synthesis of Reports on Resettlement inLong District, Luang Namtha province, Lao PDR*. Action Contre La Faim mission in Lao PDR. Lyttleton, C. 2005. "Market-bound: relocation and disjunction in northwest Lao PDR". In Toyota, M., Jatrana, S., and Yeoh, B., 2003 (eds.) *Migration and Health in Asia.* Routledge. Alton, C. and Houmphanh Rattanavong, 2004. *Service Delivery and Resettlement: Options for Development Planning*, unpublished report, UNDP: Lao PDR, Vientiane. McCaskill D. and K. Kampe (eds.) 1997. *Development or Domestication: Indigenous Peoples of Southeast Asia* Chiang Mai: Silkworm Press.

comprehensive data that include ethnicity and hospitals. Overall, the government is lacking information, policy and plan to address the needs of both remote EGs and migrants.

Health policy is under preparation. A strategy and plan to improve health services access of remote people, both EGs and others, may need to be developed as will.

Myanmar has many religious, political, and grass-root organizations that play a major role in health services delivery. Myanmar also has many national and international NGOs, with some playing a more active role in health services delivery. PSI has also set up an extensive network for social marketing and affordable quality private health services. International agencies and INGOs have either worked separately or through government health services. However, projects were typically managed separately, based on an agreement with MOH. The new Government is yet to decide whether to encourage and allow NGOs to provide services or let state health offices take over.

Ethnic minority organizations that provide social services such as health care are key stakeholders for project implementation in the seven States. Most of these have arisen after cease-fire agreements between the military government and ethnic armed opposition groups. The armed groups and their affiliated organizations administer the territories under their control, and have departments responsible for areas such as education, health, finance and agriculture. In many instances, they work with local and international NGOs to set up health services in their areas. Organizations include the Kachin Independence Organization and the New Mon State Party. During the consultation process some raised concerns about the sustainability of their own health services (which they feel provide good services and have the trust of community members) in the context of the project's support to the Government's UHC program. For instance, ethnic minority community members and organizations in Mon State stated that they would like to see that the services provided by their organization are enabled to continue with the official recognition and support from the Government.

In May 2012, ethnic and community-based health organizations working in eastern Myanmar formed the Health Convergence Core Group (HCCG). Its membership in 2014 includes Chin, Karen, Karenni (Kayah) Mon and Shan ethnic health organizations, as well as community-based health organizations such as the Back Pack Health Worker Team (BPHWT), Mae Tao Clinic (MTC), the National Health and Education Committee (NHEC), and the Myanmar Medical Association (MMA).

The linkages between burden of disease and poverty and development are well known. EMGs have higher mortality rates and burden of communicable disease than the majority population. Providing effective CDC for migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs) will not only help improve health and health security, but will contribute towards child protection, better learning in school, economic productivity, and poverty reduction, all high on the Government's list of priorities. In the GMS, public and private health services are reaching the general population, which is the easier part to do. However, those not being reached by any formal health service, MEVs will continue to be at risk of acquiring, and spreading infections, including possibly more drug resistant infections. As the health status improves, the impact of those not reached by the health system becomes relatively larger, and it will become critical for the government to reach MEVs to achieve universal health coverage and public health security.

Among the reasons why both formal public and private health services have made less effort in reaching these marginal groups are living conditions and services in these areas, language problems, market failure, government regulations limiting compensation, and in general lack of

trained people, many of whom migrate after education. Hence, special arrangements are needed to reach these people, often requiring a more multi-sectoral and partnership approach.

A WHO SEARO report divides mobile and migrant populations broadly in three groups: (i) those affiliated to an employer, including semi-mobile employees and seasonal farm workers; (ii) those affiliated with the government, including military, security personnel, and border guards; and
(iii) non-affiliated, including ad hoc laborers, new settlers, highly mobile laborers and short-term migrants.[25] While all these groups would need to be targeted in terms of relevant information on prevention of diseases such as malaria, HIV/AID, tuberculosis, and other conditions, the first 2 groups are organized and therefore, in principle, easier to access. However, experience shows that it is also difficult to access organized groups of migrants working in plantations, casinos, and factories. While the Government has laws and policies in place to reach these people usually through the Ministry of Labor, this is not sufficient in terms of quality and quantity of inspection and migrant access to services. Hence, special arrangements are needed, with special agreements between those in charge.

For non-affiliated, often illegal migrants including ethnic minorities and minors, it is even more difficult to encourage them to use public services. Grass-root organizations including ethnic associations and NGOs should play a major role in this field. In view of limited capacity, the Government started contracting NGOs to manage and deliver health services, including in remote areas. However, within the last plan period, the Government decided to use health management contracts between the central level and the provincial and district governments. The Government may want to continue piloting alternative options to reach MEVs based on solid economic and social impact studies.

Overall, the government is lacking information, policy and plan to address the needs of both remote EGs and migrants. A migrant health policy is needed. A strategy and plan to improve health services access of remote people, both EGs and others, may need to be developed.

The proposed clusters and project states/region in Myanmar and provinces elsewhere are in Table 1 and Table 2. EG population distribution in Myanmar by State/region is in Table 3.

[25] WHO SEARO. Vector control and personal protection of migrant and mobile populations in the GMS: A matrix guidance on the best options and methodologies. New Delhi. 2015.

Table 1: Geographical Clusters Along Economic Corridors[26]

Cluster and Corridor	Main Ethnic Groups	Ethnic minority characteristics	Implications
Cluster 1: Northern corridor: Vietnam North, Lao North, Myanmar- east, Myanmar- east, Thailand- north-east	Large ethnic minority populations, in particular originating from China, mainly Sino-Tibetan and Hmong but also Mon-Khmer	Relatively isolated, self-sustaining highland groups with high burden of HIV, respiratory infections and other common infections, at risk of epidemics through trade, less accessing health services	Some border districts are hard to reach based on government conditions, but these highly remote people may also be less at risk of epidemics. Focus on accessible hotspots for outreach services, community workers.
Cluster 2: Central corridor : Vietnam Central, Lao-south-central, Cambodia north-east, Thailand north-east, Myanmar-central	Large ethnic minority populations, including large indigenous Mon-Khmer and related groups and migrants from northern areas	Relatively isolated, traditional, poor and less educated highland groups and migrant workers, with high burden of common diseases, at risk of epidemics of malaria and dengue and less accessing health services	Border districts may be more accessible but face political problems. Provide appropriate health services for EMG including access to suitable community workers and free health services.
Cluster 3: Southern corridor: Viet Nam-south, Cambodia south-east to north-west, Thailand east to West, Myanmar-south	Largely inhabited by non-ethnic minorities including Kinh, Khmer, Thai and Burmese. Has large migrant and Muslim populations	Largely integrated populations, better educated, mainly living in lowlands, industrial zones, high burden of dengue, diarrheal diseases, more timely reporting of diseases and accessing services	No need for special services for ethnic minorities. Needs special care for illegal migrants by providing them information and access to free health services.
North-South Corridor: China-south to major cities in the GMS	Mainly passes through non-ethnic minority populations except when passing through cluster 1 corridor	Mostly migrant ethnic groups providing unskilled labor and other services along the economic corridors	No need for special services for ethnic minorities. Needs BCC and services for migrant workers in hotspots, factories, casinos and labor camps.

Note: the corridors referred to here are not officially recognized entities.

Note: This table doesn't follow ADB's GMS terminology of economic corridors.

[26] This information is based on the crossborder cooperation work of the ADB-financed RCU and is necessarily a crude summary of the situation, but nonetheless informative.

Table 2: Targeted Project Provinces/States/Region

Participating countries	Number of targeted project provinces, states/region	Targeted project provinces/states/region
Cambodia	13	Pailin, Battambang, Banthey Meanchay, Preah Vihar, Stung Treng, Rattanakiri, Mondulkiri, Kratie, Kandal, Tbong Khmum, Prey Veng, Svey Rieng, Kampot
Lao PDR	12	Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu, Champasack
Myanmar	6	Shan North, Shan East, Kaya, Kayin, Mon, Tanintharyi
Viet Nam	36	Quang Ninh, Lang Son, Cao Bang, Ha Giang, Lao Cai, Lai Chau, Dien Bien, Son La, Thanh Hoa, Nghe An, Ha Tinh, Quan Binh, Quan Tri, Thua Thien, Quan Nam, Kon Tum, Gia Lai, Dak Lak, Lam Dong, Dak Nong, Binh Phuoc, Tay Ninh, Long An, Donh Thap, An Giang, Kien Giang, Bac Lieu, Sok Trang, Tra Vinh, Ben Tre, Ba Ria, Thai Binh, Hai Phong, Yen Bai, Tuyen Quang and Bac Kan
Neighbouring countries	**Number of neighbouring provinces**	**Neighboring provinces**
China	1	Yunnan
Thailand	12	Mae Hong Son, Chiang Mai, Chang Rai, Phayao, Buen Khan, Nhakon Phanom, Udon-Ratchatani, Sa Kaew, Tak, Kanchanaburi, Ratchaburi, Phetshaburi

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1. Social Assessment MOH 2014.
2. The Long road to Recovery, A Report by Health Information System Working Group February 2015.
3. The Republic of Myanmar, Health Review, Vol:4, No.3,2014.
4. Public Health Statistics, 2012.

Table 3: EG Myanmar Population by State/Region, 2014

State/Region	Male	Female	Total	Proportion of Total Population
Union	24,821,176	26,598,244	51,419,420	100.0
Kachin	877,664	811,990	1,689,654	3.28
Kayah	143,461	143,277	286,738	0.56
Kayin	775,375	797,282	1,572,657	3.06
Chin	230,005	248,685	478,690	0.93
Sagaing	2,518,155	2,802,144	5,320,299	10.34
Tanintharyi	700,403	706,031	1,406,434	2.74
Bago	2,324,214	2,539,241	4,863,455	9.46
Magway	1,814,993	2,097,718	3,912,711	7.61
Mandalay	2,919,725	3,225,863	6,145,588	11.95
Mon	986,454	1,063,828	2,050,282	3.99
Rakhine	1,529,606	1,659,357	3,188,963	6.20
Yangon	3,517,486	3,837,589	7,355,075	14.30
Shan	2,908,259	2,907,125	5,815,384	11.31
Ayeyawaddy	3,010,195	3,164,928	6,175,123	12.01
Nay Pyi Taw	565,181	593,186	1,158,367	2.25

Source: Myanmar Population and Housing Census 2014, Provisional Results, Department of Population, Ministry of Immigration and Population.

Appendix 2: EGDP Consultations

Consultations: 20 September-2 October 2015 and 15-26 February 2016

Topic	Questions	Responses	Proposed action
		Ministry of Health*	
Health Plans	Are policies for ethnic groups and migrants adequate?	As per constitution, all citizens have access to almost free public health services, but policies are basic and need to be strengthened further.	Support for MOH and ILO to develop migrant health policy
	Are national plans addressing needs of ethnic groups and migrants?	The Government is prioritizing least developed districts with high proportion of EMGs. Plans for migrants relate more to labor conditions. However, migrants, many of them EMGs, need to be registered to have access to health care	
	Are there legal barriers?	There are no legal barriers of EMGs and migrants follow government rules and procedures.	
	What are planning issues for ethnic groups and migrants in regional CDC?	The main problem is how to provide services in remote location, for all people, not only EMGs and migrants.	MOH is considering contracting out to NGOs
	Is investment in CDC addressing the needs of ethnic	The current funding can cover a majority of people but services in remote areas need to be improved further.	Contracting out to NGOs may be considered
	What could be negative impact of a regional CDC project on ethnic groups and migrants?	Two major concerns are alignment with the national program, and sustainability of services after project completion.	MOH to develop a regional CDC program and mainstream this
	Are Government and partners active in regional CDC?	Regional cooperation is mainly at policy and planning level. There are cross-border programs with China and Thailand for HIV, malaria, and TB. There is no specific policy or plan for regional or cross-border CDC except for implementation of IHR/APSED. These plans do not specifically address regional concerns related to EMGs and migrants, but do make some recommendations.	Migrant health policy should be linked to regional CDC program
	What would be major constraints for CDC in border areas?	There are still security problems in some areas, so the scope needs to be realistic. Management capacity to reach border areas depends on the local health office. There are staff constraints in facilities in border areas. Migrant workers and their families in cross border areas are not listed with official Government administration offices	Some areas are off bounds for now, for others contracting may be considered.
Health Status	Is the specific health status of ethnic groups and migrants known?	There are no national representative statistics on EMGs and migrants health indicators, but there are small studies and it is generally agreed that the health status of both groups is worse than the average population, in particular because of poverty and poor living conditions. EMGs are probably still having a higher prevalence of TB but less than in high risk groups. Migrants are probably more at risk of HIV but solid evidence is lacking. However, sexual exploitation is reported in migrants. Mobile sex workers have high HIV prevalence.	MOLES, MOH and ILO to establish a system to data on labor conditions and health status of migrants. The project can facilitate collection of disaggregated data in health facilities

Topic	Questions	Responses	Proposed action
	What explains the poor health status of ethnic groups and migrants	Poverty in both cases. Remote EMGs may have poor living conditions conducive to the spread of infections, and may lack access to health services. Migrants are often high school drop outs looking for work. Working and living conditions are often poor. There is insufficient regulation and supervision of migrant labor	MOLES is developing a new comprehensive labor law
	Are ethnic groups and migrants more prone to epidemics?	It depends on their exposure determined by occupation and living conditions, health status, knowledge, and timely reporting but specific risk profiles are lacking	A new data collection system should demonstrate this
Health Services	What are the problems of providing health services for ethnic groups and migrants?	For EMGs, in addition to the issues mentioned above, there may be language problems and lack of trust in the services. Unregistered migrants may avoid using health services.	Not a major issue in the targeted locations. Labor camps may be visit to find out of migrants use services
	Are health services affordable for ethnic groups and migrants?	Health services are free of charge based on certain conditions. Anyone coming to a facility is taken care of, no one is turned away. If there are expenses like medicines, the hospital can use a waver or donations to pay for services.	This needs to be further investigated through interviews of patients
State Health Office			
Health Plans	Are EMGs and migrants specifically referred to?	Plans are primarily targeting gaps in health services in certain locations, but may refer to specific issues and needs of EMGs and migrants as necessary. However, the general direction is to make services available to the general public, irrespective of ethnic status.	EMG issues should be mainstreamed in state plans
Health Status	Occurrence of epidemics	The main problem dengue outbreaks when hospital attendance can triple during these dengue outbreaks. There have not been major cases of emerging infectious diseases	The project should assist with dengue outbreak control
	What are the specific health problems of EGs and migrants?	EMGs often have hygiene and poverty related diseases like diarrheal diseases, pneumonia, tuberculosis and malnutrition. Prevalence of sexually transmitted diseases may be higher in migrants but they usually go to a private clinic. But we don’t know.	The project should assist with health promotion and safe sex in communities, and link people to health facilities
Health Services	What are the major hurdles for ethnic groups and migrants to access services?	Some ethnic groups prefer traditional medicine. If they live far away, travel time and transport costs are problems. Migrants may be reluctant to access public health services, or may not get permission	Apart from forthcoming labor regulation, mobile clinics may be used to reach remote EMGs and labor camps
	For those who can’t pay out of pocket, are there arrangements?	Yes the hospital has arrangements to wave any fees but this is not used so much, people who come can usually afford a small contribution.	To be investigated if this works adequately
Health Monito -ring	Are health and health services data split by ethnic groups and migrants?	No we don’t have records by EMG and migrant status. Some NGO services may keep this record.	The project may assist in the project locations

Topic	Questions	Responses	Proposed action
Health Staff			
Health Plans	Are you aware of any special arrangements for EMGs and	No, not aware	To be investigated
Health Status	What do you see as the major health problems of ethnic groups and migrants?	Most people belong to EMGs, many are well do to. Any poor people may not practice hygiene so they suffer from common infections. For migrants, they have less access to services because of working conditions.	Health problems to be identified by the IA outreach team using a participatory approach with target groups
	Do you think HIV and TB are higher or lower among ethnic groups and migrants?	Don/t know, but HIV is high among sex workers, most of whom come from other locations. TB appears more common among poor and often malnourished elderly people.	This requires a more formal study, beyond the scope of this Project
Health Services	Are ethnic groups and migrants using these health services as others?	Most people here belong to one EMG, they all use the health services, they don't consider them as EMG in their own home. Migrants appear to use health services less, we know little of them, sometimes the company has its own clinic and they only come for major problems.	IA outreach teams will identify this in location
	Are there specific access problems in the provision of health services to ethnic groups and migrants?	There are some parts less accessible due to security problems but not here. We didn't visit labor camps.	As above
	Are there language problems?	Yes	
	Are there affordability problems?	Sometimes, when expensive treatment is needed which the hospital can't province	As above
	Any other problems?	Salary is sometimes delayed, and we contribute for poor patients. We should have change to get more training	To be investigated by the IA
Ethnic Community Representatives			
Health Plans	Are you involved in discussions to improve health services?	Government staff visit us some time to discuss community health problems, not hospital problems	Outreach teams will follow participatory approach
	Do you think plans are appropriate for the local community/	Don't know the plans	As above
Health Status	What do you see are the major health problems in your community?	All kind of health problems for men, women, children, old people, hard to say	To be identified by the outreach team
	Did you have any major epidemics?	Dengue is the big problem with many hospital admissions. Malaria is much less a problem now. Seasonal cough and diarrhea.	The project will support this
	Are TB and HIV major health problems?	HIV is also a big problem. For TB, people go to the hospital	The project will target high risk groups
	Are there specific groups more at risk?	Maybe small children and old people. Also sex workers and drug addicts	As above

Topic	Questions	Responses	Proposed action
Health Services	What are the good parts of the health services?	Good behavior of staff, they are there and really try, but sometimes don't have the means.	
	What parts of the health services would you like to see improved?	Better qualified staff and more resources to run the services	The project will support dengue and infection case management training
	Are health services affordable for the poor?	We usually manage but difficult for expensive treatment.	To be investigated
Ethnic Patients			
Health Status	What is the reason for your admission?	Dengue, diarrhea, delivery, fever, malaria, gastrointestinal	
Health Services	Do you find the hospital clean,	Yes	The project will support infection
	you get clean water and toilet?		prevention and control
	From how far did you travel?	Mostly distant areas	The project will examine catchment population
	Are you happy with the quality of	Staff is trying hard	The project focuses on IPC
	Are health services affordable?	Sometimes we need to buy extra because the hospital doesn't have	The IA will examine this
Female and Male Ethnic Members			
Health Status	What are main health problems in your community?	Malnutrition, diarrhea, cough, dengue, gastrointestinal	The Project will outbreak response, education, screening, and facilitate referral
Health Services	Are health services adequate	Basic ok, not for emergencies, need to go to State/Regional Hospitals	Support for vehicles/ambulances in border towns
	What is availability and attitude of staff?	They are helpful	
	Are medicines available?	Mostly available	
	Other issues?	Improve emergency services	Support for vehicles/ambulances in border towns
Partners*			
Health Plans	What are planning issues for ethnic groups and migrants in regional CDC?	There is lack of information on the specific health statistics of EMGs and migrants. However, one third of the population is EMG. This is probably more important for migrants, whether EMG or not. But there probably are specific issues for some small EMGs in remote border areas. Some information may be available from local NGOs such as Mae Tao Clinic and Kayin Department of Health and Welfare (KDHW) in Kayin State, Kayinni Mobile Healh Committee (KnMHC) in Kayah State, Shan State Development Foundation (SSDF) in Shan State.	The Government to conduct a survey for the migration health policy. The project can help collect disaggregated data in target areas.

Topic	Questions	Responses	Proposed action
	Is investment in CDC addressing the needs of ethnic groups and migrants?	EMGs are serviced through the general health system. Although there are exceptions, most have access. For migrants, needs and issues are much less recognized and organized, although the Government has endorsed a 2014 ILO report on labor conditions. This needs to be followed with policies and plans, including for health services.	This needs to be examined at project level through outreach and at national level through survey
	Are there legal issues for ethnic groups and migrants?	Officially not, but there are some hurdled in accessing health services.	To be investigated by MOH in preparation of the Migration Health Policy
	What are major gaps?	First of all lack of information to be used as a dialogue with government. Removing of any legal barriers. Developing a comprehensive multi-sectoral program endorsed by all stakeholders including the private sector for regulation and implementation	To be assessed in preparation of the Migration Health Policy
Health Status	What is the HIV and TB status among ethnic groups and migrants?	There are no conclusive data on the status of EMGs and migrants. There are small studies, not representative, suggesting higher prevalence of both. HIV in sex workers, often mobile, reached 33% in 2007 before it started dropping, in part as infected people had no access to treatment	This requires a special survey, which is beyond the scope of the project
	Is the surveillance system reaching ethnic groups and migrants?	The surveillance systems for specific diseases and outbreaks are reaching almost all communities. There may be exceptions if there are security problems	The project will strengthen the surveillance system
Health Services	How is access to health services for ethnic groups and migrants?	Public health services are fully accessible for all citizens irrespective of ethnic status, but may not reach some remote groups. Migrants should be able to access public health services but may avoid this or not be allowed to do so.	The project will explore this through outreach, but not survey this
	What is the government capacity in providing services to ethnic groups and migrants?	The government has limited capacity to provide services in remote rural areas, in part due to lack of staff and government conditions. Even though recent graduates are required to rotate in these locations, and hardship allowances are available, this is not enough.	MOH is considering contracting out in this project
	What works better in reaching ethnic groups and migrants?	Partners often support government health services to improve working conditions. NGOs may also do the same.	Contracting NGOs is less sustainable, other modalities may be explored

Sources: *IHD, DCDC, PHD, DMS; ** IOM, WHO, UNAIDS, Gender Coordinating NGO; ***ILO 2015, International Labor Organization. Building and Evidence-base on patterns in migration, human trafficking, and forced labor.

Appendix 3: Ethnic Group Development Plan

	Sub-outputs	EMG Design Features/Activities	Performance Targets/Indicators
Output 1: Improved Regional Cooperation and CDC in Border Areas	1.1. Improved regional, cross-border and inter-sector cooperation 1.2 Enhanced knowledge management and community of practice (COP) 1.3 Increased access to CDC in border areas, in particular for vulnerable groups such as migrants, HIV positive youth, pregnant women, and isolated EMGs	Enhance participation, capacity building and decision making opportunities for representatives of EMG in regional, cross-border, and inter-sectoral events. Use workshops for EMG advocacy and increasing EMG awareness among workshop participants and stakeholders/governments. Ensure full participation of IP staff for outreach activities using IP-sensitive education and care procedures. Proactively target IPs at increased risk of infectious diseases with CDC activities in border areas.	Participation of EMG representatives in all these events (baseline unknown). Workshop materials clearly demonstrate mainstreaming of EMG issues and promotion of EMG-sensitive strategies. Participation of EMG staff in outreach activities. Decreased prevalence of infections among EGs in border areas based on health statistics.
Output 2: Strengthened national disease surveillance and outbreak response systems	2.1 Strengthened surveillance 2.2. Strengthened response	Collect, analyze and report EMG-disaggregated data. Ensure participation of EMG staff in any outbreak response teams. Increase participation of EMGs in field epidemiology training.	EMG disaggregated reporting for CDC project activities in each country. In districts with over 20% EMGs, each outbreak response team has at least one EMG staff. Of participants in field epidemiology training, at least 5% are EMGs in Cambodia, 30% in Lao PDR, 30% in Myanmar, and 10% in Viet Nam.
Output 3: Improved laboratory services and hospital infection prevention and control	3.1 Improved laboratory quality and biosafety 3.2 Improved infection prevention and control in hospitals	Ensure representative EMG participation in laboratory training programs for districts with large EMG population. Ensure representative participation of EMGs in scholarships for hospital infection prevention and control. Ensure EMG sensitive facilities in isolation wards	Representative participation of EMGs laboratory management and quality assurance training programs Representative participation of EGs in hospital infection and control training. All repaired isolation wards provide arrangements for EMGs
Project Management	3.1 Ensure Integration of project activities in regular services	All implementation plans for specific project activities and annual operational plans (AOPs) supported provinces address	Proportion of project implementation plans and AOPs that address EMG dimensions adequately.

	Sub-outputs	EMG Design Features/Activities	Performance Targets/Indicators
	3.2 Improve efficiency and governance.	gender and EMG dimensions of project activities All implementing agencies have an EMG focal point All quarterly reports report on progress in EMG issues At least 50% of consultants have experience working with EMGs.	Proportion of active focal points in implementing agencies (based on participation in events). Proportion of quarterly reports that report on EMG issues. Proportion of consultants with EMG experience.

Ethnic Group Development Plan, Viet Nam

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS

(as of 31 May 2016)

Currency Unit	–	Viet Nam dong (VND)
VND1.00	=	$0.0000445
US$1.00	=	VND22,145

NOTES

(i) The fiscal year (FY) of the Government of Viet Nam and its agencies ends on 31 December (from 2016 onwards). “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

This ethnic group development plan is a document of the borrower. The views expressed herein do not necessarily represent those of ADB's Board of Directors, Management, or staff, and may be preliminary in nature.

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ACRONYMS

ADB	Asian Development Bank
AIDS	acquired immunodeficiency syndrome
AOP	annual operational plan
APSED	Asia-Pacific Strategy for Emerging Diseases
BCC	behavioral change communication
CDC	communicable diseases control
CDC1	First GMS Regional Communicable Diseases Control Project
CDC2	Second GMS Regional Communicable Diseases Control Project
CEMA	committee of ethnic minority affairs
CLMV	Cambodia, Lao PDR, Myanmar and Viet Nam
DHS	department of hospital services
EA	executing agency
EGDP	ethnic group development plan
EID	emerging infectious disease
EMG	ethnic minority group
GDPM	general department of preventive medicine
GOV	Government of Viet Nam
GSS	gender and social safeguards specialist
HIV	human immunodeficiency virus
IA	implementing agency
IHR	international health regulations
IP	indigenous people
IPC	infection prevention and control
IT	information technology
MEV	migrants and mobile people, ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
NGO	nongovernmental organization
PAM	project administration manual
PHD	provincial health department
PIA	provincial implementing agency
PIU	project implementation unit
PMU	project management unit
RCU	regional coordination unit
RSC	regional steering committee
VWU	Viet Nam women’s union
WHO	World Health Organization

Executive Summary

This Ethnic Group Development Plan (EGDP) summarizes the Viet Nam-specific analysis, strategy, and plan for addressing indigenous peoples' aspects for the GMS Health Security Project based on the Government's Law on Ethnic Minorities[1] and ADB's Safeguard Policy Statement (SPS).[2] Indigenous people (IP) make up about 14% of the population of Viet Nam, and mainly lives in the northern mountains and central highlands. While they live in diverse socio-economic settings with different customs and languages, it is practical to focus on the vulnerable IP that are poor and lack access to services, are being displaced, or lack citizen rights and empowerment. In the context of the project, this EGDP focuses on the first group that are poor and lack access to services, as well as internal and external migrants, some of whom are IP. The control of regional infectious diseases in these two subgroups is a priority in this project, and will in particular be addressed through the first output of the project.

The proposed GMS Health Security Project for Cambodia, the Lao PDR, Myanmar and Viet Nam aims to improve regional public health security by strengthening health security systems and communicable disease control (CDC) in border areas, in particular for migrants and mobile people, ethnic minorities and other vulnerable groups (MEVs). Three components or outputs[3] are proposed: (i) improved GMS cooperation and CDC in border areas; (ii) strengthened national disease surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

The project is designed to support regional cooperation and national capacity building for prevention and control of emerging infectious diseases (EID) and other diseases of regional importance such as malaria, dengue, cholera, tuberculosis, HIV/AIDS, and drug-resistant infections. The project will cover a total of 36 provinces in Viet Nam, in addition to 13 provinces in Cambodia, 12 provinces in Lao PDR, and 5 states and one region in Myanmar.

According to SPS, the Borrower is required to ensure benefits and mitigate adverse impact of IP. To this effect, the Borrower prepares the Indigenous People Plan (IPP), sometimes called the EGDP. According to the Indigenous Peoples Safeguards Sourcebook[4]"*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook, "*IPs safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)." Furthermore, "the project is expected to have only limited impact and is accordingly categorized as B (para 67)." As per the ADB SPS, "if IPs are the sole or the overwhelming majority of direct project beneficiaries and when only positive impacts are identified, the elements of an [EGDP] could be included in the overall project design in lieu of preparing a separate IPP."*

This EGDP for Viet Nam summarizes the findings of the assessment and consultation process. Rather than referring to 'indigenous peoples', the Government of Viet Nam (GOV) uses the term 'ethnic group' as many of the affected ethnic minorities are not indigenous, and are in fact recent

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1 Government of Viet Nam. Policy on Ethnic Minorities.
2 ADB. 2009. *Safeguard Policy Statement*. Manila.
3 Government uses the term 'components' and ADB uses 'outputs', and therefore both terms are used in this EGDP.
4 ADB. 2013. *Indigenous Peoples Safeguards: A Planning and Implementation Good Practice Sourcebook* (Draft Working Document).

migrants. Therefore, the term Ethnic Group Development Plan (EGDP) will be used for the Viet Nam component documentation.

The project is expected to have only positive impact on IP. However, IP are not the sole or overwhelming majority of project beneficiaries. Given the scale and complexity of this regional project, and the potential for not achieving certain intended positive impact on IP justifies a **category B** and warrants preparation of an EGDP to help achieve intended impact on IP and other vulnerable groups. This EGDP for Viet Nam summarizes the findings of the assessment and consultation process and proposed project implementation measures.

No negative impact is foreseen. It appears that sufficient legislation is in place to address the needs of IP, except for migrants. MOH gives high priority to services for IP. However, the major concern is that proposed benefits for Ethnic Minority Groups (EMGs) do not fully materialize. Implementation of EGDPs in earlier, similar projects for communicable diseases control was not fully satisfactory in terms of effort and use of opportunities, even though it has improved over the years. Also for this Project, the major IP concern is that, during project implementation, proposed benefits for IP, migrants, and other vulnerable groups are not fully realized. Potential shortcomings may concern (i) project relevance and appropriateness for certain IP, (ii) project effort and efficiency and (iii) sustainability of interventions.

In particular, for Output 1 - CDC in border areas, activities such as community engagement for diseases prevention and case finding, training, campaigns and outreach services should be appropriate for the particular IP. Surveillance and response systems should also be appropriate given limited local capacity. IP should be facilitated to access screening and manage infections. Sustainability of interaction of communities and health services will depend on appropriateness of staff and affordability of services, as well as on integration of IP needs in provincial annual plans and budgets. Inclusivity in the central and provincial planning and monitoring processes along with special efforts to reach certain IP and other vulnerable groups will be critical success factors.

For this project, MOH has committed to provide the necessary leadership and inputs to fully implement the EGDP. MOH aims to maximize project benefits for vulnerable groups likely to be at increased risk of infectious diseases in border areas. Vulnerable groups include migrants and mobile people, ethnic minorities, and other vulnerable groups including youth and poor women. In alignment with national policy and context, MOH proposes to mainstream IP concerns in all Project activities. The EGDP is to (i) enhance equal opportunity, (ii) target vulnerable groups, and (iii) promote IP in alignment with priorities.

The Government is facing several challenges in implementing the EGDP such as MOH capacity, provincial priorities, staff shortage in remote health centers and health posts, and financial and logistic constraints. MOH is aware of its constraints to reach isolated villages and migrants. MOH has limited experience and mechanisms in place to work with other agencies and grassroots organizations for social mobilization and village health development. MOH is encouraging partners to help finance these investments.

MOH plans to engage beneficiaries in participatory planning and monitoring processing. IP engagement and services, along with other activities to be supported by the project will all be included in provincial and district annual operational plans and budgets, and in staff training and project management. Key features of the EGDP are mirrored in the project design and monitoring framework, loan covenants, and project administration manual. The PMU and implementing provinces will have a focal point for implementing the EGDP to

ensure that IP issues are being addressed. MOH will also engage a chief technical adviser and a gender and social safeguards expert to assist in this process. The PMU will also seek to include MEV disaggregated indicators, and report on progress of implementing the EGDP in every quarterly and annual project report, and on the project website.

I. PROJECT DESCRIPTION

1. GMS leaders are committed to enhance regional health security following outbreaks of emerging infectious diseases (EIDs), notably severe acute respiratory syndrome (SARS) in 2003, and highly pathogenic avian influenza (HPAI) in 2004. Recent outbreaks of Ebola hemorrhagic fever (EHF) in West Africa and Middle-East Respiratory Syndrome (MERS) in South Korea show respectively, how EIDs can get out of control with major human impact, and how a relatively small outbreak in a hospital can also have major economic impact. New zoonosis diseases also pose a constant threat in the region.

2. The misuse of antibiotics for bacterial infections is causing drug resistance, while new antibiotics are few and expensive. Nosocomial infections in hospitals are increasing due to poor infection prevention and control (IPC). Common infections like dengue and cholera show genetic adaptation. Climate change including global warming and frequent flooding may also further increase the burden of infectious diseases. While the incidence of HIV/AIDS, tuberculosis and malaria have declined following major investments, drug resistant strains of diseases, such as for malaria and tuberculosis, are also considered EIDs and major threats for the control of these diseases. Childhood infections preventable through immunizations are resurging due to weak vaccination systems. Continued investment will be needed to keep communicable diseases under control.

3. The overarching drivers for GMS control of emerging and re-emerging infectious diseases (EIDs) are the International Health Regulations (IHR, 2005), Asia Pacific Strategy for Emerging Diseases (APSED, 2010) and other (WHO) regional disease control and system building strategies for improved public health security, including: surveillance and outbreak response, risk analysis and communication, community preparedness, laboratory services, hospital infection control, regional cooperation, and monitoring. Viet Nam is also implementing WHO strategies to address regional priorities such as the control of malaria, dengue, HIV/AIDs and tuberculosis, strengthening of laboratory services, infection control in hospitals, and efforts to control fake drugs, and drug resistance.

4. The term health security[5] refers to a public health goal of prevention of epidemics or other disasters with major impact on health and the economy, and is concerned with the health of populations. In contrast, universal health coverage is concerned with the right of every individual to access affordable, quality health care. Investment in the control of emerging diseases has strong public goods, market failure and equity rationale, in addition to potential economic and political consequences of a major epidemic or pandemic.

5. Overall, public health security systems for APSED and other significant diseases need to become more mainstreamed, standardized, reliable, and financially sustainable. Second, in view of the increase in communication, urbanization and industrialization, the traditional dependence on a single public health system no longer holds, and MOH will need to strengthen its capacity for collaboration with other sectors. Progress in APSED is affected by health system limitations, but these are not clearly identified. Key areas are IT connectivity, basic capacity of staff as well as administrative and management capacity. In general, the private sector is a big unknown in terms of surveillance and response.

[5] According to WHO, health security is achieved through a set of activities, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations.

6. While there is a high risk of the spread of diseases and drug resistance, surveillance and response systems have not been fully capable of real-time and accurate information, indicating epidemic status at local levels. Several disease reporting systems are in place, but are not linked, do not reach communities, and fail to provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, which further limits efforts to improve disease control and community prevention and preparedness.

7. One way to address this is through integration of public outreach services, including community health promotion, prevention and outbreak preparedness, active case finding, screening, and, if necessary outbreak response ranging from food poisoning and dengue control to simulation exercises and control of the EIDs. Such packaging of services could make services more efficient and provide tangible staff learning opportunities. Capacity building for control of EIDs and other regional health threats can be combined. Further quality and efficiency improvement can be gained by combining services, such as for combining laboratories in regional hubs; and by improving quality control and audit of public health services, in both public and private sectors.

8. Laboratory services are complex, requiring some 20 subsystems to be in place. In Viet Nam, insufficient effort has gone into strategic planning, human resource development, referral and maintenance systems, quality assurance and audit, and medical-laboratory linkages. Addressing these system gaps will enhance benefits of past investments.

9. Hospitals are the most likely recipients for any emerging disease, and also pose a major concern in terms of spreading these and other diseases. In addition, hospitals are a source of nosocomial infections and drug resistance. Current facilities and practices in health facilities regarding infection prevention and control (IPC) are substandard, in terms of IPC management, staff capacity, facilities (isolation ward, sanitary ware, laundry, medical wears), hygiene practice standards, and practices (handwashing, visitors).

10. Regional cooperation consists mainly of ad hoc information exchange and at times, joint outbreak response, but without standard operating procedures and regularity of reporting. Cross-border cooperation is gaining momentum but needs to be integrated as part of regular CDC. In previous projects, knowledge management activities have been quite prominent and have generated technology transfer, staff capacity, leverage, competition and commitment, and monitoring progress. But their potential, e.g. for developing disease control strategies, early warning of outbreaks, and joint diseases control, is yet to be fully developed. Regional workshops on health security need to focus more on agreements for action, and follow-up. The regional cooperation unit may need to be strengthened.

11. The proposed Greater Mekong Subregion Health Security Project (the Project) is designed to support regional cooperation and national capacity building for prevention and control of EIDs and other diseases of regional importance including malaria, dengue, cholera, tuberculosis, HIV/AIDS, and nosocomial and drug-resistant infections.

12. The Project builds on the achievements and lessons learned of the Governments of the GMS and partners in enhancing GMS health security and reducing the burden of communicable diseases. The Project aims to expand beyond core APSED capacities to reach geographical areas that have received less attention, in particular, communities and hard to reach groups in border areas, by increasing cooperation and linkages and improving the quality and bio-safety of

services. The Project will strengthen the preventive medicine system and services for improved public health security and disease prevention and control, especially in poor border districts.

13. The impact will be GMS public health security strengthened. The outcome will be improved GMS health system performance, with regard to health security. The proposed project locations are provinces and districts along the borders and economic corridors. Selection of project provinces is based on (i) economic status of the province; (ii) health and health services statistics; (iii) regional risks and priority clusters; and (iv) existing support from other partners. In Cambodia, the project will cover 13 provinces; in Lao PDR, 12 provinces; in Myanmar, 6 states and regions; and in Viet Nam, 36 provinces. The project outputs will be: (i) improved GMS cooperation and CDC in border areas; (ii) strengthened national diseases surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

(i) **Strengthened regional, cross-border, and inter-sectoral CDC.** Output 1 will: (a) strengthen regional, cross-border and inter-sectoral cooperation for the control of epidemics including EIDs, dengue and other important regional diseases, and (b) increase access to CDC for at risk youth, migrants and ethnic groups in border areas by providing outreach services using outbreak response teams.

(ii) **Strengthened national disease surveillance and outbreak response.** Output 2 will enhance the current surveillance and response system by: (a) expanding web-based reporting for improved surveillance and response capacities, and (b) improved community preparedness and syndromic reporting at village level.

(iii) **Improved laboratory services and hospital infection prevention and control**. Output 3 will: (a) improve quantity and biosafety of laboratory services; (b) scale up where appropriate for monitoring hospital based infection and drug resistance, and (c) improve hospital hygiene and management of highly infectious diseases.

14. **Cost estimates and financing**. In Viet Nam, the estimated Project cost is $84 million, to be financed by an ADB loan of $80 million and $4 million in Government counterpart funds. About $6 million is reserved for regional and cross-border cooperation and CDC in border areas directly targeting MEVs, who will also benefit from the general improvement of health services provided they use these services. Provincial administrations will encourage EMGs to use services as part of the Project participatory planning process.

15. **Project implementation**. The Ministry of Health (MOH) will be the executing agency (EA). The EA is represented by the General Department of Preventive Medicine (GDPM) in MOH, with the deputy director general of GDPM, as the Project Director, who reports to the director general of GDPM and the MOH Steering Committee for ADB funded projects chaired by the Vice Minister of Health for Preventive Services.

16. In Viet Nam, the existing CDC2 project management unit (PMU) and GDPM will continue with project administration, coordination, and implementation of some activities. Two deputy project directors in GDPM will assist the project director in day-to-day project coordination and management, including administration. The Medical Service Administration, the National Institute of Hygiene and Epidemiology (NIHE), the Institute of Hygiene and Epidemiology in Central Highland, the Pasteur Institutes of Ho Chi Minh City and Nha Trang, and 36 provincial preventive medicine centers will serve as IAs. Within each project management unit (PMU), a gender and social safeguards specialist (GSS) will be engaged to help plan, provide capacity

building for, and monitor implementation of the Gender Action Plan. The PMU will support: (i) annual operational planning, coordination and budgeting, (ii) project implementation activities, (iii) proper procurement, financial management, (iv) adherence to safeguards, and (v) monitoring and reporting. At provincial or township level, the provincial/township health department (P/THD) will be the designated project implementation units (PIUs). There are up to 3 positions in each PIU to be financially supported by the Project in each province/township, depending on the workload.[6] This includes a provincial project coordinator, a technical officer and an account assistant.

17. The Regional Steering Committee (SC) established under CDC1 will give guidance in Project implementation, policy dialogue, and building of regional capacity and cooperation for CDC, facilitating country decisions on the use of pooled funds for regional activities. It will be chaired by the minister or vice-minister of the host country and will consist of leading representatives from the national SCs, project directors, and ADB and WHO representatives. The Regional Coordination Unit (RCU) will act as the secretariat for regional coordination activities and the management of regional funds. Regional project meetings will be held 6 months before the RSC meeting to follow up regional activities and organize regional events, and report these to the RSC.

18. **Scope**. To support regional health security, the Project will directly support Cambodia, Lao PDR, Myanmar, and Viet Nam and encourage the participation of the Peoples Republic of China (PRC) and Thailand in regional and cross border activities. All country project proposals include regional cooperation, CDC in border areas, disease surveillance and response, and laboratory quality improvement, as well as hospital hygiene. However, there are differences in project emphasis among the 4 countries. For example, both MOH Cambodia and MOH Lao PDR give emphasis to reaching those not being reached with CDC in border areas. While in Myanmar, the aim at this early stage is to develop model services in state laboratories and major border hospitals. In Viet Nam, on the other hand, the development the district health center, is among their priorities.

19. **Location**. The Project is to cover 3 east-west corridors and one multi-limbed north- south corridor representing 4 distinct geographical clusters of MEV issues, as shown in Appendix 1. In Myanmar, it includes Shan North, Shan East, Kaya, Kayin, and Mon States, and Tanintharyi region bordering China, the Lao PDR, and Thailand. In Cambodia, 13 provinces are included in 3 clusters in the north-west, north-east, and south-east. In the Lao PDR, 12 provinces are included in 3 clusters in the north, center and south of the country.

20. In Viet Nam, 36 provinces (see Appendix 1, table 4 and map) are included along the northern border with China and the western border with the Lao PDR and Cambodia. The north-south corridor connects major industrial areas in China with industrial areas in Viet Nam, Lao PDR, Cambodia, Thailand, and Myanmar and is the important one in terms of traffic flow, while migration flows are mainly to Thailand. The central corridor comprises most EMGs, and the north-south corridor passes through few locations with high concentration of EMGs, which could be hotspots for targeting.

21. In Viet Nam, poverty rates are highest in the northern mountains and central highland, up to 35% in 2004. But MEVs are poorer in general. Within all border districts along economic corridors, hotspots and communities with high burden of communicable diseases and low CDC coverage will be selected, using reported and estimates cases. Selection criteria will also consider local commitment, presence of partners, and feasibility of having impact on these

[6] In Viet Nam, the Province Medicine Centers will be PIU and provide project administrative staff.

communities. The project districts will conduct a participatory assessment and planning process, and ensure that plans are included in the provincial annual operational plan, and sustained from local sources after project completion.

22. Variations in population, disease patterns and services will require different responses, e.g., districts may have more malaria, dengue, HIV or TB depending on location and district implementation capacity. A customized bottom-up district and provincial planning approach as part of the regular annual planning process would take into consideration a range of interventions, disease priorities, health services capacity, and funding constraints.

II. SOCIAL IMPACT ASSESSMENT

A. Legal and Institutional Framework

23. According to ADB's 2009 *Safeguard Policy Statement (SPS)*, the objectives of Indigenous People safeguards are to design and implement projects in a way that fosters full respect for Indigenous Peoples' identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by the Indigenous Peoples themselves so that they: (i) receive culturally appropriate social and economic benefits; (ii) do not suffer adverse impacts as a result of projects; and (iii) can participate actively in projects that affect them. ADB indigenous peoples policy as presented in the SPS includes the following principles:

- Screen early on to determine (i) whether Indigenous Peoples are present in, or have collective attachment to, the project area; and (ii) whether project impacts on Indigenous Peoples are likely.

- Undertake a culturally appropriate and gender-sensitive social impact assessment or use similar methods to assess potential project impacts, both positive and adverse, on Indigenous Peoples. Give full consideration to options the affected Indigenous Peoples prefer in relation to the provision of project benefits and the design of mitigation measures. Identify social and economic benefits for affected Indigenous Peoples that are culturally appropriate and gender and inter-generationally inclusive and develop measures to avoid, minimize, and/or mitigate adverse impacts on Indigenous Peoples.

- Undertake meaningful consultations with affected Indigenous Peoples communities and concerned Indigenous Peoples organizations to solicit their participation (i) in designing, implementing, and monitoring measures to avoid adverse impacts or, when avoidance is not possible, to minimize, mitigate, or compensate for such effects; and (ii) in tailoring project benefits for affected Indigenous Peoples communities in a culturally appropriate manner. To enhance Indigenous Peoples' active participation, projects affecting them will provide for culturally appropriate and gender inclusive capacity development. Establish a culturally appropriate and gender inclusive grievance mechanism to receive and facilitate resolution of the Indigenous Peoples' concerns.

- Ascertain the consent of affected Indigenous Peoples communities to the following project activities: (i) commercial development of the cultural resources and knowledge of Indigenous Peoples; (ii) physical displacement from traditional or customary lands; and (iii) commercial development of natural resources within customary lands under use that would impact the livelihoods or the cultural, ceremonial, or spiritual uses that define the identity and community of Indigenous Peoples. For the purposes of policy application, the consent of affected Indigenous Peoples communities refers to a collective

expression by the affected Indigenous Peoples communities, through individuals and/or their recognized representatives, of broad community support for such project activities. Broad community support may exist even if some individuals or groups object to the project activities.

- Avoid, to the maximum extent possible, any restricted access to and physical displacement from protected areas and natural resources. Where avoidance is not possible, ensure that the affected Indigenous Peoples communities participate in the design, implementation, and monitoring and evaluation of management arrangements for such areas and natural resources and that their benefits are equitably shared.

- Prepare an Indigenous Peoples plan (IPP) that is based on the social impact assessment with the assistance of qualified and experienced experts and that draw on indigenous knowledge and participation by the affected Indigenous Peoples communities. The IPP includes a framework for continued consultation with the affected Indigenous Peoples communities during project implementation; specifies measures to ensure that Indigenous Peoples receive culturally appropriate benefits; identifies measures to avoid, minimize, mitigate, or compensate for any adverse project impacts; and includes culturally appropriate grievance procedures, monitoring and evaluation arrangements, and a budget and time-bound actions for implementing the planned measures.

- Disclose a draft IPP, including documentation of the consultation process and the results of the social impact assessment in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected Indigenous Peoples communities and other stakeholders. The final IPP and its updates will also be disclosed to the affected Indigenous Peoples communities and other stakeholders.

- Prepare an action plan for legal recognition of customary rights to lands and territories or ancestral domains when the project involves (i) activities that are contingent on establishing legally recognized rights to lands and territories that Indigenous Peoples have traditionally owned or customarily used or occupied, or (ii) involuntary acquisition of such lands.

- Monitor implementation of the IPP using qualified and experienced experts; adopt a participatory monitoring approach, wherever possible; and assess whether the IPP's objective and desired outcome have been achieved, taking into account the baseline conditions and the results of IPP monitoring. Disclose monitoring reports.

24. The Borrower is required to prepare an EGDP to protect, and ensure benefits for ethnic minorities affected by the project. According to the Indigenous People's Safeguards Sourcebook, "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook, *"[Ethnic Groups] safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* In the same Sourcebook, it is noted that *"a stand-alone [EGDP] may not have to be prepared when only positive impacts are expected from the project."* ADB clarified that given the scale and complexity of this regional project, the

potential for not achieving certain intended positive impact on ethnic monitories justifies a category B and warrants preparation of the EGDP to help achieve intended impact on EMG.

25. The Government of Viet Nam (GOV) does not use the term "*indigenous peoples*" for any groups, but generally refer to "*ethnic minorities*" as those who are living in mountainous areas, and formally defined as: "those people who have Vietnamese nationality, who live in Viet Nam but do not share 'Kinh' characteristics such as language, culture and identity." Within the context of ADB policy, recent migrants, often being squatters on government land, are also entitled to be compensated in case of resettlement. On the other hand, an EMG that has lost collective attachment to geographically distinct habitats or ancestral territories in the project area because of forced severance also remains eligible for compensation.

26. The GOV recognizes 54 different EMGs in the country (see details on the EMGs in Appendix 4), in which definition of an EMG is based on the following criteria: (i) a language different from the national language; (ii) long traditional residence on, or relationship with land; and long traditional social institutional system; (iii) a self-provided production system; and (iv) a distinct cultural identity and self-identification as a distinct cultural group that is accepted by neighboring ethnic groups. Article 5 of the 2013 Constitution acknowledges the following general principles:

(i) The Socialist Republic of Viet Nam is the unified State of all nationalities living together in the country of Viet Nam;

(ii) All ethnicities are equal, unified, respect and assist one another for mutual development; all acts of national discrimination or division are strictly forbidden;

(iii) The national language is Vietnamese. Every ethnic group has the right to use its own language and system of writing, to preserve its national identity, to promote its fine customs, habits, traditions and culture;

(iv) The State implements a policy of comprehensive development, and provides conditions for the ethnic minorities to promote their physical and spiritual abilities and to develop together with the nation.

27. The Constitution also mandates preferential treatment of EMG in education and healthcare in Articles 36 and 39. Articles in the Civil Law (as amended in 2005) also explicitly mention the rights and responsibilities of EMGs. The GOV has passed numerous resolutions on EMGs development issues and policy areas: (i) relating to the creation of conditions for sedentary agriculture and the settlement of EMG; (ii) relating to the creation of conditions for the holistic socioeconomic and cultural development of upland EMGs; and, (iii) relating to the allocation of land and to utilize land in upland areas traditionally occupied by EMGs.

28. It is a requirement in Viet Nam that the adaptation of economic and social policies to each region and each group should take into account the needs of ethnic minorities. The Socio-Economic Development Plan and Socio-Economic Development Strategy of Viet Nam specifically call for attention to ethnic minorities. Major programs targeting ethnic groups include Program 135 (infrastructure in poor and remote areas) and Program 134 (eradication of poor quality houses). A national policy on education and health care for ethnic groups is in place. The national legal framework was updated in 2007 with several documents relating to regional planning, the Program 135-Phase 2, land administration and compensation.

29. Under the Prime Minister's office, the Committee of Ethnic Minority Affairs (CEMA) (equivalent to a Ministry) is the lead government agency overseeing EMG issues. CEMA will play a key role in the implementation of EGDP for this project at all levels from the central to province/district/commune. PMU at all levels should engage CEMAs (full-time staff from CEMA or based on joint-working group mechanism) at the same level in implementing EGDP's activities.

30. The project is guided by and compliant with key GOV policies including:

(i) GOV Decision No.135/1998/QD-TTG (1998) on approval of the "socioeconomic development program for the extremely difficult mountainous and remote communes" that mandates those who live in mountainous and remote areas will be entitled to preferential health examination and treatment.

(ii) National Assembly Resolution No.18/2008/QH12 (2008) stipulates accelerated performance of socialization policies and laws to promote the quality of healthcare services and to ensure attention will be paid to the budget allocation for the healthcare for the poor, farmers, ethnic groups and those living in difficult and extremely difficult socio-economic situations.

(iii) GOV Decision No.139/QD-TTG (2002) on health treatment for the poor, which states that all people who are poor, live in extremely difficult areas under Program 135, and EMGs will receive free medical check-up and treatment.

31. Health care for the poor and EMGs has improved significantly with enforcement of Decision 139. Provincial governments have issued regulations on medical checks and treatment for the poor, funds for medical care including health insurance cards to those living under the poverty line or living in extremely difficult communes (under Program 135), and EMGs. Since implementation, the number of patients visiting health facilities has significantly increased, which, however, presents a significant challenge due to limited public budget in the context of increasing demands from the poor for health check-up and treatment.

32. The EGDP proposes that MOH mainstreams the IP dimensions in all project operations. The IP development strategy aims to (i) enhance equal opportunity for IP, (ii) target vulnerable groups among IP and non-IP, and (iii) promote IP dimensions in all project activities. It proposes to maximize benefits for vulnerable groups in border areas who are likely to be at increased risk of infectious diseases. These vulnerable groups include migrants and mobile people, isolated and poor ethnic minorities, and other vulnerable groups such as youth and pregnant women. The EGDP is aligned with national legislation and ADB's SPS.

B. Baseline Information

33. Key demographic, economic and social indicators of the 4 targeted GMS countries are in Table 1.

Table 1: Key Demographic, Economic and Social Indicators in the GMS

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Economic growth rate %	7.0	6.5	8.0	6.0
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Population below 15 years	31.1	34.7	24.5	23.2
Median age in years	24.5	19.3	28.5	29.6

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Sex ratio (% m/f)	95	99	94	112
Population growth rate (%)	1.8	1.9	0.8	1.0
Population density per square kilometer	85	29	79	279
Urban population (%)	20.5	37.6	33.6	33.0
Urban growth rate (%)	2.7	4.9	2.5	3.0
Per capita income in US$	1008	1589	1184	1868
People earning below $1.25 per day (%)	19	23	26	13
Unemployed as % of labor force	0.3	1.4	3.4	2.0
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	NA	1.184	11
Tourist arrivals (1,000)	4.200	2.500	2.000	7.500
Mobile phones subscribers/100 persons	134	66	12.8	131
Internet users estimate (% population)	6	13	1	44
Primary/Secondary GER f/m	81/89	76/82	79/78	89/87
Child mortality general population	42.5	41.9	62.4	21.7
Child malnutrition in main population %	28.3	33.9	28.0	16.9
HIV prevalence in main population %	0.6	0.3	0.7	0.5
HIV prevalence among sex workers %	4.6	1.3	18.4*/**	3
TB incidence main population /100,000	390	189	369	140
Malaria cases confirmed total	21,309	46,202	333,871	17,128
Malaria deaths confirmed / 100,000	1.7	4.4	5.4	0.1
Full Immunization main population %	NA	49	NA	>95%
Full Immunization EMGs %	NA	NA	NA	<85%
Contraceptive prevalence rate (%)	51	50	46	78

Sources: *Viet Nam Economic and Development Strategy Handbook, 2004; ** anecdotal reports, e.g., one study reports under age Hmong sex workers for tourists in Sapa; *** e.g., one study for Lao migrants returning from Thailand; **** BWHO National Survey of Tuberculosis Prevalence 2010; */* SEAJTM Prevalence of Tuberculosis in Migrants 1996; */** HIV data from UNAIDS 2008; HIV data from UNAIDS 2014 report; WHO and World Bank indicators; SEAJTM Prevalence of Tuberculosis in Migrants 1996 **** Vietnam Health Statistical Yearbook 2013.

34. The countries show strong economic growth due to foreign investment in economic zones, plantations, and services, causing rapid industrialization (table 1). The population shifts (mostly internal migrants) in search of employment including IP, which in turn contributes to urbanization. It also shows a young population in Cambodia and Lao PDR. About 5-10% of external migrants are below the age of 18 years. While per capita income has been increasing rapidly, poverty is still common, in particular among ethnic minorities. While child mortality has declined, child malnutrition remains high, and so does the prevalence of major communicable diseases, while health sector coverage of the population is not yet universal.

35. Ethnic minorities mostly live in the highlands in the GMS. About 14% of the population are EMGs and mostly live in the northern mountains bordering China, the hill in north central Viet Nam bordering Laos, and central highlands bordering Cambodia. Most EMGs are fully assimilated in Kinh society and may no longer identify themselves as EMGs, which would exclude them as per ADB definition. Urban IP may be hesitant to identify themselves as belonging to an EMG, which is considered a lower social status in Viet Nam, but in rural areas people strongly identify themselves with particular community.

36. Appendix 4 provides the ethnographic profile of these EMGs. There are 54 recognized ethnic groups divided into 8 language groups: Viet-Muong including Kinh, Tay-Thai, Mon-Khmer, Mong-Dao, Kadai, Polynesian including Cham and Ede, Han, and Tibeto-Burma. They share many common values: ancestor worship, family, community, hard work and care for children. What is often different is the customs relating to religion, marriage, land ownership, housing and particular skills, which are typically reflecting their ecological challenges. What is also evident from the list of ethnic groups is that they are dispersed throughout the region, and often will have relatives across the border and/or cross the border frequently. Hence the concept of border is relative when it comes to people mobility and the spread of diseases. This makes strong surveillance systems at village level even more important.

37. Basic indicators regarding the specific health status of EMG are lacking. Information on EMG status may be recorded in some health facilities, but this is not aggregated. Surveys typically do not ask for ethnic group unlike other indicators like gender and age. However, some subnational or selective surveys have provided information on selective indicators. The 2002 Demographic and Health Survey is dated and while overall indicators have improved, these data provide a comparison of regions in Viet Nam, with the Central Highlands and Northern Mountain (Uplands) having the largest groups of IP, followed by the North Central region. Indicators of infectious diseases such as malaria and tuberculosis are difficult to interpret in terms of access of health services, as this depends on disease burden and programs impact. However, indicators of reproductive health and immunization, care that everyone needs more or less equally, give a better idea of access to services. This shows surprisingly high levels of family planning possibly linked to the two children policy except in the Central Highlands (with high in-migration from lowlands), but still about 5% of people who do not access health services at all, measured by having zero vaccination. Many of these will be isolated IP and of particular concern for improving their health and infectious diseases control.

Table 2: Key Health Indicators by Region in Viet Nam

	National	Northern Uplands	Red River Delta	North Central	Central Coast	Central Highlands	South East	Mekong River Delta
Total fertility rate	1.9	2.0	1.7	1.9	2.4	3.0	1.5	1.7
Contraceptive use married women, any method	78.5	78.4	82.8	79.8	77.2	66.3	75.7	76.7
No antenatal care in pregnancy in last 3 years	13.2	23.2	2.3	9.8	14.3	27.2	9.1	15.2
Infant mortality	24.8	40.9	20.5	30.9	13.1	22.7	11.6	22.3
Under-five mortality	32.9	51.8	26.5	36.9	15.9	40.9	22.8	30.9
Vaccination coverage	66.7	45.1	88.4	55.9	76.0	na	76.0	80.8
No vaccination	4.7	8.9	0.0	5.2	0.0	na	6.6	6.8

Source: Committee for Population, Family and Children. 2002. Demographic and Health Survey.

C. Stakeholders and Consultations

38. In MOH, EMG issues are referred to in general plans. As the government aims to mainstream EMGs, there is no specific policy, strategy, plan or designated unit for EMGs. The General Department of Preventive Medicine (GDPM) is tasked with ensuring adequate services for EMGs in view of achieving Universal Health Coverage (UHC), which will among others

require improving the monitoring system and planning special investments. In every village, there is a system that the health workers take responsibility for assisting with the implementation of health activities, reporting diseases, and planning village health improvements.

39. There are several organizations that are involved in the wellbeing of EMGs, including the border defense force, mass organizations (such as Women's Union, Fatherland Front, Farmer Association, Youth's Union, Labor Union), NGOs, and Government services. The lead government agency in regard to EMGs is the Committee for Ethnic Minority Affairs (CEMA). CEMA is a ministerial-level agency of the Government, which functions to perform management over the ethnic issues throughout the country and public services. CEMA plays a key role in the implementation of EGDP for this project at all levels from the central to province/district/commune.

40. In Viet Nam, the proportion of migrants that belong to EMGs is not known. EMG migrants may be more disadvantaged to benefit from the Vietnamese Labor Code which aims to ensure a wide range of rights, benefits and protections. The presence of national or international organizations or interest groups for specific EMGs may not extend to the most disadvantaged groups and to remote areas. One problem is that of skilled EMGs migrating to big cities (like Ho Chi Minh city, Da Nang, Binh Duong) or abroad for job (mostly manual jobs such as construction work, garment industry). The impact of this process on the EMG transition is not known. However, this new leadership could play an important role in policy making and planning.

41. The consultation process has covered some stakeholders including community representatives (see Appendix 2 for consultation documentation), but also relies on information gained from the CDC2 project. International and national safeguards consultants took field visit to Tay Ninh province, major borders with Cambodia, casinos, and large migrant populations.

D. Vulnerabilities, Risks, and Project Effects

42. EMGs in GMS border areas can no longer be thought of simply in terms of disadvantaged due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. EMGs are beginning this process of integration from a very disadvantaged position. Migrants, EMGs and other vulnerable groups (MEVs) such a youth and pregnant women need special attention in any health administration, but this is often not happening, in part because health plans are disease-focused. See Appendix 1 for more background of MEVs in the GMS.

43. EMG populations living near regional economic corridors bear a disproportion burden of the health costs of the rapid social and economic changes created by these developments. Relocation and/or resettlement of EMGs have been supported by governments and donors in CLMV for various reasons. In some provinces, movements of highland EMGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas[7].

[7] Gebert, R. 1995. *Socio-economic baseline survey*. Muang Sing: GTZ Integrated Food Security Programme. Cohen, P.T. 2000a. "Lue across borders: pilgrimage and the Muang Sing reliquary in Northern Lao PDR. In G. Evans, C. Hutton and Kuah-Khun Eng (eds.) *Where China Meets Southeast Asia: Social and Cultural Change in the Border Region*. Singapore: Institute of Southeast Asian Studies. Cohen, P.T., 2000. "Resettlement, opium and labor

44. When highland-dwelling EMGs move to lower altitudes, they are exposed to malaria, to which they have little acquired resistance, so in the early phase of relocation to lower altitudes, there have been high mortality rates from malaria, as well as morbidity resulting from exposure to other water-born and environmentally-related infectious diseases.

45. EMG populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.

46. Some EMGs may use health services, when they are available, only as a last resort. This may be because of lack of experience but also reflects anxiety about modern health services and expense of accessing them. Traditional beliefs and practices are common especially in remote areas. Shifting cultivation practices also limit the opportunities to access the health service for some EMGs, especially women. EMGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel ashamed and reluctant to access services, and numerous reports of belittling treatment of EMGs by government health workers were shared informally during the field research. Programs aiming to promote behavior change (e.g. building and using latrines, drinking boiled water, removing disease vector breeding sites, hygienic management of animals, hand-washing, using bed nets, and acceptance of vaccination) are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EMG villages. Behavior Change Communication (BCC) programs linked to products availability (using commercial approaches) may also be considered. In Viet Nam, the Kinh-Hoa majority ethnic group consistently have better health access and outcomes. For example, child mortality for the general populace is 21/1000, while the figure if 39 for EMGs. Similarly, child malnutrition in Kinh is believed to be around 3.5-15%, while in EMGs the figure is 34%. Fewer EMG women deliver using skilled birth attendants (96% versus 46%) (Table 6 Appendix 1).

47. Provision of free health insurances has enabled poor EMGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered by the health cards.

48. Although EMGs are more likely to have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EMGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The disparities are highlighted in country specific data showing that provinces with high infant and child mortality rates also have high concentrations of EMGs. Surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is

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dependence: Akha-Tai relations in Northern Laos", *Development and Change*, 31:179-200. Romagny, L. and Daviau, S. 2003. *Synthesis of Reports on Resettlement in Long District, Luang Namtha province, Lao PDR*. Action Contre La Faim mission in Lao PDR. Lyttleton, C. 2005. "Market-bound: relocation and disjunction in northwest Lao PDR**"**. In Toyota, M., Jatrana, S., and Yeoh, B., 2003 (eds.) *Migration and Health in Asia.* Routledge. Alton, C. and Houmphanh Rattanavong, 2004. *Service Delivery and Resettlement: Options for Development Planning*, unpublished report, UNDP: Lao PDR, Vientiane. McCaskill D. and K. Kampe (eds.) 1997. *Development or Domestication: Indigenous Peoples of Southeast Asia* Chiang Mai: Silkworm Press.

collected by health centers and hospitals. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive.

49. The Project does not impose any vulnerabilities or risks or negative project effect on the EMGs in the project area. The only risk there may be is that EMGs are excluded from the benefits of the Project. Hence the EGDP aims to ensure that the project design, implementation, and monitoring maximizes benefits for EMGs.

E. People's Perceptions

50. As indicated in the comments of local health staff, village leaders and patients summarized in Appendix 2, common health problems are diarrhea, malaria and dengue, and problems of pregnancy and accidents that require emergency referral. The presence of patients tuberculosis and HIV was also observed. No specific reference was made to vector control and the spread of infections such as dengue and malaria, although the epidemic aspects are understood. In addition, the public is familiar with cholera, flu outbreaks and avian influenza in poultry but not with other emerging diseases, which are rare conditions.

51. Patients generally found health services acceptable for both women and men. Issues were staff availability, a shortage of medicines, and extra charges for services and transport. Lack of 24 hour services and ambulance services was also raised. Local health staff noted the need for more in-service training and outreach services. Government officials emphasized that everyone has access to free health services including all ethnic groups and migrants. However, they also noted a lack of qualified staff in local health facilities, and that certain EMGs were hard to reach and did not make much use of public health services. Out of pocket payment was not considered an issue for the poor as the health facility provided services for free, or could provide waiver for poor people.

F. Proposed Measures

52. In preparation of project implementation, each PHD will request border districts to identify MEVs along economic corridors, and engage the village health group, community based organizations (CBOs) or other representative groups to engage in a participatory assessment to identify gaps in health security and plan for a package of activities including screening, diagnostics, disease control, and referral to the established programs. Village or facility CDC plans will be included in district annual plans and budgets, and if possible scaled up to provincial level. This should help achieve benefits for MEVs in this project. Progress in rolling out EGDPs should be reported to MOH.

III. INFORMATION, DISCLOSURE, CONSULTATION AND PARTICIPATION

53. Key questions concerning EMGs in project design[8], apart from general health status, include (i) their understanding of communicable diseases, causes, treatment, and prevention; (ii) EMG's use of services and their perceptions of acceptability, availability, quality and affordability of government and other health services; and (iii) community organization for health services and participation in the project cycle. The project has no negative impact on EMGs, so the focus is on how to improve positive impacts for EMGs.

[8] KAP studies, key informant interviews and FGD sessions might be assigned perhaps supporting a postgraduate project looking into these matters might yield additional information.

54. The national and international social safeguard specialists conducted an assessment of social impact, including review of documents, field visits, stakeholder meetings, workshops, and assessment and disclosure of social impacts and mitigating measures from 3-16 October 2015. They met with MOH departments, other ministries, partners, and other stakeholders. From 6-8 October 2015, meetings were held with GDPM, the Medical Services Administration and the Department of Planning and Finance and other departments in MOH, CEMA in the Ministry of Labor, Invalids and Social Affairs (MOLISA), Viet Nam Women's Union (VWU), and partners.

55. Following visits of national consultants to other provinces, the full team visited Ha Giang and Tay Ninh provinces and conducted interviews with state officials, health staff, and community members. Tools adopted by consultants for gathering information during field visits included open interviews and observations. Respondents were asked about their circumstances, views on health services, and health priorities. As there are no negative effects expected from the Project, the focus was on understanding the conditions and how the EMGs could be assisted better through the project design. This is provided in the consultation documentation in Appendix 2. The provincial and district health authorities will disclose the EGDP contents to community representatives benefitting from the project. The project will finance outreach activities during which relevant portions of the EGDP will be disclosed and local safeguards experts hired by the project will support disclosure of the EGDP to beneficiaries. The EGDP will also be posted on the websites of the Regional Coordination Unit and ADB.

56. Village health committees already participated in CDC projects in terms of model healthy village development, disease reporting and community preparedness, facilitating immunization and case finding, and referring people. The proposed project interventions did not raise any objections. However, EMGs reside in isolated, hilly regions far from community facilities and systems. Community-based interventions require thorough preparation to achieve the desired results. It will be important to promote a sense of ownership of project interventions. Based on 10 years of ADB-supported project experience, the proposed project interventions are much appreciated. The perceived problem is on the supply side rather than the demand side, in that MOH lacks the means to reach remote EMGs and migrants, and may be unable to assign staff to these places.

57. Among the risks noted were: (i) lack of interest of targeted EMGs; (ii) weak provincial effort in participatory planning, implementation, and monitoring; (iii) lack of effort reaching isolated EMGs, migrant camps, and hotspots; and (iii) insufficient technical and financial backstopping of MOH. For migrants an additional issue is that it may be difficult for migrants to access health services due to unregistered migration and employment conditions; and for health staff to access and inspect labor camps, factories and casinos, which requires collaboration with the Ministry of Labor and business owners. These risks need to be mitigated as part of the EGDPs.

58. In view of these risks of insufficient focus on ensuring project benefits for EMPs as per EGDP, each level in the health system has clear arrangements between the officer in charge, the focal point, consultants, and any third parties for planning, implementation and monitoring of the EGDP as part of overall project implementation. Each level will ensure consultation of potential beneficiaries or their representatives on a quarterly basis and at each stage of the process. These risks need to be mitigated as part of the EGDP.

IV. BENEFICIAL MEASURES

59. Direct beneficiaries in Component 1 will include prioritized EMGs[9], migrants, laborers in camps, youth, local health staff, and community health workers. It is expected that in the 300 targeted districts, the project will reach about 1 million MEVs, mostly through outreach. Migrants, youth, pregnant women, and remote EMGs will receive additional screening and referral for treatment as needed. Project implementation units in provinces will conduct results-based, participatory planning to ensure strong commitment from all stakeholders, and prepare annual plans with activities and targets to be financed from project funds. It is expected that the provision of motorcycles (under Component 1) and vehicles (under Component 2) will increase mobility of provincial teams to reach out to these communities. Component 1 will also support regional, cross-border, and inter-sectoral cooperation for joint planning to extend services to the target groups, and joint activities. Monitoring and supporting this component will be critical and the main assignment of the CTAs, and the gender and social safeguard experts.

60. Component 2 will help improve community preparedness, timely detection, investigation, risk analysis, risk communication, and containment of emerging and other diseases of regional significance, such as malaria, dengue, cholera, tuberculosis and HIV/AIDS. Direct beneficiaries in Component 2 include health staff, and community health workers, who will improve outbreak reporting and response and community preparedness that is appropriate for EMG communities.

61. Component 3 will improve diagnostic capacity by improving laboratory quality, and also reduce the risk of spread of dangerous infections through better laboratory biosafety, hospital infection control, and better case management of infectious diseases. Direct beneficiaries in Component 3 include laboratory staff and hospital staff, many of whom belong to EMGs, and will work in EMG areas.

V. MITIGATION MEASURES

62. The purpose of this EGDP is to (i) outline the potential positive and negative impacts of the project on ethnic groups; (ii) specify actions to address these impacts; and (iii) help mitigate negative impacts and enhance benefits to IP and other ethnic minority communities. During project preparation, IP and EMGs and their representatives were consulted using key informant and focus group discussions (consultation will be continued during project implementation). To increase support for IP, other EMGs and achieve positive outcomes for IP and EMGs in the project, project management units at central (CPMU) and provincial levels (PPMU) will ensure full implementation of the EGDP. To facilitate this process, key features of this EGDP are mirrored in the project DMF, loan assurances, and PAM and aligned with the existing national policy commitments to ethnic group development in the four project countries. These include participatory assessment and planning with IP and EMGs, outreach to migrants, and disease control campaigns, as well as improved disease reporting and outbreak response, and better access to diagnostic services and hospital treatment of infections.

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[9] Component 1 targets people in border districts, including migrants and mobile populations, vulnerable women and infants, ethnic groups, and in general, poor and people living in remote areas. These populations suffer from a high burden of illnesses and common infections such as malaria, tuberculosis, dysentery, diarrhea, typhoid fever, acute respiratory infections, measles, and parasitic infections. Poverty and economic integration also pushes and pulls these people into professions and habits with high risk of HIV/AIDS and drug resistance. Without appropriate care these diseases result in high mortality, disability, and malnutrition, impact on learning and productivity. In addition, these marginalized high risk people that are not in touch with the public health system also pose a risk for the unnoticed spread of these diseases that may result in outbreaks.

63. The actions in the EGDP (Appendix 3) support integration of IP and EMG needs and interests into Project outputs, and ensure effective participation and access to Project benefits. Measures have been identified to enhance and ensure equitable sharing of project benefits. No negative project impacts were identified that would require mitigation measures, however lack of participation and weak implementation threatens the desired positive impact.

VI. CAPACITY BUILDING

64. The EGDP activities are mainstreamed into project implementation activities which will be implemented by the district and provincial health management and service teams. In order to ensure the EGDP is disseminated and that each level understands the actions and activities proposed under the EGDP and the grievance procedures; and that all understand their corresponding role and responsibilities, pre-start up training for provincial and district managers is recommended.

65. The Project will assist with training and capacity building of MOH/PMU and S/RDs/S/RMUs, including for implementation of the EGDP. This will be supported by the CTA and safeguards specialists, who will particularly focus on Component 1 with most EMG issues. It will be critical for MOH to attract competent mid-career consultants to provide effective capacity building. Training will also be provided for IPC nurses and field epidemiologists, with some orientation towards ethnic minority and migrant concerns. Key features of the EGDP such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, Loan Covenants, and PAM.

VII. INSTITUTIONAL ARRANGEMENTS

66. As the lead agency in the Project, the GDPM will be responsible to the Minister of Health for quality, effectiveness, efficiency of Project implementation within funds allocated. MOH with its assigned coordinating departments have demonstrated acceptable experience with donor funded projects including ADB and World Bank, though there is room for improvement. Vice-Minister CDC will hold quarterly meetings with GDPH and others on invitation to monitor progress, and ADB will be provided minutes of these meetings. It will be critical for GDPM to attract competent mid-career consultants to provide capacity building. However, the government pay scale for consultants is not aligned with current market rates.

67. Provincial Health Departments (PHDs) with assistance of the Provincial Preventive Medicine Centers (PPMCs) will be responsible for implementing the Project in their respective provinces. Each PHD will nominate and ensure performance of focal points for gender and social safeguards, in addition to (i) project coordination and administration, (ii) project planning and monitoring, (iii) technical, and (iv) procurement and accounting. The PHO will also nominate a focal point in each implementing district. PHDs, PPCs, and district and commune staff will be provided with training on implementing the project including the EGDP.

68. GDPM will represent MOH as the Executing Agency and will be responsible for overall project leadership, planning, coordination, supervision, administration, procurement, financial management, and performance monitoring. GDPM, 4 institutes of hygiene and epidemiology and 36 provincial health offices will be implementing agencies. The Deputy Director General GDPM will be the Project Director. MOH will also nominate a Deputy Project Director (Technical and Monitoring) and a Deputy Director (Administration and Finance). The Project Director will report to the MOH steering committee for guidance.

69. The Central Project Management Unit (CPMU) will be established in GDPM and be adequately staffed to manage the project on a day to day basis. A Chief Technical Advisor (CTA), Gender and Social Safeguards Specialist (GSS), a Procurement Expert, and a Laboratory Expert will be among the consultants to be engaged. The CTA and GSS will in particular be assisting with Component 1, which mostly concerns EMGs. Provincial Health Office with assistance of Provincial Preventive Medicine Centers and District Health Centers will manage project implementation at provincial level.

70. The Regional Steering Committee (RSC) established under CDC1 will facilitate regional and cross-border activities including for EMGs and function as the secretariat for the Regional Steering Committee and the project knowledge management team.

71. The Project Director at central level, the provincial health officer at provincial level, the officer in charge of the district health center at district level, and the officer in charge of the commune health unit at commune level will be responsible for implementing the EGDP at their respective levels. They will be assisted by focal points for gender and social safeguards, CTA and GSS, and interested third parties such as the VWU. This entails staff orientation, facilitating the participatory planning process to identify EMG/MEV priorities, facilitating implementation, sharing progress, and monitoring implementation. Linkages will be established with community-based organizations such as VWU and partners such as IOM as needed.

72. Related ADB health projects have shown a steady improvement in EGDP implementation. Project Directors are committed to provide the necessary leadership and inputs to fully implement the EGDP. Key features of the EGDP such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and PAM.

VIII. GRIEVANCE REDRESS MECHANISM

73. Local stakeholders' opinions and concerns will be incorporated in project planning, implementation, and monitoring. Quarterly meetings and consultation with representatives of project beneficiaries including IP and other vulnerable groups will be held. People will be informed on progress and encouraged to raise any concerns. The project representatives at various levels (commune, district, province and central level) will be responsible for reporting any grievances up to the appropriate level. Any complaint will be assessed and negotiated into a solution between the project representative (focal point or IA) and local authorities within a period of 1.5 months, and then fed back to the communities as part of the participatory planning process. If the conflict is not solved amicably, it will be taken to the next level, up to the PMU or MOH Steering Committee under the MOH, each within a period of 1.5 months. Any issue should be resolved within 6 months. The particular activities will be carried out after such conflict is resolved satisfactorily. In cases where affected households (AHs) do not have the writing skills or are unable to express their grievances verbally, AHs are allowed to seek assistance from any recognized local group, NGO, family member, village heads or community chiefs to have their complaints or grievances written for them. Throughout the grievance redress process, the responsible committee will ensure that the concerned AHs are provided with copies of complaints and decisions or resolutions reached. All formal complaints and responses will be made public through the website of the regional cooperation unit, and the ADB website.

IX. MONITORING, REPORTING, AND EVALUATION

74. Monitoring, reporting and evaluation of the project EGDP will follow the overall project monitoring, reporting and evaluation arrangements. PMU and S/RMUs, in consultation with beneficiaries, will ensure that appropriate EGDP sensitive indicators are collected at community and health facility levels. PMU will prepare comprehensive quarterly reports based on agreed indicators as shown in the DMF. The reports will be submitted to ADB within the next quarter. The beneficiaries will also be informed about the project progress. Social Monitoring reports discussing progress in implementing the EGDP will be disclosed on ADB's website.

75. Project evaluation will be carried out in three phases: (i) Project inception: capacity building, participatory assessment and planning, identification of sites, planning implementation details; (ii) Mid-term evaluation: assessment of progress of EGDP implementation and adjustments, after 1.5 years; and (iii) End-of-Project evaluation and impact assessment after 5 years. The inception report, mid-term evaluation and project evaluation will be made available on internet. Each S/RMU will carry out assessment of all training activities, and baseline and end-of-project data collection for assessing trends in the use of CDC services by EMG in border areas under Component 1. No survey will be done: community and health facility records will be used to assess trends. Project evaluation will include an assessment of the effectiveness of EGDP, in terms of enhancing positive impacts. The evaluation will also assess the participation of stakeholders in project implementation. Beneficiaries will be informed about progress through community meetings, brochures, and reports available on the website of the regional cooperation unit and the ADB, and through distribution of brochures.

X. BUDGET AND FINANCING

76. The estimated costs of CDC for vulnerable groups are budgeted under Component 1, at a cost of about $3 million, for regional and cross-border meetings and workshops, mapping and participatory planning with targeted communities, and specific community campaigns and outreach services, part of which will benefit IP and other vulnerable groups in the targeted provinces.

77. The participatory planning process to prepare the detailed project plan and EGDP for each of the targeted provinces is expected to be completed within 3 months. This will include health staff orientation, collection of health services statistics, mapping and participatory assessment of IP and other vulnerable groups, and meetings and consultations. The EGDP will be incorporated in the five year and project implementation plan and budget. About half of the budgeted amount for Output 1 is expected to directly benefit IP. IP will also benefit -related training and communication activities will be incorporated into general project training and communication activities.

Appendix 1: Information on Vulnerable Groups

The GMS is an increasingly interlinked geographical and economic region that shows remarkable ethnic and social diversity. Historically, it has seen successive dynasties, migrations, conflicts, and occupations, but despite this intermingling has retained distinct populations and EMGs. While some of the EMGs are original inhabitants, others migrated later from neighboring countries, either by conquest or to lands traditionally less populated, in particular the highlands and mountains, and habitats rive with endemic diseases. These EMGs maintained practices and customs from their homeland, and adjusted in various ways to their new surroundings. Remarkably, many of these EMGs have remained isolated and homogenous, even when adapting to new economic opportunities in agriculture, tourism, trade and migrant labor. Many EMGs in the GMS are trans-border people, and form a major part of the population in some parts of Cambodia, Lao PDR, Viet Nam, and Myanmar.

Road construction is rapidly improving regional and local connectivity, opening up new areas and creating economic corridors and employment. Settlements along these roads attract entrepreneurs and migrants. Immigration and trade agreements stimulate the flow of people and goods between countries. Tourism promotion and increased wealth add regional travel and demand for services. These economic developments accelerate social change, and are likely to have both positive and negative impacts on health.

More recently, rapid expansion of plantations and industrial zones with labor opportunities in areas traditionally settled by EMGs have caused rapid transition in terms of changing social structures, labor, consumption, and exploitation. While some EMGs have benefited from new economic opportunities, many have difficulty adjusting, at times with serious consequences such as new poverty, malnutrition, and diseases. Communicable diseases are a major concern, both in terms of new behavior, such as increasing risks of TB and HIV, and habitat, such as increasing risk of malaria and dengue. Furthermore, lack of knowledge of diseases and access to services make them prone to spreading diseases, including EIDs.

Migrants, ethnic and other vulnerable groups (MEVs) in border areas are more likely to be exposed to different types of infectious diseases, and vary by occupation and location. MEVs may also be less willing to access services due to lack of awareness, financial hardship, illegal labor, addiction, and lack of rights. Cross-border migrant workers with HIV or TB may not be able to continue treatment. There are two major child rights issues: youth are particularly vulnerable for exploitation resulting in HIV and STIs, and may have less access to services. Pregnant women are also more vulnerable to infectious diseases, and may pass HIV and other infections on to their children.

Providing effective CDC will help to improve health, child protection, better learning in school, economic productivity, and poverty reduction, all highly prioritized by Government. Better connectivity, urban development, social and environment changes all continue to facilitate the spread of infectious diseases in the region, and require effective and sustained regional and cross-border information exchange and cooperation on CDC to control them.

In the GMS, public and private health services reach a large part of the population. While Viet Nam is also focused on providing services to the general public, MEV and others not reached by the formal health service continue to be at risk of infections, including possible drug resistant infections. As health status improves, the impact of those not reached by the health system becomes relatively larger, and it will become more cost-effective for the government to develop ways to reach these groups, at a higher unit cost.

Access to the public health system is less than satisfactory (such as unaffordable service fees, complicated procedure on health insurance, poor service quality) in about 300 poor and often mountainous border districts. The population in these districts includes ethnic groups and migrants from other districts, and mobile people working cross-border. While these people have a higher disease burden and may sustain the spread of infections, their access to health services is less due to the aforementioned factors.

Public and private health services efforts to reach MEV face a range of challenges, including poor living conditions and services in these areas, language barriers, market failure. Government regulations that limit adequate compensation for health workers (e.g. unaffordable allowances, inadequate provision of training and refresh training), and in general, lack of trained people, many of whom migrate after education. Hence, special arrangements are needed to reach these people, often requiring a more multi-sectoral and partnership approach. This should be done as soon as possible to help the health workers continue to dedicate to their works by providing more allowance and refresh training.

Table 1 summarizes the demographic, economic and social environment in the four Project GMS countries, which provides the context for EMGs. In Viet Nam, EMGs in the northern mountains and the majority Kinh from the red river delta and other places have been encouraged to move to the central highlands. Some EMGs (e.g. Ba Na, Gia Rai, E De) in the central highlands have been relocated (mainly in Dak Lak, and Gia Lai, Lam Dong) to make place for major rural developments (Yaly Hydro-power plant, Da Nhim Hydro-power plant, coffee and rubber plantation). This has contributed to impoverishment of some of these groups, and associated health problems. Non-immune migrants moving to forested areas have also contributed to the re-emergence of malaria in those areas. Injecting drug use among EMGs is also contributing to the HIV epidemic.

Lao's EMGs are closely related to those of Viet Nam, and both Cambodia and Lao are attracting migrants from Viet Nam, including skilled workers, farmers, and farm laborers for rapidly developing services, industries and plantations. Even so, the total number of external migrants is small for Viet Nam, in particular compared to internal migrants, each of which includes a high proportion of EMGs that may have less access to supportive services and health insurance. However, specific data are lacking. Some EMGs still live in isolated locations in the region, but most are exposed in one way or another to developments at home and abroad, which bring opportunities in terms of trade and labor, and risks in terms of social instability, diseases and drugs. Mobility and migration of EMGs are therefore a major concern in the context of regional health security.

A remarkable feature is the low median age of populations, in particular in the Lao PDR. Also in Viet Nam, either for employment or as a result of exploitation, minors below 18 migrate internally, often to contribute to the family income as child labor. In addition, as shown in several UN studies, a large proportion of external migrants are below 18 years of age, but reportedly less so than in other GMS countries. These minors are especially vulnerable to all kinds of exploitation, and those returning home may have less access to health services. Child migration and its consequences is a serious child rights issue which is not receiving adequate attention in the health sector. Another concern in Viet Nam is the high male female ratio, suggesting, among others, gender-based selective abortion.

Table 1: Key Demographic, Economic and Social Indicators in the GMS

Indicator (latest available, 2013–2015)	Cambodia	Lao PDR	Myanmar	Viet Nam

Indicator (latest available, 2013–2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Population below 15 years	31.1	34.7	24.5	23.2
Median age in years	24.5	19.3	28.5	29.6
Sex ratio (% m/f)	95	99	94	112
Population growth rate (%)	1.8	1.9	0.8	1.0
Population density per square kilometer	85	29	79	279
Urban population (%)	20.5	37.6	33.6	33.0
Urban growth rate (%)	2.7	4.9	2.5	3
Per capita income in US$	1008	1589	1184	1868
People below $1.25 per day (%)	19	23	26	13
Unemployed as % of labor force	0.3	1.4	3.4	2.0
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	Na	1.184	11
Tourist arrivals (1,000)	4.200	2.500	2.000	7.500
Mobile phones subscribers/100 persons	134	66	12.8	131
Internet users estimate (% population)	6	13	1	44
Primary/Secondary GER f/m	81/89	76/82	79/78	89/87
Contraceptive prevalence rate (%)	51	50	46	78

Source: UN Statistics Division, 2013-2015

As table 1 above illustrates, there are related developments which may be both beneficial and harmful to ethnic groups, migrants and minors including the rapidly expanding labor market and increasing per capita income, increasing cost of living, increasing demand for products and services, tourism, and increasing popularity of internet and mobile phones.

Several studies of the World Bank, UN, and other agencies have documented that ethnic groups and migrants, have on average less income, are more often poor and very poor, have less access to health services, and have worse health indicators, as illustrated in tables 2 and 3. Data comparing ethnic groups with similar residence is not available.

Table 2: Poverty Headcount by Ethnic Group in Viet Nam

	Kinh-Hoa	Khmer-Cham	Tay-Thai-Muong-Nung	Other Northern Upland EMGs	Other Central Highlands EMGs
Poverty Headcount %	13.5	34.6	45.2	72.4	73.6
As share of population %	15	70			

Source: Bauch et all, 2009.[10]

[10] Viet Nam Academy of Social Sciences. *Poverty reduction in Viet Nam: Achievements and Challenges*. Hanoi 2011.

Table 3: Health Disparity by Ethnic Group in Viet Nam

Indicator	Kinh	EMGs
Child mortality	21	39
Received skilled birth attendance	96	46

Source: WHO[11]

In Viet Nam, the gaps in poverty and health indicators are actually widening.[12] This is not unusual for a country in transition, with uneven distribution of economic development whereby urban and industrial zones move ahead, and the Government, recognizing this, has brought a range of policy directors and investments to address this[13]. It is expected that, with increasing education and economic participation of ethnic groups, economic gaps among ethnic groups will reduce, but that inequity will increase between income groups.

Increasing mobility and affluence will also increase the risk of communicable diseases, and some ethnic groups are ill informed about these risks, or may have customs which obstruct prevention of diseases. In certain traditional communities, for example, there are fears that vaccination of children will lead to infertility. Tracking recent outbreaks of polio, it was found that some Hmong communities have extremely low vaccination coverage. Similarly, it was found that migrants have higher levels of HIV and TB infections.

In summary, EMGs have higher levels of poverty, higher mortality rates, and burden of communicable disease than the majority populations. Use of health services is mostly lower including for vaccination. Political conflict, geographical and social isolation, language barriers, traditional customs, and poverty have contributed to the disparities between EMGs and majority ethnic groups and need to be taken into consideration when preparing project interventions.

While migration carries additional health risks and problems such as drug addiction, overall it has been a major force for poverty reduction in the region. Studies show that ethnic groups are left behind mainly due to lack of economic opportunity, e.g. lack of quality agricultural land and access to markets due to geographical isolation, social exclusion, and lack of credit[14]. The problem relates to the nature of migration, often illegal, or with misinformation about salary and labor conditions, and sometimes confinement, coercion and sale of migrants. Studies show that migrants often live in very cramped conditions, with six people or more sleeping in one room.

A WHO SEARO report divides mobile and migrant populations (MMPs) broadly in three mobile groups: (i) those affiliated with an employer, including semi-mobile employees and seasonal farm workers; (ii) those affiliated with the government, including military, security personnel, and border guards; and (iii) non-affiliated, including ad hoc laborers, new settlers, highly mobile laborers and short-term migrants[15]. While all these groups need to be targeted with basic public health interventions, the first two groups are organized and therefore, in principle, easier

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[11] Malqvist M et al. in Bulletin of the World Health Organization. *Maternal health care utilization in Viet Nam: Increasing Ethnic Inequity*. Geneva. 2013.

[12] Hai-an Dang, World Bank. *Indigenous Peoples, Poverty and Development.* Chapter 8: A Widening Gap for Ethnic Minorities. 2010.

[13] World Bank. *Poverty Reduction in Viet Nam. Achievements and Challenges.* 2010.

[14] http://siteresources.worldbank.org/EXTABOUTUS/Resources/Gender.pdf.

[15] WHO SEARO. *Vector control and personal protection of migrant and mobile populations in the GMS: A matrix guidance on the best options and methodologies*. New Delhi. 2015.

to access. However, experience shows that it is also difficult to access organized groups of migrants working in plantations, casinos, and factories. While laws and policies are in place to reach these people, usually through the Ministry of Labor, they lack sufficient quality and quantity of inspection and migrant access to services, and require special arrangements with agreements between those in charge. For non-affiliated, often illegal migrants including ethnic groups and minors, it is even more difficult to encourage them to use public services. Grassroots organizations and NGOs can play a major role in this field. Viet Nam has so far shown little recognition of this potential resource.

Three east-west corridors and one multi-limbed north-south corridor represent four distinct geographical clusters of MEV issues, as shown in table 4. The north-south corridor connects major industrial areas in China with similar production areas in Viet Nam, Lao PDR, Cambodia, Thailand, and Myanmar.

Table 4: Geographical Clusters along Economic Corridors

Cluster and Corridor	Main Ethnic Groups	Ethnic Group Characteristics	Implications
Cluster 1: Northern corridor: Viet Nam North, Lao North, Myanmar- east, Myanmar- east, Thailand- north-east	Large ethnic minority populations, in particular originating from China; Includes the Hoa and Hmong	Relatively isolated, self-sustaining highland groups with high burden of HIV, respiratory infections and other common infections, at risk of epidemics through trade, less accessing health services	Some border districts are hard to reach based on government conditions, but these highly remote people may also be less at risk of epidemics. Focus on accessible hotspots for outreach services, community workers.
Cluster 2: Central corridor: Viet Nam Central, Lao-south-central, Cambodia north-east, Thailand north-east, Myanmar-central	Large ethnic minority populations, including large indigenous Mon-Khmer and related groups and migrants from northern areas	Relatively isolated, traditional, poor and less educated highland groups and migrant workers, with high burden of common diseases, at risk of epidemics of malaria and dengue and less accessing health services	Border districts may be more accessible but face political problems. Focus on providing (ethnic minority friendly services[16] at health facilities, free services, and community workers
Cluster 3: Southern corridor: Viet Nam-south, Cambodia south- east to north-west, Thailand east to west, Myanmar-south	Largely inhabited by non-ethnic minorities including Kinh, Khmer, Thai and Burmese. Has large migrant and Muslim populations	Largely integrated populations, better educated, mainly living in lowlands, industrial zones, high burden of dengue, diarrheal diseases, more timely reporting of diseases and accessing services	No need for special services for ethnic minorities. Needs special care for illegal migrants by providing them information and access to free health services.
North-South Corridor: China-south to major cities in the GMS	Mainly passes through non-ethnic minority populations except when passing through Cluster 1 corridor	Mostly migrant ethnic groups providing unskilled labor and other services along the economic corridors	No need for special services for ethnic minorities. Needs BCC and services for migrant workers in hotspots, factories, casinos and labor camps.

[16] From the "Second Health Care in the Central Highlands Project" - Project No.44265, IPP document, para 51 shows that: i) Some ethnic people disagree with using the examination room for both men and women, because they think the examination is private. A mutual usage may cause them to feel ashamed, shy or even humiliated, ii) In clinical practices, the patients have to expose a part of or the whole of their bodies to be examined or to experience medical techniques, then the design of windows, door, construction materials should be appropriate with the facility but should ensure the privacy, iii) Some ethnic groups even think the direction of the facility and the door should be appropriate with indigenous culture, thus, before the construction of the new facility, there should be a survey of cultural feature and a meeting with the representatives and indigenous people to seek for an appropriate solution.

Primary targeted provinces/ states/ regions in CLMV countries and neighboring states and provinces in China and Thailand are listed in Table 5 below.

Table 5: Targeted Provinces/States/Region and Neigboring Provinces

Cambodia	13	Pailin, Battambang, Banthey Meanchay, Preah Vihar, Stung Treng, Rattanakiri, Mondulkiri, Kratie, Kandal, Tbong Khmum, Prey Veng, Svey Rieng, and Kampot Provinces
Lao PDR	12	Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu and Champasack Provinces
Myanmar	6	Shan North, Shan East, Kaya, Kayin, and Mon States, and and Tanintharyi Region
Viet Nam	36	Quang Ninh, Lang Son, Cao Bang, Ha Giang, Lao Cai, Lai Chau, Dien Bien, Son La, Thanh Hoa, Nghe An, Ha Tinh, Quan Binh, Quan Tri, Thua Thien, Quan Nam, Kon Tum, Gia Lai, Dak Lak, Lam Dong, Dak Nong, Binh Phuoc, Tay Ninh, Long An, Donh Thap, An Giang, Kien Giang, Bac Lieu, Sok Trang, Tra Vinh, Ben Tre, Ba Ria, Thai Binh, Hai Phong, Yen Bai, Tuyen Quang and Bac Kan Provinces
China	1	Yunnan Province
Thailand	12	Mae Hong Son, Chiang Mai, Chang Rai, Phayao, Buen Khan, Nhakon Phanom, Udon-Ratchatani, Sa Kaew, Tak, Kanchanaburi, Ratchaburi and Phetshaburi Provinces

Within these provinces/ states, border districts/ townships will be selected which have ‘hotspots’ along economic corridors with high burden of communicable diseases and low CDC coverage in MEVs. Selection criteria will also consider local commitment, presence of partners, and cost-effective reach, with impact on these MEVs. The Public Health Offices and Provincial Preventive Medicine Centers will need to conduct the selection process after initial orientation. Plans will need to be included in provincial annual operational plans, approved at higher level, and investment sustained from local sources in subsequent years.

EMG populations living near regional economic corridors bear a disproportion burden of the health costs of the rapid social and economic changes created by these developments. Relocation and/or resettlement of EMGs have been supported by governments and donors in CLMV for various reasons. In some provinces, movements of highland EMGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas.[17]

When highland-dwelling EMGs move to lower altitudes, they are exposed to malaria, to which they have little acquired resistance, so in the early phase of relocation to lower altitudes, there

[17] Gebert, R. 1995. *Socio-economic baseline survey*. Muang Sing: GTZ Integrated Food Security Programme. Cohen, P.T. 2000a. "Lue across borders: pilgrimage and the Muang Sing reliquary in Northern Lao PDR. In G. Evans, C. Hutton and Kuah-Khun Eng (eds.) *Where China Meets Southeast Asia: Social and Cultural Change in the Border Region*. Singapore: Institute of Southeast Asian Studies. Cohen, P.T., 2000. "Resettlement, opium and labor dependence: Akha-Tai relations in Northern Laos", *Development and Change*, 31:179-200. Romagny, L. and Daviau, S. 2003. *Synthesis of Reports on Resettlement in Long District, Luang Namtha province, Lao PDR*. Action Contre La Faim mission in Lao PDR. Lyttleton, C. 2005. "Market-bound: relocation and disjunction in northwest Lao PDR". In Toyota, M., Jatrana, S., and Yeoh, B., 2003 (eds.) *Migration and Health in Asia.* Routledge. Alton, C. and Houmphanh Rattanavong, 2004. *Service Delivery and Resettlement: Options for Development Planning*, unpublished report, UNDP: Lao PDR, Vientiane. McCaskill D. and K. Kampe (eds.) 1997. *Development or Domestication: Indigenous Peoples of Southeast Asia* Chiang Mai: Silkworm Press.

have been high mortality rates from malaria, as well as morbidity resulting from exposure to other water-born and environmentally-related infectious diseases.

EMG populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.

Some EMGs may use health services, when they are available, only as a last resort. This may be because of lack of experience but also reflects anxiety about modern health services and expense of accessing them. Shifting cultivation practices also limit the opportunities to access the health service for some EMGs, especially women. EMGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel ashamed and reluctant to access services, and numerous reports of belittling treatment of EMGs by government health workers were shared informally during the field research. Programs aiming to promote behavior change (e.g. building and using latrines, drinking boiled water, removing disease vector breeding sites, hygienic management of animals, hand-washing, using bed nets, and acceptance of vaccination) are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EMG villages.

Provision of free health insurances has enabled poor EMGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered by the health cards. An International Organization for Migration (IOM) program on the Thai-Cambodia border found 127 cases of TB when screening deportees, with about 3% of migrants returning from Thailand to Lao PDR testing positive for HIV. A major problem is that these returning migrants do not get pre-screening nor do they have access to treatment in Lao PDR or Cambodia, so they have to try to return to Thailand to continue treatment. Default rate is high, leading to drug resistance.

In summary, most EMGs in GMS border areas can no longer be thought of simply in terms of disadvantaged due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. In most cases, EMGs are beginning this process of integration from a very disadvantaged position.

Although EMGs are more likely have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EMGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The disparities are highlighted in country specific data showing that provinces with high infant and child mortality rates also have high concentrations of EMGs. Surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by health centers and hospitals. Therefore, most epidemiological data, unless based

on special surveys, is not ethnically sensitive. Table 6 uses some proxy indicators comparing health status of EMGs with the general population:

Table 6: Health status of MEV use of Health Services compared to General Population

Indicator (latest available)	Viet Nam
Population (millions)	92.5
Ethnic minority population (%)	14
Internal migrants per year (1,000)	1.400
Estimated external migrants (1,000)	68
Refugees (1,000)	11
Child mortality general population	21
Child malnutrition in Kinh %	15
Child malnutrition ethnic minorities %	34.2
HIV cases in youth below 18 years	5300
HIV cases in antenatal women	77000
HIV prevalence among sex workers %	3.0
Tuberculosis prevalence general population %	1.45
Skilled birth attendance Kinh %	96
Skilled birth attendance EMGs %	46
Complete Basic Immunization Kinh %	95
Complete Basic Immunization EMGs %	85

Sources: Viet Nam Economic and Development Strategy Handbook, 2004; BWHO National Survey of Tuberculosis Prevalence 2010; SEAJTM Prevalence of Tuberculosis in Migrants 1996 HIV data from UNAIDS 2014 report

The project design will need to include special strategies to reach these MEVs, and budget allocations that take into account the factories and casinos expected to provide medical services, and which may not include MCH care. The provincial health office also has less authority over these establishments. Hence, the project design will support the development and harmonization of strategies where appropriate. The project will support implementation through CDC activities in border areas, as per output 1.

Governments have demonstrated strong political commitment to containing EID, including establishment of policies and plans, but substantial and sustainable financing is still lacking, while priorities shift to non-communicable diseases, and to a lesser extent CDC.

APSED provides a strong strategic framework, but weak on implementation, and spread over many departments within MOH. One option is to integrate APSED into system strengthening and health sector planning and budgeting in general, to provide more of a program approach. In any case, health security depends on overall health systems capacity, and should not be managed separately. At a second level, it is important to develop one strategic approach in the GMS, or at least alignment of country programs, which will help strengthen each country’s efforts. In this context, the Project can play an important role, and hopefully the four Project countries will agree to cooperation and adopt a common but country-specific approach.

APSED implementation, which is evaluated each year, provides a strong monitoring framework for overall Project progress, but lacks a plan to roll out various strategic areas. Based on APSED self-evaluation, major gaps include: (i) surveillance and response in groups outside the reach of regular services; (ii) risk analysis and communication; (iii) laboratory services and biosafety; (iv) infection prevention and control in hospitals; and particular (v) inter-sectoral,

cross-border and regional cooperation. These will be assessed further for possible project support.

In the past, ADB has engaged in many subsectors including HIV and malaria control, control of dengue, surveillance and response, laboratory services and regional coordination and knowledge management, and less involved in hospital, market infection, and TB control. Guidance is needed on whether ADB support should consolidate, target certain subsectors or strategic areas, or follow more of a system building approach. Is there scope to explore further during project implementation? How does current project design accommodate this concern?

Large groups of MEVs are basically unknown to Provincial health officers who may not know the actual population of MEVs in their province as a basis for budgeting and services. Migrant workers in factories and casinos are supervised by other ministries, and receive limited work place care, but not necessarily CDC. Hence, multi-sectoral cooperation is needed to improve surveillance and response. Tracking systems should be put in place for all migrants and visitors, and to check for infections. Illegal loggers who are at higher risk of, and spreading drug resistant malaria, are not captured by formal registration systems, and therefore need to be tracked using other means. Specific gender issues affecting access also need to be considered, in particular for women's empowerment to take decisions as the typical caretaker in case of illness.

Border populations often speak different languages from the majority population. Those who have attended school may speak Vietnamese, but adults (particularly women) do not, and are unlikely to read and write. They have different customs and beliefs to the mainstream populations of the country, which is likely to influence their perceptions of illness and health. Few health workers are from EMG because of their generally lower levels of education. Where village health volunteers are engaged in the district health service, they are predominantly male.[18] Accordingly, there are challenges in communicating information on CDC effectively, especially to women who are key targets for CDC information.

A large number of HIV/AIDS and TB cases go undetected. Despite Global Fund (GF) support, funding is insufficient to treat even known cases. As GF scales down, domestic budgets have increased, but not enough. As mentioned above, EID are also seriously underfunded with health and economic implications. Sustainable solutions for recurrent cost financing are needed. Governments recognize the need for regional public goods and goods with externalities. However, loan funds for hardware like infrastructure, vehicles, and equipment are preferred. It will be important to demonstrate economic returns of this Project, which is complicated by the uncertainty of EID risks.

[18] Except in Cambodia where it is policy to appoint one health worker of each sex.

MAP VIET NAM WITH PROJECT PROVINCES

Appendix 2: Ethic Group Development Plan Consultation

Note: Stakeholder meetings, workshops, and assessment and disclosure of social impacts and mitigating measures were held from 3–16 October 2015. Meetings with MOH departments, other ministries, partners, and other stakeholders were held from 6–8 October 2015.

Topic	Questions	Responses	Proposed action
Ministry of Health*			
Health Plans	Are policies for ethnic groups and migrants adequate?	All people have access to health care. Health services for EMGs and migrants are the same as for other people. Not enough legislation for MOH supervision of the workplace.	MOH to work with MOJ to improve legislation
	Are national plans addressing needs of ethnic groups and migrants?	The Government gives priority to poor districts where many EMGs live. Through poverty reduction, health and education programs EMGs receive considerable support. No specific plans for migrants' health	MOH to address this. Project can assist with improving provincial annual plans
	Are there legal barriers?	MOH has insufficient authority to inspect workplaces for migrants and non-migrants	MOH to address
	What are planning issues for ethnic groups and migrants in regional CDC?	Not enough understanding of issues of EMGs, lack of information of conditions and health problems of migrants, and no migrant health policy	DPHIS to improve information collection
	Is investment in CDC addressing the needs of ethnic groups?	EMGs live in remote places where there is less access to health services, needs more effort	The project will make more funds available
	What could be negative impact of a regional CDC project on ethnic groups and migrants?	Promising services that don't materialize	The project should be well managed
	Are Government and partners active in regional CDC?	Government participates in regional events but cross-border work needs to be stepped up	The project will make funds available for cross border work
	What would be major constraints for CDC in border areas?	The main problem is access, especially during rainy season. Funding is also insufficient to expand CDC to hard-to-reach group. A third problem is posting health staff to rural areas	The project will make funds available for outreach services

Topic	Questions	Responses	Proposed action
Health Status	Is the specific health status of ethnic groups and migrants known?	Data are not collected by ethnic group, some small studies suggest that EMGs suffer more from usual infections like malnutrition, pregnancy complications, pneumonia, diarrheal diseases and tuberculosis	DPHIS to improve data collection system for universal health coverage
	What explains the poor health status of ethnic groups and migrants?	The main problem is poverty. The second is EMG's backward custom and culture. The third is the poor	Target the poor communities in the project area
		accessibility to health services due to difficult and remote geographic condition. EMGs are increasingly informed and ready to use health services as well as traditional health care	
	Are ethnic groups and migrants more prone to epidemics?	Hard to say, migrants probably, remote ethnic groups are self- sufficient and isolated but some may engage in cross-border trade	DPHIS to improve data collection system
Health Services	What are the problems of providing health services for ethnic groups and migrants?	Mainly problem of resources: access, staff, and funds for operations.	The project can link communities with services, but not scale up services
	Are health services affordable for ethnic groups and migrants?	Travel cost is high. Poor EMGs have special card for free health care but often still need to pay out of pocket due to lack of medicines	No project subsidy will be provided for the poor, only information, screening, and referral
Provincial Health Departments			
Health Plans	Are EMGs and migrants specifically referred to in plans?	Reference is made to both groups but there are no specific plans for EMGs. Migrants health is an issue under consideration	The project will help to improve plans
Health Status	Occurrence of epidemics	Mainly food poisoning and dengue, some zoonotic cases	The project will improve the surveillance system
	What are the specific health problems of EMGs and migrants	EMGs have same old diseases as Khmer, but maybe more because of poverty and poor hygiene. Migrants are more at risk of HIV/AIDS	The project will help assess health problems
Health Services	What are the major hurdles for ethnic groups and migrants to access services?	For EMGs probably high cost of travel, for migrants perhaps company restrictions.	The project can't address this, only indirectly through legislation

Topic	Questions	Responses	Proposed action
	For those who can't pay out of pocket, are there arrangements?	Yes, free health care card, but may still have some out of pocket payment	The project can facilitate accessing health cards
Health Monito - ring	Are health and health services data split by ethnic groups and migrants?	No	DPHIS is considering this
Health Center Staff			
Health Plans	Are you aware of any special arrangements for EMGs and migrants?	No, but many migrants in factory workers don't use public health services, they go to factory clinic	MOH to address this issue
Health Status	What do you see as the major health problems of ethnic groups and migrants?	Common infections, high blood pressure, diabetes, and complications of delivery	The project will help collect information on health problems
	Do you think HIV and TB are higher or lower among ethnic groups and migrants?	Don't know, but HIV higher among sex workers, who may be migrants from Viet Nam, China or upcountry. TB perhaps higher in old people.	As above
Health Services	Are ethnic groups and migrants using these health services as others?	Factory workers have less access to health services. There are no remote ethnic groups here, all have access	MOH to address legal access issues
	Are there specific access problems in the provision of health services to ethnic groups and migrants?	All people have access to health services. Foreigners have to pay.	The project to help examine out of pocket payment
	Are there language problems?	Sometimes with Vietnamese and Chinese speaking people, but they go to their own private doctors	
	Are there affordability problems?	No, people can pay for medicine	As above
	Any other problems?	Lack of ambulance for emergencies, lack of staff for 24 hour services	The project will provide ambulances
		Village Headmen	
Health Plans	Are you involved in discussions to improve health services?	Attends village health group meetings	The village health group will be engaged in planning
	Do you think plans are appropriate for the local community?	Health services are improving, still insufficient resources for health center	MOH is preparing for a new HSP3 to support this

Topic	Questions	Responses	Proposed action
Health Status	What do you see are the major health problems in your community?	Delivery, road accidents, and common health problems	The project will provide an ambulance for emergencies
	Did you have any major epidemics?	Usual common diseases, Dengue	The project will improve reporting, outbreak response, and community preparedness
	Are TB and HIV major health problems?	Few cases	The project will help screen and refer suspected cases
	Are there specific groups more at risk?	Road accidents common among young people, pregnancy complications	The project will provide an ambulance
Health Services	What are the good parts of the health services?	Improved staff and medicines	
	What parts of the health services would you like to see improved?	Ambulance	As above
	Are health services affordable for the poor?	Still need to pay extra for medicines, some people can't afford	The project will examine and report this matter
Patients			
Health Status	What is the reason for your admission?	Became ill	
Health Services	Do you find the hospital clean, can you get clean water and toilet?	Mostly clean	
	From how far did you travel?		
	Are you happy with the quality of care?		
	Are health services affordable?		
Female and Male Community Members			
Health Status	What are main health problems in your community?	Malaria, diarrhea	
Health Services	Are health services adequate?	Yes, same for both men and women	
	What is availability and attitude of staff?	Not always available	

Topic	Questions	Responses	Proposed action
	Are medicines available?	Not really, only simple medicines	
	Other issues?		
		Partners**	
Health Plans	What are planning issues for ethnic groups and migrants in regional CDC?	Lack of information, no specific targeting, difficult to access EMGs in remote areas and to legal issues to reach migrants in factories	MOH/DPHIS will examine this and propose legislation and investment
	Is investment in CDC addressing the needs of ethnic groups and migrants?	Insufficient policy and funds	As above
	Are there legal issues for ethnic groups and migrants?	MOH can access factories and casinos for outbreak invitation but not routine inspection, MOL has a narrower agenda	As above
	What are major gaps?	MOH inspection of workplaces	As above
Health Status	What is the HIV and TB status among ethnic groups and migrants?	HIV likely higher among migrants because of lifestyle but no data available. TB is higher in poor people, diabetic, prisoners,	As above
	Is the surveillance system reaching ethnic groups and migrants?	Yes, but factories and casinos need to report to do self-reporting to provincial health office and MOH for investigation	CDCD is considering how to improve the surveillance system in workplaces
Health Services	How is access to health services for ethnic groups and migrants?	EMGs have same rights and free health care but access in remote areas less. Factory workers need permission to access services	MOH/DPHIS will examine this and propose legislation and investment
	What is the government capacity in providing services to ethnic groups and migrants?	Problems of staff availability in rural areas. Factories are usually in locations with good health services, migrants can access if permitted during working hours	MOH/DPHIS will examine this and propose legislation and investment
	What works better in reaching ethnic groups and migrants?	For remote areas, it might be better to contract out services to NGOs, or provide additional resources to provide services	MOH has not agreed to do contracting out for this project

*DPHIS, CDCD, DHS, NIPH, TB and HIV/AIDS programs
** IOM, WHO, USAID

Appendix 3: Ethnic Group Development Plan

Project Outputs	Sub-outputs	Ethnic Groups' Design Features/Activities	Performance Targets/Indicators
Output 1: improved GMS cooperation and CDC in border areas	1.1. Improved regional, cross- border and inter-sector cooperation 1.2 Enhanced knowledge management and community of practice (COP) 1.3 Increased access to CDC in border areas, in particular for vulnerable groups such as migrants, HIV positive youth, pregnant women, and isolated ethnic minorities.	Enhance participation, capacity building and decision making opportunities for representatives of EMG in regional, cross-border, and inter-sectoral events (continues throughout project) Use workshops for EMG advocacy and increasing EMG awareness among workshop participants and stakeholders/governments. (continues throughout project) Ensure full participation of EMG staff for outreach activities using EMG-sensitive education and care procedures. Project staff responsible for the implementation of EGDP. And they will develop this with the assistance of the project consultants in charge of EGDP. (continues throughout project) Proactively target EMGs at increased risk of infectious diseases with CDC activities in border areas. (continues throughout project)	Participation of EMG representatives in all these events (baseline unknown). Workshop materials clearly demonstrate mainstreaming of EMG issues and promotion of EMG-sensitive strategies. Participation of IP staff in outreach activities. Decreased prevalence of infections among EMGs in border areas based on health statistics.

Output 2: strengthened national disease surveillance and outbreak response systems	2.1 Strengthened surveillance 2.2. Strengthened response	Collect, analyze and report EMG-disaggregated data. (continues throughout project) Ensure participation of EMG staff in any outbreak response teams. (first year of project) Increase participation of EMGs in field epidemiology training. (continues throughout project)	EMG disaggregated reporting for CDC project activities in each country. In districts with over 20% IPs, each outbreak response team has at least one EMG staff. Of participants in field epidemiology training, at least 5% are EMG in Cambodia, 30% in Lao PDR, 30% in Myanmar, and 10% in Viet Nam.

Project Outputs	Sub-outputs	Ethnic Groups' Design Features/Activities	Performance Targets/Indicators
Output 3: improved laboratory services and hospital infection prevention and control	3.1 Improved laboratory quality and biosafety 3.2 Improved infection prevention and control in hospitals	Ensure representative EMG participation in laboratory training programs for districts with large IP population. (continues throughout project) Ensure representative participation of EMGs training in hospital infection prevention and control. (continues throughout project) Ensure EMG sensitive facilities - in isolation wards (continues throughout project)	Representative participation of EMGs laboratory management and quality assurance training programs Representative participation of IPs in hospital infection and control training. All repaired isolation wards provide arrangements for EMGs

Project Management	3.1 Ensure Integration of project activities in regular services 3.2 Improve efficiency and governance	All implementation plans for specific project activities and annual operational plans (AOPs) supported provinces address gender and EMG dimensions of project activities (continues throughout project) All implementing agencies have an EMG focal point (continues throughout project) All quarterly reports report on progress in EMG issues (every quarter) At least 50% of consultants have experience working with EMGs. (continues throughout project)	Proportion of project implementation plans and AOPs that address IP dimensions adequately. Proportion of active focal points in implementing agencies (based on participation in events. Proportion of quarterly reports that report on EMG issues. Proportion of consultants with EMG experience.

Appendix 4: Viet Nam Ethnic Minority Groups[19]

Viet Nam has 54 recognized ethnic groups considered indigenous who migrated hundreds of years ago to Viet Nam, originating mostly from South-east Asia, and small recent exogenous groups (table 1). There are three major language families, Austro-Asian Language Family, Austronesian Language Family and Sino-Tibetan Language Family.

There are 8 recognized language groups:

- (i) Viet-Muong Group: Chut, Kinh, Muong and Tho, the ethnic majority;
- (ii) Tay-Thai Group: Bo Y, Giay, Lao, Lu, Nung, San Chay, Tay and Thai;
- (iii) Mon-Khmer Group: Ba Na, Brau, Bru-Van Kieu, Cho-ro, Co, Co-ho, Co-tu, Gie-trieng, Hre, Khang, Khmer, Kho Mu, Ma, Mang, M'Nong, O-du, Ro-mam, Ta-oi, Xinh-mun, Xo-dang and Xtieng;
- (iv) Mong-Dao Group: Dao, Mong and Pa Then;
- (v) Kadai Group: Co Lao, La Chi, La Ha and Pu Peo;
- (vi) Malayo-Polynesian: Cham, Chu-ru, Ede, Gia-rai and Ra-glai;
- (vii) Han Group: Hoa, Ngai and San Diu;
- (viii) Tibeto-Burman Group: Ha Nhi, La Hu, Lo, Phu La and Si-la.

These groups overlap with ethnic group in Cambodia, China, Lao, Myanmar and Viet Nam. For example, Cambodia has Khmer as the main ethnic group, Chham, and Mon-Kmer in the north-east of Cambodia bordering Viet Nam and Laos. Laos, with mainly Lao, has many Kinh, Lu, Mon-Khmer, Khmer, Kho Mu, Hmong, Thai and related Shan, and recent Tibeto-Burman migrants. Although they speak different languages, the ethnic groups live close to one another and can often speak other languages through everyday relations. While they are involved in daily cultural exchange, they however tend to retain their own identity, culture and customs.

Most Vietnamese are farmers accustomed to the distinct ecological zones in which they live including the cold northern mountains, the seasonal red river delta, the dry central coastal strip prone to typhoons and floods, the temperate central highlands, and the tropical Mekong delta. In the lowlands, where most Kinh live, people grow wet rice and build village culture on the background of communal houses, wells, banyan trees and green bamboo groves. In the midlands, there are many ethnic minority groups that live in houses on stilts and develop terraced fields for dry crops, especially corn, and fruit and spice trees. In the northern mountains and the central highlands, people clear and burn jungle patches as a method of farming in the pre-industry age. With a mostly sub-tropical climate, multi-cropping is carried out to prevent soil erosion.

The Kinh and most other ethnic groups share many common beliefs and customs, including ancestor worship, respect for house and property, care for family and children, and hard work. In terms of ownership of assets and marriage customs, Kinh and some ethnic groups are patrimonial, other ethnic groups are matrimonial. While communism and legislation has emphasized equal rights for women and men, Viet Nam is still highly patriarchal.

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[19] Committee for Ethnic Minorities Affairs Web Portal at http://ubdt.gov.vn/wps/portal/cema/ethnic/!ut/p/c5/hY7LDoIwEEW_yPS2EKhLwqNUhYZiBdkYFsaQCLgwfr_FFRIfM8uTM2dIQ-wO7aO7tPduHNorqUnjnUIRpK6_A0RsGKQHl5eOdgBYfpxxlRsKWSqViSR88bnNlfIhWbTZ7sOAoaALW3AdQRbsEOk4pkjon3Y1ffu7PnF8mQAL_0P_jSPNuL1fSJPrNYVwSZ6O_ZncelOjk6snoWon-g!!/dl3/d3/L3dDb0EvUU5RTGtBISEvWUZSdndBISEvNl9DR0FINDdMMDBHRVUyMEk2MDQ4UzNSMzAwMA!!/

The Kinh are the main ethnic group and live in all the provinces but more in delta areas and urban centers. They carry out cultivation in submerged fields, gardening, cattle and poultry raising, and fresh water and sea fishing. Pottery developed very early. The Kinh villages are usually surrounded by bamboo groves and many have solid gates. Each village has a communal house which is the place of meeting and common ritual ceremonies. The Kinh live in mud houses. The husband (father) is the head of the family. The eldest son is responsible for the worship of dead parents and grandparents. Each family lineage has a temple of forefathers and the head of the family lineage handles common affairs. In marriage, monogamy is observed. The family of the man seeks marriage and organizes wedding for him; after the wedding party the bride lives with her husband's family. The Kinh worship their ancestors. Buddhism, Confucianism, Taoism and imported Christianity are practiced to various extents.

The Thai live in the provinces of Lai Chau, Son La, Hoa Binh and Nghe An. The Thai have other names such as Tay, Tay Dam, Tay Khao, Tay Muoi, Tay Thanh, Hang Tong and Pu Thay. The Thai are experienced in irrigation to the fields. Wet rice is their staple food, especially sticky rice. The Thai also cultivate rice, secondary crops and other trees on burnt-over land. Each family breeds cattle and poultry, wattles bamboo articles, weaves cloths and some families have developed ceramic ware-making occupation. The Thai live in houses on stilts. A Thai village, called a ban, comprises on average 40-50 houses built side by side. Matrilocal is the rule in the Thai society. After the wedding, Thai man comes to live with his wife family until the couple have child. The Thai believe they will continue their life in another world. The Thai group comprises many family lineages. Each lineage retains its own taboos.

The Hmong live in the highland regions of the provinces: Ha Giang, Tuyen Quang, Lao Cai, Yen Bai, Lai Chau, Son La, Cao Bang and Nghe An. They have other names: Mong Do (White Mong). Mong Lenh (Variegated Mong, Mono Si (Red Mong), Mong Du (Black Mong) and Mong Sua (Man Mong). The Mong live mainly on nomadic cultivation of burnt- over land. They also grow rice and corn on terraced fields. The principal food plants are corn, rice grown on burnt-over land and rye. Apart from these, they grow linen plants to supply fibers for cloth weaving and medicinal plants. The Mong families rear cattle, dogs, horses and chickens. It is general belief among the Mong that persons of the same lineage can live and die together in the same house, and must help and support one another even at the cost of their lives if need be. Each lineage gathers in a group of habitation; its head assumes common affairs.

The Muong live in the northern provinces, The largest part is concentrated in Hoa Binh province and the mountain districts of Thanh Hoa province, The Muong are also called Mol, Mual, Moi, Moi Bi, Au ta and Ao ta. The Muong lead a sedentary life in mountain areas where arable land is available, near the roads and very convenient for production. The Muong practice farming. Wet rice is their main staple food. Family extra-occupation is to exploit forest products. Handicrafts are popular such as weaving, basketry and silk spinning.

The Gia Rai live in Gia Lai province, a part in Kon Tum province and northern Darlac province is also called Gio-rai, To Buan, Hobau, Hdrung and Chor. The Gia rai believe in the existence of Giang (genies). They chiefly live on cultivation in burnt-over land and terraced fields. Ordinary rice is the staple food. Farm implements are simple. In former days the Gia Rai possessed a large herd of horses. They also breed elephants. Men are skillful in basketry, and women in cloth weaving. Hunting, gathering and fishing are sideline occupations generating significant economic results. The Gia Rai use elongated and small houses built on stilts. The village chief and the elders have great prestige and play the role of running collective activities. Each village has a communal house for communal activities for young boys before matrimony. The matriarchal system is adopted. After wedding, the husband lives in his wife's family.

The Tay is the largest community of ethnic minorities in Vietnam. The Tay have other names such as Tho, Ngan, Phen, Thu Lao and Pa Di and inhabit the valleys and lower slopes of mountains in Cao Bang, Lang Son, Bac Thai, Quang Ninh provinces and in some regions of Ha Bac province. The Tay preserve a traditional and fairly developed agriculture with a cultivation of all kinds of plants including rice, maize, sweet potato, etc., and seasonable fruit and vegetables. The Tay villages are always set up at the foot of a mountain or along a stream and are named after a mountain, a field or a river. Each village contains about 15-20 households. A large village is divided into many small hamlets. The houses are built on stilts or level with the ground. The houses in the frontier region are called "defense houses" protected by a stone wall and ditch. room in the house is for men and the rear one serves as women's bedroom. The Tay prefer sons to daughters. Ancestor worship is practiced. The women are not permitted to come near the ancestor altar.

The Dao have many other names such as Dao quan trang (Dao with white trousers), Dao quan chet (Dao with tight trousers), Dao Ten (Dao with coins), Dao Thanh Y (Dao with blue dress), Dao Do (Red Dao), Man, Dong, Trai, Xa, Diu Mien, Lim Mien, Lu Giang, LanTen, Dai Ban, Tieu Ban, Coi Ngang, Coi Mua and Son Dau. The live along the Sino -Vietnamese and Vietnamese-Lao borders and in some midland provinces and provinces along the coastline of northern Vietnam. The Dao mainly live from rice cultivation ether on burnt-over land and in submerged fields. They also grow subsidiary crops. They still use rudimentary farm tools. Sideline occupations are developed including weaving, carpentry, black smiting, paper-making and vegetable oil-pressure. Their meals are mainly cooked with bamboo shoots and vegetable. The Dao rear plenty of pigs and poultry, but mainly use these for rituals and offerings. The houses are built either on stilts, level with the ground or half on stilts and half on beaten earth. The Dao believe in the existence of the souls and demons, and have complicated and expensive rituals every year. Relationships among members of the same lineage are always very close. They are able in traditional medicine.

The E De live in Darlac, south Gia Lai and western parts of Khanh Hoa and Phu Yen provinces. The Ede are also called Rade, De, Kpa Adham, Krung, Klul, Dlierue, Blo, Epan. Mdhun and Bich. The Ede mainly practice cultivation on burnt-over land. Besides cultivation, the Ede also practice animal husbandry, hunting, gathering, fishing, basketry and weaving. In Ede society, matriarchy is prevailed. The Ede practice polytheism, so they retain many taboos and worships to pray for bumper harvests, health and avoiding misfortunes and losses. The Ede live in houses on stilts. The houses are generally elongated.

The Nung live in the provinces of Lang Son, Cao Bang, Bac Thai, Ha Bac and Tuyen Quang. They have other names such as Xuong, Giang, Nung An, Nung Coi, Phan Sinh, Nung Chao, Nung Inh, Qui Rin, Nung Din and Khen Lai. The Nung mainly worship their ancestors. The Nung live on rice and corn. They cultivate rice either in submerged fields along the ravines and in terraced fields on the hillsides. They grow cash crops and fruit trees such as tangerines and persimmons. Anise is the most valuable trees of the Nung which has brought them high profit every year. Handicrafts are a continuing activity, particularly weaving cloth to supply local needs, then come carpentry, blacksmithing, basketry and ceramic ware-making. The Nung villages are often set up on the hillsides, in front of them are the submerged fields and behind are burnt- over land and gardens. The Nung houses are built on stilts.

The Ba Na live in Kon Tum, Binh Dinh and Phu Yen provinces. The Ba na live mainly a cultivation of burnt-over land which brings them rice, subsidiary crops, vegetable, fruit, sugarcane and cotton for cloth weaving. Apart from burnt-over land cultivation, the Ba Na rear

cattle, poultry, pus and goats. Almost the villages have forges. In certain places, the Ba Na have produced simple potteries, women weave cloth to make their family dressing. Men practice basketry and mat-making. In the past, the elongated houses were popular in accordance with the extended families. In each village, there is a communal house. According to matrimonial custom, a young man and woman can each take the initiative in marriage. After marriage, the young couple live alternately in both their parents' families with an interval arranged by the two families. After the birth of the first child, they are allowed to set up their nuclear family. The Ba na children have the equal rights of inheritance. The Ba na venerate the spirits relating to human being.

Viet Nam Population by Ethnicity

No.	Ethnicity	Population	Location	Share*
	Total population	**85,846,997**		**100**
1	Kinh	73,594,427	Over the nationwide	85.73
2	Tày	1,626,392	Hà Giang, Tuyên Quang, Lào cai, Yên Bái, Cao Bằng, Lai Châu, Bắc Giang, Bắc Ninh	1.89
3	Thái	1,550,423	Sơn La, Lai Châu, Nghệ An, Thanh Hoá, Lào Cai, Yên Bái, Hoà Bình, Lâm Đồng	1.81
4	Mường	1,268,963	Hoà Bình, Thanh Hoá, Vĩnh Phú, Yên Bái, Sơn La, Ninh Bình	1.48
5	Khơ Me	1,260,640	Kiên Giang, Hải Phòng, Vĩnh Long, Trà Vinh, Quảng Ninh, Đồng Nai, Hậu Giang, Cà Mau, Bạc Liêu, Hồ Chí Minh city	1.47
6	H'Mông	1,068,189	Hậu Giang, Vĩnh Long, Trà Vinh, Kiên Giang, Cà Mau, Bạc Liêu, Tây Ninh,Hồ Chí Minh city, Bình Dương, Bình Phước, An Giang	1.24
7	Nùng	968,800	Cao Bằng, Lạng Sơn, Bắc Giang, Bắc Ninh, Hà Giang, Tuyên Quang, Quảng Ninh, Hồ Chí Minh city, Lâm Đồng, Đắc Lắc, Lào Cai	1.13
8	Hoa	823,071	Hà Giang, Yên Bái, Lào Cai, Lai Châu, Sơn La, Cao Bằng, Lạng Sơn, Nghệ An, Thanh Hóa, Hoà Bình, Bắc Cạn, Thái Nguyên	0.96
9	Dao	751,067	Hà Giang, Tuyên Quang, Lào Cai, Yên Bái, Cao Bằng, Lạng Sơn, Bắc Cạn, Thái Nguyên, Lai Châu, Sơn La, Vĩnh Phúc, Phú Thọ, Bắc Ninh, Bắc Giang, Thanh Hoá, Quảng Ninh, Hoà Bình, Hà Tây	0.87
10	Gia Rai	411,275	Gia Lai, Kon Tum, Đắc Lắc	0.48
11	Ê Đê	331,194	Đắc Lắc, Phú Yên, Khánh Hoà	0.39
12	Ba Na	227,716	Kon Tum, Bình Định, Phú Yên	0.27
13	Xơ Đăng	169,501	Bắc Cạn, Thái Nguyên, Tuyên Quang, Quảng Ninh, Bắc Giang, Bắc Ninh, Lạng Sơn, Vĩnh Phúc, Phú Thọ, Yên Bái	0.20
14	Sán Chay	169,410	Ninh Thuận, Bình Thuận, An Giang, Hồ Chí Minh city, Bình Định, Phú Yên, Khánh Hoà	0.20
15	Cơ Ho	166,112	Kon Tum, Quảng Nam, Quảng Ngãi	0.19
16	Chăm	161,729	Quảng Ninh, Bắc Giang, Bắc Ninh, Hải Dương, Hưng Yên, Bắc Cạn, Thái Nguyên, Vĩnh Phúc, Phú Thọ, Tuyên Quang	0.19
17	Sán Dìu	146,821	Quảng Ngãi, Bình Định	0.17
18	Hrê	127,420	Lâm Đồng, Ninh Thuận, Bình Thuận, Khánh Hoà	0.15
19	Ra Glai	122,245	Ninh Thuận, Bình Thuận, Khánh Hoà, Lâm Đồng	0.14
20	M'Nông	102,741	Đắc Lăc, Lâm Đồng	0.12
21	X'Tiêng	85,436	Nghệ An, Thanh Hoá	0.10
22	Bru-Vân Kiều	74,506	Bình Dương, Bình Phước, Tây Ninh, Lâm Đồng, Đắc Lắc	0.09
23	Thổ	74,458	Sơn La, Lai Châu, Nghệ An, Yên Bái	0.09
24	Khơ Mú	72,929	Quảng Bình, Quảng Trị	0.08
25	Cơ Tu	61,588	Lào Cai, Hà Giang, Lai Châu	0.07

No.	Ethnicity	Population	Location	Share*
	Total population	**85,846,997**		**100**
26	Giáy	58,617	Quảng Nam, Thừa Thiên-Huế	0.07
27	Giẻ Triêng	50,962	Quảng Nam, Đà Nẵng, Kon Tum	0.06
28	Tà Ôi	43,886	Quảng Trị, Thừa Thiên-Huế	0.05
29	Mạ	41,405	Lâm Đồng, Đồng Nai	0.05
30	Co	33,817	Quảng Ngãi, Quảng Nam	0.04
31	Chơ Ro	26,855	Đồng Nai	0.03
32	Xinh Mun	23,278	Lai Châu, Lào Cai	0.03
33	Hà Nhì	21,725	Sơn La, Lai Châu	0.03
34	Chu Ru	19,314	Lâm Đồng, Ninh Thuận, Bình Thuận	0.02
35	Lào	14,928	Lai Châu, Sơn La	0.02
36	Kháng	13,840	Hà Giang	0.02
37	La Chí	13,158	Lao Cai, Lai Châu, Sơn La, Hà Giang	0.02
38	Phú Lá	10,944	Lai Châu	0.01
39	La Hủ	9,651	Lai Châu, Sơn La	0.01
40	La Ha	8,177	Lai Châu	0.01
41	Pà Thẻn	6,811	Hà Giang, Tuyên Quang	0.01
42	Chứt	6,022	Hà Giang, Cao Bằng, Lào Cai	0.01
43	Lự	5,601	Quảng Bình	0.01
44	Lô	4,541	Lai Châu	0.01
45	Mảng	3,700	Hà Giang	0.004
46	Cờ Lao	2,636	Hà Giang, Lào Cai	0.003
47	Bố Y	2,273	Yên Bái, Sơn La	0.003
48	Cống	2,029	Lai Châu	0.002
49	Ngái	1,035	Quảng Ninh, Hồ Chí Minh city, Hải Phòng	0.001
50	Si La	709	Lai Châu	0.001
51	Pu Péo	687	Hà Giang	0.001
52	Rơ măm	436	Kon Tum	0.001
53	Brâu	397	Kon Tum	0.000
54	Ơ Đu	376	Nghệ An	0.000
55*	**Others**	2,134		0.002

Source: The 2009 Vietnam Population and Housing Census - General Statistical Office (Completed results, June, 2010); Source: Vietnam Fatherland Front at http://mattran.org.vn/Home/DatnuocVN/Cac%20dan%20toc/index-DT.htm.

Resettlement Framework

May 2016

Cambodia: Greater Mekong Subregion Health Security Project

Prepared by the Ministry of Health, Cambodia, and endorsed by the Ministry of Economy and Finance (Chairman of the Interministerial Resettlement Committee) for the Asian Development Bank.

This is a draft and revised version will be posted on http://www.adb.org/projects/

CURRENCY EQUIVALENTS
(as of 1 May 2016)

Currency unit	–	riel (KHR)
KHR1.00	=	$0.00025
$1.00	=	KHR4,050

ABBREVIATIONS

ADB	–	Asian Development Bank
AH	–	affected household
AP	–	Affected person
CTA	–	Chief Technical Advisor
EA	–	executing agency
DPHIS	–	Department of Planning and Health Information Systems
GMS	–	Greater Mekong Subregion
GRM	–	Grievance Redress Mechanism
HSP	–	Health Security Project
MoH	–	Ministry of Health
RPF	–	Resettlement Policy Framework
VDC	–	Village Development Committee

NOTES

(i) The fiscal year (FY) of the Government of Lao PDR and its agencies ends on 31 December. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

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Executive Summary

1. Resettlement screening has been undertaken for the proposed Greater Mekong Subregion Health Security Project (GMSHSP). The proposed project will be implemented on a subregional level and the overarching goal will be to increase GMS health security against emerging diseases and other infectious diseases of regional and global importance. The project will focus on helping countries achieve IHR/APSED standards and help address gaps in regional cooperation, CDC in border areas, surveillance and response, laboratory services, and hospital infection and control.

2. The project activities focus on capacity building for information exchange, outreach services and improving existing services. Existing provincial laboratories and hospitals will receive small support for internal repairs and refurbishment. There will be no construction of new facilities or extension of existing facilities, and no land acquisition is required.

3. The project has been assessed as having no adverse effects, as any improvements to health facilities will be done internally only, within existing facilities and facility grounds (Category C as per ADBs Safeguard Policy Statement 2009, OM/F1). A screening checklist has been formulated for use in the selection of health facilities to be refurbished, which will reject any proposed site which would incur negative impacts from the permanent or temporary loss of land, loss of access, loss of income, or any other losses and resulting calls for compensation.

A. Introduction

1. The purpose of this report is to present the due diligence that has taken place to assess if any, and if so, what, involuntary resettlement impacts will be expected to occur on the project; and to provide an approach to screen out any activities that may trigger Safeguard Requirement 2 for involuntary resettlement, that will form part of the project administration manual and guide project activity selection and implementation.

B. Project Description

2. The Governments of Myanmar, Cambodia, Lao PDR, and Viet Nam have agreed with the Asian Development Bank (ADB), a multi-lateral development agency with headquarters in Manila, Philippines, to prepare the Greater Mekong Subregion Health Security Project (the Project). To help countries comply with the International Health Regulations (IHR) and implement the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), the Project will strengthen regional and national health security systems for the prevention and control of emerging infectious diseases and other diseases of regional importance in the Greater Mekong Subregion (GMS).

3. In Cambodia, MOH Cambodia will be the executing agency, represented by the Department of Planning and Health Information Systems (DPHIS). The project will be implemented in 13 provinces. The 13 provincial health departments (PHDs) in targeted provinces will be implementing agencies. The existing MOH steering committee chaired by the Minister of Health will direct and monitor Project implementation. The advisory regional steering committee will guide regional coordination and activities and advise on project implementation. The regional coordination unit (RCU) to support regional activities will be hosted by MOH Lao.

4. A province-customized approach is proposed to ensure effective and efficient investment. Each province will, as part of its regular annual health plan and that of the operational districts (ODs), propose project investments for improving health security within the agreed scope, including improving surveillance and response and laboratory and hospital services, and outreach for migrants, ethnic minorities and other vulnerable groups (MEVs). These annual plans will be approved by MOH and checked by ADB to ensure that these are within the project scope. MOH confirms that the project does not entail any civil works beyond small internal repairs of existing facilities, nor land acquisitions or resettlements.

C. Project Outcomes

5. The Project is designed to support regional cooperation and capacity building for disease prevention and control. The proposed regional goal is strengthened GMS health security, with indicators of (i) no major outbreak of emerging or other epidemic disease in excess of 100 case fatalities, (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year, and (iii) reduced incidence of major communicable diseases.

6. The proposed project outcomes are (i) improved coverage of GMS public health security system based on IHR/APSED and (ii) CDC coverage increased in vulnerable groups in CLMV border areas, in particular for migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs).

7. The proposed project output are: (i) improved GMS collaboration and MEV access to CDC in border areas, (ii) strengthened national surveillance and response system, (iii) improved

diagnostic and management capacity of infectious diseases and (iv) efficient and effective project management.

D. Project Location

8. In Cambodia, the project is to cover 13 border provinces of a total of 24 provinces (not included the capital region), and 40 border districts, some of which have a larger hospital and laboratory. Proposed project provinces in the north-west are Pailin, Battambang and Banteay Meanchey. Preah Vihear, Stung Treng, Rattanakiri, Mondulkiri and Kratie in the north-east, and Kandal, Prey Veng, Svey Rieng, Kampot and Tbong Khmum in the south-east. These are mostly poor border provinces, with those in the north-east being the poorest with a large proportion of ethnic groups.

E. Scope of Work

9. Civil works under the project will be limited and restricted to minor renovations within the existing provincial hospital buildings already established on government land. Minor repairs and renovations would include works such as repair of doors and windows, fixing ceilings and roofing, replacement of worktables, tiling of floors and walls, fixing of sinks and showers, electrical re-wiring and lighting, and repair of waste management systems. At this stage it is not known exactly how many facilities will receive minor refurbishment and what kind of repairs and refurbishment will be done, as this will depend upon a detailed assessment.

F ADB Safeguards Policy Statement

10. The objectives of the ADB Safeguards Policy Statement (ADB's SPS. 2009) are (a) to avoid impacts on people and the environment, where possible; (b) where avoidance is not possible, minimize, mitigate, or compensate for adverse project impacts on the environment and the affected people; and (c) help the executing agency strengthen its safeguard system. Towards this end, ADB resettlement policy includes the following principles:

i. Screen the project early on to identify past, present, and future involuntary resettlement impacts and risks. Determine the scope of resettlement planning through a survey and/or census of affected persons, including a gender analysis, specifically related to resettlement impacts and risks.
ii. Improve, or at least restore, the livelihoods of all affected persons through (i) land-based resettlement strategies when affected livelihoods are land based where possible or cash compensation at replacement value for land when the loss of land does not undermine livelihoods, (ii) prompt replacement of assets with access to assets of equal or higher value, (iii) prompt compensation at full replacement cost for assets that cannot be restored, and (iv) additional revenues and services through benefit sharing schemes where possible.
iii. Provide physically and economically affected persons with needed assistance, including the following: (i) if there is relocation, secured tenure to relocation land, better housing at resettlement sites with comparable access to employment and production opportunities, integration of resettled persons economically and socially into their host communities, and extension of project benefits to host communities; (ii) transitional support and development assistance, such as land development, credit facilities, training, or employment opportunities; and (iii) civic infrastructure and community services, as required.

iv. Improve the standards of living of the affected poor and other vulnerable groups, including women, to at least national minimum standards. In rural areas provide them with legal and affordable access to land and resources, and in urban areas provide them with appropriate income sources and legal and affordable access to adequate housing.
v. Develop procedures in a transparent, consistent, and equitable manner if land acquisition is through negotiated settlement.
vi. Ensure that affected persons without titles to land or any recognizable legal rights to land are eligible for resettlement assistance and compensation for loss of non-land assets.
vii. Prepare a resettlement plan elaborating on affected persons' entitlements, the income and livelihood restoration strategy, institutional arrangements, monitoring and reporting framework, budget, and time-bound implementation schedule.
viii. Disclose a draft resettlement plan, including documentation of the consultation process in a timely manner, before project appraisal, in an acceptable place and a form and language(s) understandable to affected persons and other stakeholders. Disclose the final resettlement plan and its updates to affected persons and other stakeholders.
ix. Conceive and execute involuntary resettlement as part of a development project or program. Include the full costs of resettlement in the presentation of project's cost and benefits. For a project with significant involuntary resettlement impacts, consider implementing the involuntary resettlement component of the project as a stand-alone operation.
x. Pay compensation and provide other resettlement entitlements before physical or economic displacement. Implement the resettlement plan under close supervision throughout project implementation.
xi. Monitor and assess resettlement outcomes, their impacts on the standards of living of affected persons, and whether the objectives of the resettlement plan have been achieved by taking into account the baseline conditions and the results of resettlement monitoring. Disclose monitoring reports.

G. Government Resettlement Policies in ADB-Financed Projects

11. The Government of Cambodia has several legislations in place regarding resettlement. Existing laws that govern land acquisition and resettlement in Cambodia, together with the ADB's SPS (2009) shall govern the land acquisition and compensation of affected households (AHs) under all subprojects where there will be land acquisition and/or resettlement. The legal and policy framework for addressing the adverse social impacts of any subproject or component of project is provided by ADB's SPS (2009) and laws of the government.

12. The 1993 Constitution of Cambodia, article 44, states that all Khmer legal entities and persons, individually or collectively, shall have the right to ownership. Legal private ownership shall be protected by law. The right to confiscate properties from any persons shall be exercised only in the public interest as provided for under the law and shall require fair and just compensation in advance.

13. The rights to land and property in Cambodia are governed by the 2001 Land Law. Article 5 states that "No person may be deprived of his ownership, unless it is in the public interest. Any ownership deprivation shall be carried out in accordance with the governing procedures provided by law and regulations, and after the payment of fair and just compensation in

advance." Other provisions of the Land Law that are relevant to land acquisition, compensation and resettlement are:

(i) Legal possession is the sole basis for land ownership as defined by law, and all transfers or changes of rights of ownership shall be carried out in accordance with the required general rules for sale, succession, exchange and gift or by court decision. (Article 6);
(ii) Any regime of ownership of immovable property prior to 1979 shall not be recognized. (Article 7);
(iii) Ownership of immovable properties described in Article 25 is granted by the state to indigenous minorities as collective ownership. This collective ownership includes all of the rights and protections as enjoyed by private owners. The exercise of collective ownership rights shall be subject to the responsibility of traditional authorities and decision making mechanisms of the indigenous community, according to their customs and subject to the laws of general enforcement related to immovable property such as the law on environmental protection. (Article 26);
(iv) As per Article 23 of the Land Law, "An indigenous community is a group of people that resides in Cambodia whose members manifest ethnic, social, cultural and economic unity and who practice a traditional lifestyle, and who cultivate the lands in their possession according to the customary rules of collective use.

14. The Expropriation Law (February 2010) defines the procedures for acquiring private property for the national or public interest. Article 2: the law has the following purposes: (a) ensure reasonable and just deprivation of a legal right to ownership of private property; (b) ensure payment of reasonable and just prior compensation; (c) serve the public and national interests; and (d) further the development of public physical infrastructure. Article 7: Only the state may carry out an expropriation for use in the public and national interest. Article 8: The state shall accept the purchase of the remaining part of real property left over from an expropriation at a reasonable and just price at the request of the owner of land/or the holder of rights in the expropriated real property, if he is no longer able to live near the expropriated scheme or build a residence or conduct any business. Article 22: Stipulates the amount of compensation to be paid to the owner of and/or holder of rights in the real property, which is based on the market value of the real property or the replacement cost as of the date of the issuance of the Prakas on the expropriation scheme. The market value or the replacement cost shall be determined by an independent commission or agent appointed by the expropriation committee.

15. MEF Circular No. 006 on the Resettlement Implementation Procedure for development projects dated April 2014 provides instructions for the administrative management and role and responsibility of all relevant implementing agency and provinces in implementing the resettlement for development project. A culturally appropriate indigenous peoples plan is to be developed in full consultation with affected indigenous peoples.
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16. As may be observed, there are some contradictory areas between ADB's safeguard policy and Cambodia's legislation regarding resettlement, in particular regarding the rights of illegal squatters. In terms of reconciliation of Government and ADB Policies, the resettlement Policy of RGC as determined in RGC's law and regulation is applied to all projects. However, projects supported by external agencies are governed by the resettlement policies of the donors and RGC laws and regulations. Where gaps or inconsistencies are noted between the government's laws, regulations and procedures relating to land acquisition and involuntary

resettlement and ADB's SPS (2009) ADB's SPS will be applied, and the Government's requirements will be waived, as agreed in this approved RF.

H. Sector-wide Resettlement Policy Framework

17. The World Bank, the leading partner supporting the Health Sector Program through Sector-wide Management (SWIM), has prepared a resettlement policy framework (RPF) for the Cambodia Health Equity and Quality improvement Program. The proposed project will be administered under the umbrella of this program. Accordingly, RPF and the Resettlement Framework should be aligned. RPF features relevant for this project are summarized as follows.[1]

(i) Infrastructure screening measures during program implementation will ensure that no major land acquisition or resettlement-related impacts occur;
(ii) Those infrastructures which require acquisition of land or other assets but whose impacts do not exceed certain thresholds are allowed to be financed provided that mitigation measures are provided in line with the RPF;
(iii) The fundamental principle incorporated in the RPF is that all necessary measures will be undertaken to improve, or at least restore, incomes and living standards of all persons adversely affected as a result of land acquisition.

18. The World Bank reports further notes that involuntary resettlement may cause severe long-term hardship, impoverishment and environmental damage unless appropriate measures are carefully planned and carried out.[2]

World Bank Resettlement Policy Framework

"(i)	Acquisition of land and other assets should be avoided when feasible and otherwise minimized;
(ii)	If any persons are to be adversely affected, mitigation measures must provide them with sufficient opportunities to improve, or at least restore, incomes and living standards;
(iii)	Lost assets should be replaced in kind, or compensated at replacement cost;
(iv)	Compensation should be paid in full, net of taxes, fees or any other deductions for any purpose;
(v)	If any persons are required to relocate, transfer costs and subsistence allowances will be paid in addition to compensation at replacement cost for lost structures and other assets;
(vi)	Absence of legal title to land or other affected assets will not be a barrier to compensation or other suitable forms of assistance; and
(vii)	Adversely affected persons will be provided information relating to impacts and entitlements, will be consulted as to their preferences regarding implementation arrangements, and will be informed regarding methods and procedures for pursuing grievances."

19. The RPF notes that there are currently no laws and regulations that govern the process of acquisition and the determination of just compensation. According to the 2001 Land Law, those who opened land for residential or farming purposes before August 30th, 2001 may be recognized as legal occupants of State land in the future when land is registered as State

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[1] http://documents.worldbank.org/curated/en/2015/12/25650634/cambodia-health-equity-quality-improvement-project-resettlement-plan-resettlement-policy-framework

[2] World Bank OP 4.12

private land, but those who occupied it later will be considered as illegal occupants. Article 18 of the Land Law provides states that encroachers do not "have the right to claim compensation or reimbursement for expenses paid for the maintenance or management of immovable property that was illegally acquired" (Article 19). A Circular No. 02 issued by the Royal Government of Cambodia on Illegal Occupation of State Land dated February 26, 2007, states that while occupation of land as a form of possession became illegal after August 30th, 2001, there is a need for the state to undertake SLCs for poor people and disadvantaged groups to meet their needs for land deriving from population growth, demobilization of soldiers, and land loss due to natural disasters. However, the current anarchical illegal taking of state land also provides opportunities for land speculators and powerful persons to take illegal possession of state lands through various means. To address this situation, Circular Number 02 determines that: (i) generally, the illegal state land holders, especially land speculators, are not entitled to compensation (Para 6.1 in Circular No. 02); (ii) Illegal state land holders, who are poor families and landless or lack land and are disadvantaged, would not be entitled to compensation, but may receive preferential treatment to obtain an appropriate amount of land for their livelihood (Para 6.2 in Circular No. 02).

20. The RPF further notes that the Royal Government of Cambodia 2001 Land Law has created a legal mechanism called Social Land Concession (SLC) to transfer parts of State land to landless and land-poor families for residential and/or family farming purposes.

21. The RPF also states that in the event of conflict or inconsistency between Cambodian law and Bank principles as established in this framework, the RGC will waive Cambodian law to the extent necessary for effective implementation of this project. The Bank will reserve the right not to finance project activities if they, after all efforts to bridge the gap, still do not comply with the Bank safeguard policies.

I. Due Diligence

22. During project preparatory technical assistance in October 2015, Svay Rieng and Banteay Meanchey provinces were visited. It was observed that no private dwellings, non-titled land users or informal small businesses were located within any of the facility compounds visited. The appropriateness of the screening checklist to be used for health facility refurbishment selection was also confirmed during the site visits.

23. Based on the field observations and discussions with representative from the DPHIS, it is expected that no hospital or laboratory will require land acquisition or involuntary resettlement under the refurbishment activity. One possible resettlement issue in this Project could be the presence of private shops or illegal squatters on hospitals compounds that could be affected by project activities, however none has been identified so far. The project will screen out any activity that would trigger Safeguard Requirement 2 for involuntary resettlement by using the checklist. The project is categorized as Category C under the ADB's Safeguard Policy Statement (2009).

J. Hospital Screening Process

24. A checklist (Table 1) has been developed for use by provincial health offices to screen out any project activity that may trigger Safeguard Requirement 2 for involuntary resettlement. The checklist will be completed by representatives of the responsible provincial health office requesting facility repair and renovation, and signed off by the Provincial Health Officers and the National Project Director. Any affirmative response to any one of the issues in the checklist will

result in automatic rejection of the site. No refurbishment activity may be started until the screening checklist has been certified by all parties as required.

25. The following checklist is to be used to screen out the selection of any hospital at which refurbishment or improvements under the project would result in any permanent or temporary loss of land, structures, assets, access, occupation and or income or livelihood. An affirmative response to any item must result in the rejection of that facility under the GMSHSP.

Table 1: Screening Checklist

Involuntary Resettlement Effects	Yes	No	Remarks
Will the activity require permanent or temporary land acquisition?			
Has the facility been constructed recently on new land in anticipation of obtaining further assistance for the facility from this ADB project?			
When the facility was built, was the land acquired legally under Cambodia Government Law? (unknown = No)			
Are there any outstanding complaints about the land used or acquired for the existing facilities?			
Will the activity require permanent or temporary relocation or displacement of any people (titled or non-titled)?			
Are there any non-titled people (squatters) who live at the site or within the COI / Right of Way / public land?			
Will there be any loss of housing or accommodation?			
Will there be any loss of vegetable gardens or agricultural plots?			
Will there be any losses of crops, fruit trees, or private structures?			
Will any small or informal businesses have to be moved or closed temporarily or permanently?			
Will there be temporary or permanent loss of employment as a result of the renovation?			

K. Monitoring and Audit

26. During semi-annual monitoring, one to two targeted hospitals will be subject to audits to confirm that they did not trigger any of the safeguard requirements. It is recommended that all 12 hospital selected for repair and refurbishment are visited to confirm the completed and certified screening checklists. The audit should be conducted by the Safeguard Specialist and a representative from the Project Management Office (PMO) at central level.

L. Grievance Redress Mechanism

27. Although there are no resettlement or land acquisition impacts envisaged, grievance and redress mechanisms are required under ADB’s Safeguard Policy Statement (2009) and also under Articles 12 and 13 of Government of Lao PDR Prime Ministerial Decree No. 192/PM (2005). One of the important functions of the PMO is to ensure that any affected persons (APs) are aware of the procedures in filing complaints or grievances that may arise during project implementation so that unnecessary delays in civil works construction could be avoided.

28. Grievance Redress Committees (GRCs) at the provincial level will be mobilized if and when needed, and they will be composed of the members of existing provincial resettlement committees.

29. Grievances or complaints from any affected person will be solved in a timely and satisfactory manner. The APs can submit their grievances to the local Village Development Committee (VDC) either in verbal or written form, at no cost to them. The procedural steps for filing and resolution of grievance and complaints are described in Table 2 below.

Table 2: Grievance Procedure

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to the village committee. If unwritten the VDC will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VDC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint at the district level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the district level, he/she can seek redress at provincial GRC that should decide the issue within 10 days.
Stage 4	The AP may elevate the complaint for hearing at the PMO if still unsatisfied with the decision of GRC at the central level. The PMO will ensure to resolve each complaint within 10 days after receiving the appeal.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, VDC = Village Committee

M. Implementation Arrangements

30. The project is implemented through DPHIS of MOH, and project activities implemented by the participating provincial health offices. Management coordination and support units will be established at provincial level. This resettlement framework will form part of the project administration manual (PAM).

31. MOH and provincial managers have responsibility to ensure that the resettlement framework and PAM is followed and particularly to ensure that the screening checklists are applied rigorously. The head of the provincial health office must certify each screening report being submitted for health facility refurbishment; and the PMO National Project Director will also countersign approved screening reports as accurate and correct. If there is any doubt as to the accuracy, the case should be audited immediately.

32. Provincial teams should assign one person to act as the focal point for social safeguards work. Safeguard oversight will be provided through the Project Management Unit (PMU) with guidance from the Chief Technical Advisor (CTA) who will provide about 3 years of intermittent input to the project, and the national Gender and Social Safeguard Specialist who will provide about 12 months of intermittent input. The CTA and Safeguards Specialist will cover gender and all three safeguard areas of resettlement, ethnic groups, and also environment. Technical

assistance is required to ensure safeguard plans are implemented and monitored correctly and also to raise local capacity in regards to awareness and understanding the rationale and triggers for safeguard measures. The CTA and Safeguard Specialist will play a key role in ensuring that the Resettlement screening checklists are audited and the results reported to both PMO and ADB.

33. The costs associated with implementing this resettlement framework are minimal as the cost of technical assistance is allocated across all three safeguard areas in the case of the Safeguard Specialist and across the entire project for the CTA. Some additional costs will be required for the conducting of screening checklists and a lump sum of US$ 5000 should be allocated for this activity.

Resettlement Framework

May 2016

Lao PDR: Greater Mekong Subregion Health Security Project

Prepared by the Ministry of Health, Lao PDR, for the Asian Development Bank.

CURRENCY EQUIVALENTS

(as of 1 May 2016)

Currency unit	–	kip (KN)
KN1.00	=	$0.000123
$1.00	=	KN8,110

ABBREVIATIONS

ADB	–	Asian Development Bank
AP	–	affected person/s
CTA	–	Chief Technical Advisor
EA	–	executing agency (or MoH)
GMS	–	Greater Mekong Subregion
HSP	–	Health Security Project
MoH	–	Ministry of Health
VC	–	Village Committee

NOTES

(i) The fiscal year (FY) of the Government of Lao PDR and its agencies ends on 31 December. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

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Executive Summary

1. Resettlement screening has been undertaken for the proposed Greater Mekong Subregion Health Security Project (GMSHSP). The proposed project will be implemented on a subregional level and the overarching goal will be to increase GMS health security against emerging diseases and other infectious diseases of regional and global importance. The project will focus on helping countries achieve IHR/APSED standards and help address gaps in regional cooperation, CDC in border areas, surveillance and response, laboratory services, and hospital infection and control.

2. The project activities focus on capacity building for information exchange, outreach services and improving existing services. Existing provincial laboratories and hospitals will receive small support for internal repairs and refurbishment. There will be no construction of new facilities or extension of existing facilities, and no land acquisition is required.

3. The project has been assessed as having no adverse effects, as any improvements to health facilities will be done internally only, within existing facilities and facility grounds (Category C as per ADBs Safeguard Policy Statement 2009, OM/F1). A screening checklist has been formulated for use in the selection of health facilities to be refurbished, which will reject any proposed site which would incur negative impacts from the permanent or temporary loss of land, loss of access, loss of income, or any other losses and resulting calls for compensation.

A. Introduction

1. The purpose of this report is to present the due diligence that has taken place to assess if any, and if so, what, involuntary resettlement impacts will be expected to occur on the project; and to provide an approach to screen out any activities that may trigger Safeguard Requirement 2 for involuntary resettlement, that will form part of the project administration manual and guide project activity selection and implementation.

B. Project Description

2. The Governments of Myanmar, Cambodia, Lao PDR, and Viet Nam have agreed with the Asian Development Bank (ADB), a multi-lateral development agency with headquarters in Manila, Philippines, to prepare the Greater Mekong Subregion Health Security Project (the Project). To help countries comply with the International Health Regulations (IHR) and implement the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), the Project will strengthen regional and national health security systems for the prevention and control of emerging infectious diseases and other diseases of regional importance in the Greater Mekong Subregion (GMS).

3. In the Lao PDR, MOH Lao PDR will be the executing agency, represented by DPIC. The project will be implemented in 12 provinces. The 12 provincial health offices (PHOs) in targeted provinces will be implementing agencies. The existing MOH steering committee chaired by the Minister of Health will direct and monitor Project implementation. The advisory regional steering committee will guide regional coordination and activities and advise on project implementation. It will be hosted and chaired by each country on rotation basis. The regional coordination unit (RCU) to support regional activities will be hosted by MOH Lao.

4. A province-customized approach is proposed to ensure effective and efficient investment. Each province will, as part of its regular annual health plan, propose project investments for improving health security within the agreed scope, including improving surveillance and response and laboratory and hospital services, and outreach for migrants, ethnic minorities and other vulnerable groups (MEVs). These annual plans will be approved by MOH and checked by ADB to ensure that these are within the project scope. MOH confirms that the project does not entail any civil works beyond small internal repairs of existing facilities, nor land acquisitions or resettlements.

C. Project Outcomes

5. The Project is designed to support regional cooperation and capacity building for disease prevention and control. The proposed regional goal is strengthened GMS health security, with indicators of (i) no major outbreak of emerging or other epidemic disease in excess of 100 case fatalities, (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year, and (iii) reduced incidence of major communicable diseases.

6. The proposed project outcomes are (i) improved coverage of GMS public health security system based on IHR/APSED and (ii) CDC coverage increased in vulnerable groups in CLMV border areas, in particular for migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs).

7. The proposed project output are: (i) improved GMS collaboration and MEV access to CDC in border areas, (ii) strengthened national surveillance and response system, (iii) improved

diagnostic and management capacity of infectious diseases and (iv) efficient and effective project management.

D. Project Location

8. The proposed project targets 12 border provinces of a total of 18 Provinces in Lao PDR, and 24 border districts, some of which have a category A district hospital with a laboratory. Proposed project provinces in the north are Phongsaly, Luang Namtha, Bokeo, Udomxay, Xiang Quang and Huaphan; in the center Bolikhamsay and Khammouane, and in the south Champasack, Attapeu, Saravan, and Sekong. These are poor border provinces not supported by other projects with a large proportion of ethnic groups.

E. Scope of Work

9. Civil works under the project will be limited and restricted to minor renovations within the existing provincial hospital buildings already established on government land. Minor repairs and renovations would include works such as repair of doors and windows, fixing ceilings and roofing, replacement of worktables, tiling of floors and walls, fixing of sinks and showers, electrical re-wiring and lighting, and repair of waste management systems. At this stage it is not known exactly how many facilities will receive minor refurbishment and what kind of repairs and refurbishment will be done as this will depend upon a detailed assessment.

F ADB Safeguards Policy Statement

10. The objectives of the ADB Safeguards Policy Statement (ADB's SPS. 2009) are (a) to avoid impacts on people and the environment, where possible; (b) where avoidance is not possible, minimize, mitigate, or compensate for adverse project impacts on the environment and the affected people; and (c) help the executing agency strengthen its safeguard system. Towards this end, ADB resettlement policy includes the following principles:

i. Screen the project early on to identify past, present, and future involuntary resettlement impacts and risks. Determine the scope of resettlement planning through a survey and/or census of affected persons, including a gender analysis, specifically related to resettlement impacts and risks.
ii. Improve, or at least restore, the livelihoods of all affected persons through (i) land-based resettlement strategies when affected livelihoods are land based where possible or cash compensation at replacement value for land when the loss of land does not undermine livelihoods, (ii) prompt replacement of assets with access to assets of equal or higher value, (iii) prompt compensation at full replacement cost for assets that cannot be restored, and (iv) additional revenues and services through benefit sharing schemes where possible.
iii. Provide physically and economically affected persons with needed assistance, including the following: (i) if there is relocation, secured tenure to relocation land, better housing at resettlement sites with comparable access to employment and production opportunities, integration of resettled persons economically and socially into their host communities, and extension of project benefits to host communities; (ii) transitional support and development assistance, such as land development, credit facilities, training, or employment opportunities; and (iii) civic infrastructure and community services, as required.
iv. Improve the standards of living of the affected poor and other vulnerable groups, including women, to at least national minimum standards. In rural areas provide them

with legal and affordable access to land and resources, and in urban areas provide them with appropriate income sources and legal and affordable access to adequate housing.

v. Develop procedures in a transparent, consistent, and equitable manner if land acquisition is through negotiated settlement.

vi. Ensure that affected persons without titles to land or any recognizable legal rights to land are eligible for resettlement assistance and compensation for loss of non-land assets.

vii. Prepare a resettlement plan elaborating on affected persons' entitlements, the income and livelihood restoration strategy, institutional arrangements, monitoring and reporting framework, budget, and time-bound implementation schedule.

viii. Disclose a draft resettlement plan, including documentation of the consultation process in a timely manner, before project appraisal, in an acceptable place and a form and language(s) understandable to affected persons and other stakeholders. Disclose the final resettlement plan and its updates to affected persons and other stakeholders.

ix. Conceive and execute involuntary resettlement as part of a development project or program. Include the full costs of resettlement in the presentation of project's cost and benefits. For a project with significant involuntary resettlement impacts, consider implementing the involuntary resettlement component of the project as a stand-alone operation.

x. Pay compensation and provide other resettlement entitlements before physical or economic displacement. Implement the resettlement plan under close supervision throughout project implementation.

xi. Monitor and assess resettlement outcomes, their impacts on the standards of living of affected persons, and whether the objectives of the resettlement plan have been achieved by taking into account the baseline conditions and the results of resettlement monitoring. Disclose monitoring reports.

G. Government Resettlement Policies in ADB-Financed Projects

11. The Government of the Lao PDR has several legislations in place regarding resettlement, including the Environmental Protection Law (EPL), dated 1999 and the Decree on the implementation of the EPL, 2001; Decree No 192/PM, dated 7 July, 2005 on the Compensation and Resettlement of People Affected by Development Projects and Regulations No2431/STEA for Implementing the Decree 192/PM on Compensation and Resettlement (C & R)of People Affected by Development Projects; Technical Guidelines, 2005 on Compensation and Resettlement in Development Projects; and General Guidelines on Public Involvement in Development Projects (2013). ADB, World Bank and other partners have assisted the Government with improving country safeguards systems (Strengthening and Use of Country Safeguards Systems (TA 97566-REG) (ADB 2011).

12. For projects with major resettlement issues, specific policies and decrees may be developed such as for NT2, which serves as a model for resettlement. Comprehensive social development plans are used to identify and mitigate project impact, on the principle that affected people must be better off than before resettlement.

13. However, several issues relating to resettlement were identified in major projects which may also be relevant for other projects. This included, among others, compliance monitoring,

provincial reinforcement of resettlement plans, lack of independent monitoring, and lack of awareness of affected people.[1]

14. In dealing with small externally-financed projects with no major resettlement issues, the Government has adopted, on a project by-project basis, the resettlement policies of donors. These projects supported by external agencies are governed by the resettlement policies of donors and relevant laws and government regulations not consistent with donor policies are waived. For this Project, principles in Section 5(a) will apply.

H. Due Diligence

15. During project preparatory technical assistance in October 2015, Bokeo, Luang Namtha, Bolikhamsay and Khammouan provinces were visited. It was observed that no private dwellings, non-titled land users or informal small businesses were located within any of the facility compounds visited. The appropriateness of the screening checklist to be used for health facility refurbishment selection was also confirmed during the site visits.

16. Based on the field observations and discussions with representative from the DPIC, it is expected that no hospital or laboratory will require land acquisition or involuntary resettlement under the refurbishment activity. Furthermore, the project will screen out any activity that would trigger Safeguard Requirement 2 for involuntary resettlement by using the checklist. The project is categorized as Category C under the ADB's Safeguard Policy Statement (2009).

I. Hospital screening Process

17. A checklist (Table 1) has been developed for use by provincial health offices to screen out any project activity that may trigger Safeguard Requirement 2 for involuntary resettlement. The checklist will be completed by representatives of the responsible provincial health office requesting facility repair and renovation, and signed off by the Provincial Health Officers and the National Project Director. Any affirmative response to any one of the issues in the checklist will result in automatic rejection of the site. No refurbishment activity may be started until the screening checklist has been certified by all parties as required.

18. The following checklist is to be used to screen out the selection of any hospital at which refurbishment or improvements under the project would result in any permanent or temporary loss of land, structures, assets, access, occupation and or income or livelihood. An affirmative response to any item must result in the rejection of that facility under the GMSHSP.

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[1] Resettlement Policies and Practices in Lao PDR. Presentation by Mr. Daovong Phonekeo, Director General, Department of Energy Policy and Planning, Ministry of Energy and Mines and Mrs. Bouakeo Phounsavath, Director of Legislative Division, Department of Environmental and Social Impact Assessment (DESIA), Ministry of Natural Resources and Environment (MoNRE), Lao PDR.

Table 1: Screening Checklist

Involuntary Resettlement Effects	Yes	No	Remarks
Will the activity require permanent or temporary land acquisition?			
Has the facility been constructed recently on new land in anticipation of obtaining further assistance for the facility from this ADB project?			
When the facility was built, was the land acquired legally under Lao Government Law? (unknown = No)			
Are there any outstanding complaints about the land used or acquired for the existing facilities?			
Will the activity require permanent or temporary relocation or displacement of any people (titled or non-titled)?			
Are there any non-titled people (squatters) who live at the site or within the COI / Right of Way / public land?			
Will there be any loss of housing or accommodation?			
Will there be any loss of vegetable gardens or agricultural plots?			
Will there be any losses of crops, fruit trees, or private structures?			
Will any small or informal businesses have to be moved or closed temporarily or permanently?			
Will there be temporary or permanent loss of employment as a result of the renovation?			

J. Monitoring and Audit

19. During semi-annual monitoring, one to two targeted hospitals will be subject to audits to confirm that they did not trigger any of the safeguard requirements. It is recommended that all 12 hospital selected for repair and refurbishment are visited to confirm the completed and certified screening checklists. The audit should be conducted by the Safeguard Specialist and a representative from the Project Management Office (PMO) at central level.

K. Grievance Redress Mechanism

20. Although there are no resettlement or land acquisition impacts envisaged, grievance and redress mechanisms are required under ADB's Safeguard Policy Statement (2009) and also under Articles 12 and 13 of Government of Lao PDR Prime Ministerial Decree No. 192/PM (2005). One of the important functions of the PMO is to ensure that any affected persons (APs) are aware of the procedures in filing complaints or grievances that may arise during project implementation so that unnecessary delays in civil works construction could be avoided.

21. Grievance Redress Committees (GRCs) at the provincial level will be mobilized if and when needed, and they will be composed of the members of existing provincial resettlement committees.

22. Grievances or complaints from any affected person will be solved in a timely and satisfactory manner. The APs can submit their grievances to the local Village Committee (VC) either in verbal or written form, at no cost to them. The procedural steps for filing and resolution of grievance and complaints are described in Table 2 below.

Table 2: Grievance Procedure

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to village committee at village level. If unwritten the VC will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint at the district level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the provincial level, he/she can seek redress at provincial GRC that should decide the issue within 10 days.
Stage 4	The AP may elevate the complaint for hearing at the PMO if still unsatisfied with the decision of GRC at the central level. The PMO will ensure to resolve each complaint within 10 days after receiving the appeal.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, VC = Village Committee

L. Implementation Arrangements

23. The project is implemented through DPIC of MOH, and project activities implemented by the participating provincial health offices. Management coordination and support units will be established at provincial level. This resettlement framework will form part of the project administration manual (PAM).

24. MOH and provincial managers have responsibility to ensure that the resettlement framework and PAM is followed and particularly to ensure that the screening checklists are applied rigorously. The head of the provincial health office must certify each screening report being submitted for health facility refurbishment; and the PMO National Project Director will also countersign approved screening reports as accurate and correct. If there is any doubt as to the accuracy, the case should be audited immediately.

25. Provincial teams should assign one person to act as the focal point for social safeguards work. Safeguard oversight will be provided through the Project Management Unit (PMU) with guidance from the Chief Technical Advisor (CTA) who will provide about 3 years of intermittent input to the project, and the national Gender and Social Safeguard Specialist who will provide about 12 months of intermittent input. The CTA and Safeguards Specialist will cover gender and all three safeguard areas of resettlement, ethnic groups, and also environment. Technical assistance is required to ensure safeguard plans are implemented and monitored correctly and also to raise local capacity in regards to awareness and understanding the rationale and triggers for safeguard measures. The CTA and Safeguard Specialist will play a key role in ensuring that the Resettlement screening checklists are audited and the results reported to both PMO and ADB.

26. The costs associated with implementing this resettlement framework are minimal as the cost of technical assistance is allocated across all three safeguard areas in the case of the Safeguard Specialist and across the entire project for the CTA. Some additional costs will be required for the conducting of screening checklists and a lump sum of US$ 5000 should be allocated for this activity.

Resettlement Framework

May 2016

Myanmar: Greater Mekong Subregion Health Security Project

Prepared by the Ministry of Health, Myanmar, for the Asian Development Bank.

CURRENCY EQUIVALENTS

(as of 1 May 2016)

Currency unit	–	kyat (MMK)
MMK1.00	=	$0.00085
$1.00	=	MMK1,175

ABBREVIATIONS

ADB	–	Asian Development Bank
AP	–	affected person/s
CTA	–	Chief Technical Advisor
DMS	–	Department of Medical Services
DPH	–	Department of Public Health
EA	–	executing agency
GMS	–	Greater Mekong Subregion
GRM	–	Grievance Redress Mechanism
HSP	–	Health Security Project
MoH	–	Ministry of Health
PMO	–	Project Management Office
SRPMO		State Region Project Management Office
VDC	–	Village Development Committee

NOTES

(i) The fiscal year (FY) of the Government of Myanmar and its agencies ends on 31 March. "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 March 2017.

(ii) In this report, "$" refers to US dollars.

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Executive Summary

1. Resettlement screening has been undertaken for the proposed Greater Mekong Subregion Health Security Project (GMSHSP). The proposed project will be implemented on a subregional level and the overarching goal will be to increase GMS health security against emerging diseases and other infectious diseases of regional and global importance. The project will focus on helping countries achieve IHR/APSED standards and help address gaps in regional cooperation, CDC in border areas, surveillance and response, laboratory services, and hospital infection and control.

2. The project activities focus on capacity building for information exchange, outreach services and improving existing services. Existing state/region laboratories and hospitals will receive small support for internal repairs and refurbishment. There will be no construction of new facilities or extension of existing facilities, and no land acquisition is required.

3. The project has been assessed as having no adverse effects, as any improvements to health facilities will be done internally only, within existing facilities and facility grounds (Category C as per ADBs Safeguard Policy Statement 2009, OM/F1). A screening checklist has been formulated for use in the selection of health facilities to be refurbished, which will reject any proposed site which would incur negative impacts from the permanent or temporary loss of land, loss of access, loss of income, or any other losses and resulting calls for compensation.

A. Introduction

1. The purpose of this report is to present the due diligence that has taken place to assess if any, and if so, what, involuntary resettlement impacts will be expected to occur on the project; and to provide an approach to screen out any activities that may trigger Safeguard Requirement 2 for involuntary resettlement, that will form part of the project administration manual and guide project activity selection and implementation.

B. Project Description

2. The Governments of Myanmar, Cambodia, Lao PDR, and Viet Nam have agreed with the Asian Development Bank (ADB), a multi-lateral development agency with headquarters in Manila, Philippines, to prepare the Greater Mekong Subregion Health Security Project (the Project). To help countries comply with the International Health Regulations (IHR) and implement the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), the Project will strengthen regional and national health security systems for the prevention and control of emerging infectious diseases and other diseases of regional importance in the Greater Mekong Subregion (GMS).

3. In Myanmar, MOH Myanmar will be the executing agency, represented by the Department of Public Health (DPH) and the Department of Medical Services (DMS). The project will be implemented in 5 states and 1 region, and within these in 12 townships, including the State/region capital and one major border town. The state/regional health departments (SRHDs) will be implementing agencies. The existing MOH steering committee chaired by the Minister of Health will direct and monitor Project implementation. The advisory regional steering committee will guide regional coordination and activities and advise on project implementation. It will be hosted and chaired by each country on rotation basis. The regional coordination unit (RCU) to support regional activities will be hosted by MOH Lao.

4. A state/region-customized approach is proposed to ensure effective and efficient investment. Each state/region will, as part of its regular annual health plan, propose project investments for improving health security within the agreed scope, including improving surveillance and response and laboratory and hospital services, and outreach for migrants, ethnic minorities and other vulnerable groups (MEVs). These annual plans will be approved by MOH and checked by ADB to ensure that these are within the project scope. MOH confirms that the project does not entail any civil works beyond small internal repairs of existing facilities, nor land acquisitions or resettlements.

C. Project Outcomes

5. The Project is designed to support regional cooperation and capacity building for disease prevention and control. The proposed regional goal is strengthened GMS health security, with indicators of (i) no major outbreak of emerging or other epidemic disease in excess of 100 case fatalities, (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year, and (iii) reduced incidence of major communicable diseases.

6. The proposed project outcomes are (i) improved coverage of GMS public health security system based on IHR/APSED and (ii) CDC coverage increased in vulnerable groups in CLMV border areas, in particular for migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs).

7. The proposed project output are: (i) improved GMS collaboration and MEV access to CDC in border areas, (ii) strengthened national surveillance and response system, (iii) improved diagnostic and management capacity of infectious diseases and (iv) efficient and effective project management.

D. Project Location

8. The proposed project targets 5 states and 1 region out of a total of 15 states/region (including the capital region). Proposed project locations along the eastern border of Myanmar with China, Lao and Thailand are predominantly inhabited by ethnic groups such as Shan, Mon and Kayin, and are as follows:

1) Shan North- Capital:Lashio, Border towns: Namkhan/Muse
2) Shan East- Capital Keng Tung, Border town: Tachileik
3) Kayah State- Capital Loakaw, Border town: Mese
4) Kayin State- Capital Hpa-An, Border town: Myawaddy
5) Mon State- Capital: MawlaMyine, Border town: Ye
6) Tanintharyi Region- Capital Dawei, Border town: Kawthaung

E. Scope of Work

9. In terms of project design, and also given the major resettlement issues in Myanmar, this project will not engage in any major infrastructure. Civil works under the project will be limited and restricted to minor renovations within the existing laboratory and hospital buildings already established on government land. State/region hospitals have about 200 beds and function as major referral hospitals with many specialties. Township hospitals that also serve as district center at major border crossings have hospitals of about 100 beds with basic specialties and major surgery. Similarly, the laboratories at state/region level function as referral laboratories including for microbiology. Minor repairs and renovations would include works such as repair of doors and windows, fixing ceilings and roofing, replacement of worktables, tiling of floors and walls, fixing of sinks and showers, electrical re-wiring and lighting, and repair of waste management systems. At this stage it is not known exactly how many facilities will receive minor refurbishment and what kind of repairs and refurbishment will be done as this will depend upon a detailed assessment.

F ADB Safeguards Policy Statement

10. The objectives of the ADB Safeguards Policy Statement (ADB's SPS. 2009) are (a) to avoid impacts on people and the environment, where possible; (b) where avoidance is not possible, minimize, mitigate, or compensate for adverse project impacts on the environment and the affected people; and (c) help the executing agency strengthen its safeguard system. Towards this end, ADB resettlement policy includes the following principles:

i. Screen the project early on to identify past, present, and future involuntary resettlement impacts and risks. Determine the scope of resettlement planning through a survey and/or census of affected persons, including a gender analysis, specifically related to resettlement impacts and risks.
ii. Improve, or at least restore, the livelihoods of all affected persons through (i) land-based resettlement strategies when affected livelihoods are land based where possible or cash compensation at replacement value for land when the loss of land does not undermine livelihoods, (ii) prompt replacement of assets with access to assets of equal or higher value, (iii) prompt compensation at full replacement cost for

assets that cannot be restored, and (iv) additional revenues and services through benefit sharing schemes where possible.

iii. Provide physically and economically affected persons with needed assistance, including the following: (i) if there is relocation, secured tenure to relocation land, better housing at resettlement sites with comparable access to employment and production opportunities, integration of resettled persons economically and socially into their host communities, and extension of project benefits to host communities; (ii) transitional support and development assistance, such as land development, credit facilities, training, or employment opportunities; and (iii) civic infrastructure and community services, as required.

iv. Improve the standards of living of the affected poor and other vulnerable groups, including women, to at least national minimum standards. In rural areas provide them with legal and affordable access to land and resources, and in urban areas provide them with appropriate income sources and legal and affordable access to adequate housing.

v. Develop procedures in a transparent, consistent, and equitable manner if land acquisition is through negotiated settlement.

vi. Ensure that affected persons without titles to land or any recognizable legal rights to land are eligible for resettlement assistance and compensation for loss of non-land assets.

vii. Prepare a resettlement plan elaborating on affected persons' entitlements, the income and livelihood restoration strategy, institutional arrangements, monitoring and reporting framework, budget, and time-bound implementation schedule.

viii. Disclose a draft resettlement plan, including documentation of the consultation process in a timely manner, before project appraisal, in an acceptable place and a form and language(s) understandable to affected persons and other stakeholders. Disclose the final resettlement plan and its updates to affected persons and other stakeholders.

ix. Conceive and execute involuntary resettlement as part of a development project or program. Include the full costs of resettlement in the presentation of project's cost and benefits. For a project with significant involuntary resettlement impacts, consider implementing the involuntary resettlement component of the project as a stand-alone operation.

x. Pay compensation and provide other resettlement entitlements before physical or economic displacement. Implement the resettlement plan under close supervision throughout project implementation.

xi. Monitor and assess resettlement outcomes, their impacts on the standards of living of affected persons, and whether the objectives of the resettlement plan have been achieved by taking into account the baseline conditions and the results of resettlement monitoring. Disclose monitoring reports.

G. Government Resettlement Policies in ADB-Financed Projects

11. Myanmar's laws do not currently provide adequate protection for ordinary citizens and communities. Successive regimes governing Myanmar have acquired and allocated large tracts of land in all areas of the country without fully compensating displaced persons. The scale of resettlement, for plantation, industrial zones, public infrastructure, and urban development, is

unknown but believed to be large. More than 3 million acres were awarded under the previous government. In addition, land registration and record keeping is insufficient[1].

12. With poor protection of land use rights, small landholders lack security of tenure, and refrain from a complex and long land registration process. The land classification system doesn't reflect current use of land, and customary land use rights are not necessarily respected[2]. Land confiscation is one of the drivers of displacement and migration.

13. While the Constitution states that all land remains property of the State, the Farmland Bill of 2008 allows legal 'land use rights' and transfer, exchange, or lease of land. However, this works against farmers who lack proper documentation for the land they occupy. The Vacant, Fallow and Virgin Lands Management Law, passed in 2012, stipulates that any unused land can be claimed and utilized by willing individuals. Again, this Law may also be misused to justify land grapping. On the whole, legislation for resettlement is weak[3].

14. In addition to weak rule of law, project issues relating to resettlement include lack of support for affected people, weak enforcement of resettlement plans, limited administrative capacity, and lack of independent monitoring. Any voluntary land donations, land acquisitions and human resettlement should therefore be avoided or handled with great caution.

15. In dealing with resettlement issues, for small project the Government may, for the time being, consider adopting resettlement policies of partners. For major resettlements, a project specific approach would be required.

H. Due Diligence

16. During project preparatory technical assistance in October 2015 and February 2016, Mon, Kayin, and Shan East States were visited. It was observed that no private dwellings, non-titled land users or informal small businesses were located within any of the facility compounds visited. The appropriateness of the screening checklist to be used for health facility refurbishment selection was also confirmed during the site visits.

17. Based on the field observations and discussions with representative from the DMS, it is expected that no hospital or laboratory will require land acquisition or involuntary resettlement under the refurbishment activity. Furthermore, the project will screen out any activity that would trigger Safeguard Requirement 2 for involuntary resettlement by using the checklist. The project is categorized as Category C under the ADB's Safeguard Policy Statement (2009).

I. Hospital Screening Process

18. A checklist (Table 1) has been developed for use by state/region health departments to screen out any project activity that may trigger Safeguard Requirement 2 for involuntary resettlement. The checklist will be completed by representatives of the responsible state/region

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[1] Displacement Solutions. 2015. *Land Acquisition Law and Practice in Myanmar*. Overview, Gap Analysis with IFC PS1 and PS5 and Scope of Due Diligence Recommendations.

[2] V. Bowman, Director Myanmar Center For Responsible Business. 2015 *Myanmar Land Context and Challenges.* Presentation at the IFC Workshop on Defining Good Practice Approaches for Land Acquisition and Involuntary Resettlement in Myanmar.

[3] The Myanmar Investment Guide. 2013. For a broader but dated discussion of land issues, see also: UNDP, UNHabitat, and Norwegian Ministry of Foreign Affairs. *Guidance Note on Land Issues in Myanmar.*

health department requesting facility repair and renovation, and signed off by the State/Region Health Officers and the National Project Director. Any affirmative response to any one of the issues in the checklist will result in automatic rejection of the site. No refurbishment activity may be started until the screening checklist has been certified by all parties as required.

19. The following checklist is to be used to screen out the selection of any hospital at which refurbishment or improvements under the project would result in any permanent or temporary loss of land, structures, assets, access, occupation and or income or livelihood. An affirmative response to any item must result in the rejection of that facility under the GMSHSP.

Table 1: Screening Checklist

Involuntary Resettlement Effects	Yes	No	Remarks
Will the activity require permanent or temporary land acquisition?			
Has the facility been constructed recently on new land in anticipation of obtaining further assistance for the facility from this ADB project?			
When the facility was built, was the land acquired legally under Myanmar Government Law? (unknown = No)			
Are there any outstanding complaints about the land used or acquired for the existing facilities?			
Will the activity require permanent or temporary relocation or displacement of any people (titled or non-titled)?			
Are there any non-titled people (squatters) who live at the site or within the COI / Right of Way / public land?			
Will there be any loss of housing or accommodation?			
Will there be any loss of vegetable gardens or agricultural plots?			
Will there be any losses of crops, fruit trees, or private structures?			
Will any small or informal businesses have to be moved or closed temporarily or permanently?			
Will there be temporary or permanent loss of employment as a result of the renovation?			

J. Monitoring and Audit

20. During semi-annual monitoring, one to two targeted hospitals will be subject to audits to confirm that they did not trigger any of the safeguard requirements. It is recommended that all 12 hospitals selected for repair and refurbishment are visited to confirm the completed and certified screening checklists. The audit should be conducted by the Safeguard Specialist and a representative from the Project Management Office (PMO) at central level.

K. Grievance Redress Mechanism

21. Although there are no resettlement or land acquisition impacts envisaged, grievance and redress mechanisms are required under ADB's Safeguard Policy Statement (2009). The Government of Myanmar is also seeing to enhance the protection of affected people. One of the important functions of the PMO is to ensure that any affected persons (APs) are aware of the

procedures in filing complaints or grievances that may arise during project implementation so that unnecessary delays in civil works construction could be avoided.

22. Grievance Redress Committees (GRCs) at the state/region and township levels will be mobilized if and when needed, and they will be composed of the members of suitable state/region resettlement committees.

23. Grievances or complaints from any affected person will be solved in a timely and satisfactory manner. The APs can submit their grievances to the local Village Development Committee (VDC) either in verbal or written form, at no cost to them. The procedural steps for filing and resolution of grievance and complaints are described in Table 2 below.

Table 2: Grievance Procedure

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to village committee at village level. If unwritten the VDC will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VDC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint at the state/region level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the district level, he/she can seek redress at state/region GRC that should decide the issue within 10 days.
Stage 4	The AP may elevate the complaint for hearing at the PMO if still unsatisfied with the decision of GRC at the central level. The PMO will ensure to resolve each complaint within 10 days after receiving the appeal.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, VDC = Village Development Committee

L. Implementation Arrangements

24. The project is implemented through DPH and DMS of MOH, and project activities implemented by the participating SRHDs. Management coordination and support units will be established at state/region level. This resettlement framework will form part of the project administration manual (PAM).

25. MOH and state/region managers have responsibility to ensure that the resettlement framework and PAM is followed and particularly to ensure that the screening checklists are applied rigorously. The head of the SRHD must certify each screening report being submitted for health facility refurbishment; and the PMO National Project Director will also countersign approved screening reports as accurate and correct. If there is any doubt as to the accuracy, the case should be audited immediately.

26. State/region teams should assign one person to act as the focal point for social safeguards work. Safeguard oversight will be provided through the PMO with guidance from the Chief Technical Advisor (CTA) who will provide about 3 years of intermittent input to the project,

and the national Gender and Social Safeguard Specialist who will provide about 12 months of intermittent input. The CTA and Safeguards Specialist will cover gender and all three safeguard areas of resettlement, ethnic groups, and also environment. Technical assistance is required to ensure safeguard plans are implemented and monitored correctly and also to raise local capacity in regards to awareness and understanding the rationale and triggers for safeguard measures. The CTA and Safeguard Specialist will play a key role in ensuring that the Resettlement screening checklists are audited and the results reported to both PMO and ADB.

27. The costs associated with implementing this resettlement framework are minimal as the cost of technical assistance is allocated across all three safeguard areas in the case of the Safeguard Specialist and across the entire project for the CTA. Some additional costs will be required for the conducting of screening checklists and a lump sum of US$ 5000 should be allocated for this activity.

Resettlement Framework

May 2016

Vietnam: Greater Mekong Subregion Health Security Project

Prepared by the Ministry of Health, Vietnam, for the Asian Development Bank.

CURRENCY EQUIVALENTS
(as of 1 May 2016)

Currency unit	–	dong (VND)
VND1.00	=	$0.000045
$1.00	=	VND2,229

ABBREVIATIONS

ADB	–	Asian Development Bank
AP	–	affected person/s
CTA	–	Chief Technical Advisor
EA	–	executing agency
GDPM		General Department of Preventive Medicine
GMS	–	Greater Mekong Subregion
GRM	–	Grievance Redress Mechanism
HSP	–	Health Security Project
MoH	–	Ministry of Health
PHD	–	Provincial Health Department
PMO	–	Project Management Office
VDC	–	Village Development Committee

NOTES

(i) The fiscal year (FY) of the Government of Viet Nam and its agencies ends on 31 December. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

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Executive Summary

1. Resettlement screening has been undertaken for the proposed Greater Mekong Subregion Health Security Project (GMSHSP). The proposed project will be implemented on a subregional level and the overarching goal will be to increase GMS health security against emerging diseases and other infectious diseases of regional and global importance. The project will focus on helping countries achieve IHR/APSED standards and help address gaps in regional cooperation, CDC in border areas, surveillance and response, laboratory services, and hospital infection and control.

2. The project activities focus on capacity building for information exchange, outreach services and improving existing services. Existing selective provincial and district laboratories and hospitals will receive small support for internal repairs and refurbishment. There will be no construction of new facilities or extension of existing facilities, and no land acquisition is required.

3. The project has been assessed as having no adverse effects, as any improvements to health facilities will be done internally only, within existing facilities and facility grounds (Category C as per ADBs Safeguard Policy Statement 2009, OM/F1). A screening checklist has been formulated for use in the selection of health facilities to be refurbished, which will reject any proposed site which would incur negative impacts from the permanent or temporary loss of land, loss of access, loss of income, or any other losses and resulting calls for compensation.

A. Introduction

1. The purpose of this report is to present the due diligence that has taken place to assess if any, and if so, what, involuntary resettlement impacts will be expected to occur on the project; and to provide an approach to screen out any activities that may trigger Safeguard Requirement 2 for involuntary resettlement, that will form part of the project administration manual and guide project activity selection and implementation.

B. Project Description

2. The Governments of Cambodia, Lao PDR, Myanmar, and Viet Nam have agreed with the Asian Development Bank (ADB), a multi-lateral development agency with headquarters in Manila, Philippines, to prepare the Greater Mekong Subregion Health Security Project (the Project). To help countries comply with the International Health Regulations (IHR) and implement the Asia Pacific Strategy for Emerging Diseases (APSED) of the World Health Organization (WHO), the Project will strengthen regional and national health security systems for the prevention and control of emerging infectious diseases and other diseases of regional importance in the Greater Mekong Subregion (GMS). In Vietnam, the Project is estimated to cost $84 million, including an ADB contribution of $80 million and a Government contribution of $4 million.

3. MOH Viet Nam will be the executing agency, represented by the General Department of Preventive Medicine (GDPM). The project will be implemented in 32 provinces, and within these in 275 out of 320 districts. The district will be the major focus of the Project in Viet Nam. The provincial health departments (PHDs) will be implementing agencies. The existing MOH steering committee chaired by the Minister of Health will direct and monitor Project implementation. The advisory regional steering committee will guide regional coordination and activities and advise on project implementation. It will be hosted and chaired by each country on rotation basis. The regional coordination unit (RCU) to support regional activities will be hosted by MOH Lao.

4. A district-customized approach is proposed to ensure effective and efficient investment. Each province will, as part of its regular annual health plan, propose project investments for improving health security within the agreed scope, including improving surveillance and response and laboratory and hospital services, and outreach for migrants, ethnic minorities and other vulnerable groups (MEVs). These annual plans will be approved by MOH and checked by ADB to ensure that these are within the project scope. MOH confirms that the project does not entail any civil works beyond small internal repairs of existing facilities, nor land acquisitions or resettlements.

C. Project Outcomes

5. The Project is designed to support regional cooperation and capacity building for disease prevention and control. The proposed regional goal is strengthened GMS health security, with indicators of (i) no major outbreak of emerging or other epidemic disease in excess of 100 case fatalities, (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year, and (iii) reduced incidence of major communicable diseases.

6. The proposed project outcomes are (i) improved coverage of GMS public health security system based on IHR/APSED and (ii) CDC coverage increased in vulnerable groups in CLMV

border areas, in particular for migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEVs).

7. The proposed project output are: (i) improved GMS collaboration and MEV access to CDC in border areas, (ii) strengthened national surveillance and response system, (iii) improved diagnostic and management capacity of infectious diseases and (iv) efficient and effective project management.

D. Project Location

8. The proposed project targets 32 provinces and 275 districts within that, out of a total of 63 province in Viet Nam. This includes the entire northern and western border with China, Lao and Cambodia. The area is intersected by economic corridors from east to west and north to south.

E. Scope of Work

9. In terms of project design, and also given the major resettlement issues in Viet Nam, this project will not engage in any major infrastructure. Civil works under the project will be limited and restricted to minor renovations within the existing laboratory and hospital buildings already established on government land. Provincial hospitals have a bed population ratio of about 200 beds and function as major referral hospitals with many specialties. District health center (district hospitals) at major border crossings have hospitals of about 100 beds with basic specialties and major surgery. Similarly, the laboratories at provincial level function as referral laboratories including for microbiology. Minor repairs and renovations would include works such as repair of doors and windows, fixing ceilings and roofing, replacement of worktables, tiling of floors and walls, fixing of sinks and showers, electrical re-wiring and lighting, and repair of waste management systems. At this stage it is not known exactly how many facilities will receive minor refurbishment and what kind of repairs and refurbishment will be done as this will depend upon a detailed assessment.

F. ADB Safeguards Policy Statement

10. The objectives of the ADB Safeguards Policy Statement (ADB's SPS. 2009) are (a) to avoid impacts on people and the environment, where possible; (b) where avoidance is not possible, minimize, mitigate, or compensate for adverse project impacts on the environment and the affected people; and (c) help the executing agency strengthen its safeguard system. Towards this end, ADB resettlement policy includes the following principles:

i. Screen the project early on to identify past, present, and future involuntary resettlement impacts and risks. Determine the scope of resettlement planning through a survey and/or census of affected persons, including a gender analysis, specifically related to resettlement impacts and risks.

ii. Improve, or at least restore, the livelihoods of all affected persons through (i) land-based resettlement strategies when affected livelihoods are land based where possible or cash compensation at replacement value for land when the loss of land does not undermine livelihoods, (ii) prompt replacement of assets with access to assets of equal or higher value, (iii) prompt compensation at full replacement cost for assets that cannot be restored, and (iv) additional revenues and services through benefit sharing schemes where possible.

iii. Provide physically and economically affected persons with needed assistance, including the following: (i) if there is relocation, secured tenure to relocation land, better housing at resettlement sites with comparable access to employment and production opportunities, integration of resettled persons economically and socially into their host communities, and extension of project benefits to host communities; (ii) transitional support and development assistance, such as land development, credit facilities, training, or employment opportunities; and (iii) civic infrastructure and community services, as required.

iv. Improve the standards of living of the affected poor and other vulnerable groups, including women, to at least national minimum standards. In rural areas provide them with legal and affordable access to land and resources, and in urban areas provide them with appropriate income sources and legal and affordable access to adequate housing.

v. Develop procedures in a transparent, consistent, and equitable manner if land acquisition is through negotiated settlement.

vi. Ensure that affected persons without titles to land or any recognizable legal rights to land are eligible for resettlement assistance and compensation for loss of non-land assets.

vii. Prepare a resettlement plan elaborating on affected persons' entitlements, the income and livelihood restoration strategy, institutional arrangements, monitoring and reporting framework, budget, and time-bound implementation schedule.

viii. Disclose a draft resettlement plan, including documentation of the consultation process in a timely manner, before project appraisal, in an acceptable place and a form and language(s) understandable to affected persons and other stakeholders. Disclose the final resettlement plan and its updates to affected persons and other stakeholders.

ix. Conceive and execute involuntary resettlement as part of a development project or program. Include the full costs of resettlement in the presentation of project's cost and benefits. For a project with significant involuntary resettlement impacts, consider implementing the involuntary resettlement component of the project as a stand-alone operation.

x. Pay compensation and provide other resettlement entitlements before physical or economic displacement. Implement the resettlement plan under close supervision throughout project implementation.

xi. Monitor and assess resettlement outcomes, their impacts on the standards of living of affected persons, and whether the objectives of the resettlement plan have been achieved by taking into account the baseline conditions and the results of resettlement monitoring. Disclose monitoring reports.

G. Government Resettlement Policies in ADB-Financed Projects

11. Viet Nam has a multitude of laws, policies, decrees, ordinances, and guidelines relating to resettlement. Viet Nam's record in terms of compulsory migration, land confiscation for development, and compensation is also unsatisfactory.

12. The following list presents key legislation for resettlement in Viet Nam.

(i) Constitution of the Socialist Republic of Viet Nam (2013) on state and private and ownership. Until recently, the State owned all the land. Households now have the right to own, sell or lease land.

(ii) The Land Law No.45/2013/QH13, on comprehensive and administration regulations, 2013; and Decree No.43/2014/ND-CP dated May 15, 2014 on the implementation of the Land Law.
(iii) Complaint Laws No.02/2011/QH11; and Decree No.75/2012/ND-CP dated on 3 October 2012 guiding on implementation of Complaint law
(iv) Ordinance number 34/2007/PL-UBTVQH11, 2007 on requirements for consultation with and participation of people in communes.
(v) Decree No.44/2014/ND-CP dated May 15, 2014 On Regulations on Land Prices
(vi) Decree No.47/2014/ND-CP dated May 15, 2014 on compensation, rehabilitation and resettlement when the State recover lands.

13. Decree 47/2014/ND-CP, Article 19, Item 3 states that affected persons (APs) losing from more than 30% of productive land are considered severely impacted and are entitled to livelihood restoration measures. This is more restrictive than the ADB policy. The Land Law 2013, Art. 77, Item 2 & Art. 92 state that a person who has used land before 1st July 2004 and is directly involved in agriculture production will be compensated for the acquired land area. Viet Nam's resettlement issues are somewhat similar to those of Myanmar, Lao PDR and Cambodia.

14. In addition to unstable rule of law, project issues relating to resettlement include limited support for affected people, imperfect enforcement of resettlement plans, limited administrative capacity, and lack of independent monitoring.

15. In dealing with resettlement issues, for small project the Government may, for the time being, consider adopting resettlement policies of partners. For major resettlements, a project specific approach would be required.

H. Due Diligence

16. During project preparatory technical assistance in October 2015 and February 2016, Ha Giang and Thay Ninh were visited. It was observed that no private dwellings, non-titled land users or informal small businesses were located within any of the facility compounds visited. The appropriateness of the screening checklist to be used for health facility refurbishment selection was also confirmed during the site visits.

17. Based on the field observations and discussions with representative from the DMS, it is expected that no hospital or laboratory will require land acquisition or involuntary resettlement under the refurbishment activity. Furthermore, the project will screen out any activity that would trigger Safeguard Requirement 2 for involuntary resettlement by using the checklist. The project is categorized as Category C under the ADB's Safeguard Policy Statement (2009).

I. Hospital Screening Process

18. A checklist (Table 1) has been developed for use by provincial health departments to screen out any project activity that may trigger Safeguard Requirement 2 for involuntary resettlement. The checklist will be completed by representatives of the responsible provincial health department requesting facility repair and renovation, and signed off by the Provincial Health Officers and the National Project Director. Any affirmative response to any one of the issues in the checklist will result in automatic rejection of the site. No refurbishment activity may be started until the screening checklist has been certified by all parties as required.

19. The following checklist is to be used to screen out the selection of any hospital at which refurbishment or improvements under the project would result in any permanent or temporary loss of land, structures, assets, access, occupation and or income or livelihood. An affirmative response to any item must result in the rejection of that facility under the GMSHSP.

Table 1: Screening Checklist

Involuntary Resettlement Effects	Yes	No	Remarks
Will the activity require permanent or temporary land acquisition?			
Has the facility been constructed recently on new land in anticipation of obtaining further assistance for the facility from this ADB project?			
When the facility was built, was the land acquired legally under Viet Nam Government Law? (unknown = No)			
Are there any outstanding complaints about the land used or acquired for the existing facilities?			
Will the activity require permanent or temporary relocation or displacement of any people (titled or non-titled)?			
Are there any non-titled people (squatters) who live at the site or within the COI / Right of Way / public land?			
Will there be any loss of housing or accommodation?			
Will there be any loss of vegetable gardens or agricultural plots?			
Will there be any losses of crops, fruit trees, or private structures?			
Will any small or informal businesses have to be moved or closed temporarily or permanently?			
Will there be temporary or permanent loss of employment as a result of the renovation?			

J. Monitoring and Audit

20. During semi-annual monitoring, one to two targeted hospitals will be subject to audits to confirm that they did not trigger any of the safeguard requirements. It is recommended that all 12 hospitals selected for repair and refurbishment are visited to confirm the completed and certified screening checklists. The audit should be conducted by the Safeguard Specialist and a representative from the Project Management Office (PMO) at central level.

K. Grievance Redress Mechanism

21. Although there are no resettlement or land acquisition impacts envisaged, grievance and redress mechanisms are required under ADB's Safeguard Policy Statement (2009). The Government of Viet Nam is also seeing to enhance the protection of affected people. One of the important functions of the PMO is to ensure that any affected persons (APs) are aware of the procedures in filing complaints or grievances that may arise during project implementation so that unnecessary delays in civil works construction could be avoided.

22. Grievance Redress Committees (GRCs) at the provincial and district levels will be mobilized if and when needed, and they will be composed of the members of suitable provincial resettlement committees.

23. Grievances or complaints from any affected person will be solved in a timely and satisfactory manner. The APs can submit their grievances to the local Village Development Committee (VDC) either in verbal or written form, at no cost to them. The procedural steps for filing and resolution of grievance and complaints are described in Table 2 below.

Table 2: Grievance Procedure

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to village committee at village level. If unwritten the VC will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint at the district level. The GRC at the provincial level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the provincial level, he/she can seek redress at national GRC that should decide the issue within 10 days.
Stage 4	The AP may elevate the complaint for hearing at the PMO if still unsatisfied with the decision of GRC at the national level. The PMO will ensure to resolve each complaint within 10 days after receiving the appeal.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, VDC = Village Development Committee

L. Implementation Arrangements

24. The project is implemented through GDPM, MOH. Management coordination and support units will be established at province level. This resettlement framework will form part of the project administration manual (PAM).

25. MOH and provincial managers have responsibility to ensure that the resettlement framework and PAM is followed and particularly to ensure that the screening checklists are applied rigorously. The head of the PHD must certify each screening report being submitted for health facility refurbishment; and the PMO National Project Director will also countersign approved screening reports as accurate and correct. If there is any doubt as to the accuracy, the case should be audited immediately.

26. Provincial teams should assign one person to act as the focal point for social safeguards work. Safeguard oversight will be provided through the PMO with guidance from the Chief Technical Advisor (CTA) who will provide about 3 years of intermittent input to the project, and the national Gender and Social Safeguard Specialist who will provide about 12 months of intermittent input. The CTA and Safeguards Specialist will cover gender and all three safeguard areas of resettlement, ethnic groups, and also environment. Technical assistance is required to ensure safeguard plans are implemented and monitored correctly and also to raise local capacity in regards to awareness and understanding the rationale and triggers for safeguard measures. The CTA and Safeguard Specialist will play a key role in ensuring that the Resettlement screening checklists are audited and the results reported to both PMO and ADB.

27. The costs associated with implementing this resettlement framework are minimal as the cost of technical assistance is allocated across all three safeguard areas in the case of the Safeguard Specialist and across the entire project for the CTA. Some additional costs will be required for the conducting of screening checklists and a lump sum of US$ 20,000 should be allocated for this activity.

Greater Mekong Sub-Region Health Security Project (PPTA 48118 – REG)

Initial Environmental Examination

May 2016

Cambodia: Greater Mekong Subregion Health Security Project

Prepared by Conseil Santé for the Ministry of Health and the Asian Development Bank

CURRENCY EQUIVALENTS
(as of March 2016)

Currency Unit	–	Cambodian Riel (KHR)
$1.00	=	3,950 KHR

NOTE

In this report, "$" refers to US dollars

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ABBREVIATIONS

ADB	–	Asian Development Bank
AIDS	–	Acquired Immune Deficiency Syndrome
APSED	–	Asia Pacific Strategy for Emerging Diseases
BOD	–	Biological oxygen demand
CARM	–	Cambodia Resident Mission
CDC	–	Communicable Diseases Control
CEP	–	Commitment on Environmental Protection
CDCD	–	Communicable Diseases Control Department
CLMV	–	Cambodia, Lao PDR, Myanmar and Viet Nam
COD	–	Chemical oxygen demand
CPC	–	Commune People's Committee
CPMU	–	Central Project Management Unit
DHIS	–	District Health Information system
DHO	–	District Health Office
DOH	–	Department of Health
DONRE	–	Department of Natural Resources and Environment
DPC	–	District Peoples Committee
DMS	–	Department of Medical Services
DPHIS	–	Department of Planning and Health Information Systems
EA	–	Environmental assessment / Executing Agency
EARF	–	Environmental Assessment and Review Framework
EARP	–	Environmental Assessment and Review Procedures
EHF	–	Ebola Hemorrhagic Fever
EIA	–	Environmental Impact Assessment
EIAR	–	Environmental Impact Assessment Report
EID	–	Emerging Infectious Diseases
EMP	–	Environmental Management Plan
EU	–	European Union
GOL	–	Government of Lao People's Democratic Republic
GMS	–	Greater Mekong Subregion
HAI	–	Hospital acquired Infection
HCWM	–	Health Care Waste Management
HMIS	–	Health Management Information System
HSSP	–	Health Sector Support Program
HIV	–	Human Immunodeficiency Virus
IA	–	Implementing Agency
IEC	–	Information, Education and Communication
IEE	–	Initial Environmental Examination
IHR	–	International Health Regulations
INGO	–	International non-government organization
IOM	–	International Organization for Migration
IP	–	Indigenous peoples
IPC	–	Infection Prevention and Control
ISWM	–	Integrated Solid Waste Management
JICA	–	Japan International Cooperation Agency
Lao PDR	–	Lao People's Democratic Republic
MERS	–	Middle East Respiratory Syndrome
MEVs	–	Migrants and mobile populations, ethnic minorities, and other vulnerable groups

MMPs	–	Migrant and mobile populations
MEF	–	Ministry of Economics and Finance
MOH	–	Ministry of Health
MOE	–	Ministry of Environment
NGO	–	Non-government organization
PAH	–	Project affected household
PAM	–	Project Administration Manual
PCU	–	Project Coordination Unit
PM	–	Particulate matter
PHD	–	Provincial Health Department
PIA	–	Provincial Implementing Agency
PPE	–	Personal Protective Equipment
PPMU	–	Provincial Project Management Unit
PPTA	–	Project Preparatory Technical Assistance
Project	–	The Greater Mekong Subregion Health Security Project
REA	–	Rapid Environmental Assessment
RCU	–	Regional Coordination Unit
SWM	–	Solid Waste Management
TB	–	Tuberculosis
WB	–	World Bank
WHO	–	World Health Organization
WHS	–	World Heritage Site
WWTP	–	Wastewater treatment plant

I. INTRODUCTION

A. Background of the Project

1. The Greater Mekong Subregion (GMS) comprises Cambodia, China (Yunnan and Guangxi), Laos, Myanmar, Thailand, and Viet Nam, with a population of about 326 million people. The region has gone through rapid economic development, with overall GDP growth of about 7% per year during the past decade. The major demographic, economic and technological differences among the GMS countries, combined with improved connectivity and trade facilitation, bring about substantial business dynamics. Regional investments have increased rapidly, stimulated by regional security, low cost labor, and improved connectivity. Better roads, ports and trade agreements facilitate participation in the global market. Regional tourism has also increased dramatically. GMS Countries are industrializing rapidly, resulting in a rapid increase in migrant workers, mostly internally, but also externally. Urbanization is increasing rapidly, and creating new challenges that require major investments. This has also increased the risk of the spread of communicable diseases associated with increased connectivity, employment, and social and physical living environment.

2. Under the GMS economic development program, the Governments of Cambodia, Lao People's Democratic Republic (Lao PDR), Viet Nam and Myanmar, and the Asian Development Bank (ADB) aim to achieve core capacities for the control of emerging infectious diseases (EIDs) and other major public health threats based on international standards of the World Health Organization (WHO). A GMS Health Security Project (the Project) of $135 million has been proposed for 2016, with a total of $117 million in loan, $8.0 million in grants from ADB's Special Funds resources, and government counterpart funds of $7.0 million. The Project follows other health projects for communicable diseases control (CDC), HIV, Malaria, and related regional technical assistance.[1]

B. Purpose and Structure of the Report

3. The project is categorized as a Category B project in accordance with the ADB's *Environment Policy*. The Initial Environmental Examination (IEE) presented in this report is to comply with the requirements of ADB in relation to environmental assessment of ADB financed projects. In particular, the IEE has been prepared to fulfill the requirements of the ADB's *Environmental Policy* and *Operations Manual (OM) 20: Environmental Considerations in ADB Operations*. The IEE is based on a selection of representative provinces based ADB's *Environmental Assessment Guidelines* (2003).[2]

4. The following methodology has been implemented in the preparation of the IEE:

- (i) Review of project-related documents and literature relevant to the project areas initially surveyed
- (ii) Site visits to view the environmental conditions in representative project areas and the general location of the projects

[1] Including Community Action for HIV Prevention in 2001; GMS Regional Communicable Diseases Control Project in 2004; Second GMS Communicable Diseases Control Project in 2010; GMS Capacity Building for HIV/AIDS Prevention Project in 2012; Japan Fund for Poverty Reduction projects such as for Model Healthy Village; and technical assistance for malaria and dengue control, health education, e-Health, and related areas.

[2] ADB. 2003. *Environmental Assessment Guidelines.* Manila.

(iii) Consultation with local and national authorities to source information on project area characteristics and potential project impacts
(iv) Identification of existing environmental and socio-economic characteristics to develop project baseline data
(v) Analysis of typical environmental impacts of project components and identification of suitable typical mitigation measures to ameliorate potential impacts
(vi) Development of institutional arrangements for implementation of environmental management and monitoring
(vii) Development of a set of environmental criteria for future project activity selection
(viii) Development of environmental assessment and review procedures (EARPs) for future project sub-components.

II. DESCRIPTION OF THE PROJECT

A. Project Rationale

5. The Government of Cambodia aims to achieve core capacities for the control of emerging infectious diseases (EIDs) and other major public health threats based on international standards of the World Health Organization (WHO) especially at the border areas. Cambodia, aiming to comply with WHO standards to achieve GMS health security, has requested ADB project support to address critical gaps in core capacities. MOH and WHO have conducted evaluation of Asia Pacific Strategy for Emerging Diseases (APSED) implementation in 2014. Cambodia has not yet achieved International Health Regulations (IHR) and APSED targets. Core functions owned by MOH are well in place, but other functions depending more on collaboration with other countries, sectors, partners, community, and the private sector are less advanced. The recent MERS and Ebola outbreaks, and the Zika virus scare have put re-emerging infection diseases (EIDs) back in the limelight. While progress in other regional priorities is mixed, there is major progress in the control of malaria and dengue, and less progress in the control of HIV/AIDS and tuberculosis and the major emerging concerns of nosocomial infections and multiple drug resistance.

B. Project Design

6. The project goal is to strengthen the GMS health security, with the following indicators: (i) zero major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased treatment of vulnerable groups for communicable diseases. The proposed project outcomes are: (i) improved coverage of GMS public health security system and compliance with IHR/APSED; and (ii) CDC coverage increased in vulnerable groups in CLMV border areas, in particular for migrants, ethnic minorities, and other vulnerable groups (MEVs) as prioritized by the Governments. The proposed project outputs are: (i) increased GMS collaboration and MEV access to CDC in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases.

7. In Cambodia, the proposed project amount is $22.8 million of which the Government of Cambodia requested a loan of $21.0 million from the ADB Special Funds. The Government counterpart contribution in $1.8 million (9%) in taxes, allowances and in-kind contributions. The Health Sector Support Program/Department of Planning and Health Information Systems represents MOH as the Executing Agency.

8. In summary, the Government of Cambodia will use the loan to finance hardware (laboratory and infection prevention and control equipment, computers, transport vehicles and other auxiliary devices, and use government resources to finance software (training and workshops) and project management.

a. Regional cooperation and CDC in border areas

9. Regional cooperation is mainly in the form of information exchange and joint outbreak responses. While national level information exchange is affected by lack of leadership, cross-border cooperation is gaining momentum.

10. Sub-groups of MEVs in border areas have unique risk of exposure to particular diseases. The risks may vary by occupation and location. However, there are particular concerns for cross-border migrant workers returning home with HIV or TB, who may not have access to care on their return. HIV-infected youths and pregnant mothers also may have limited access to services and care. The project will explore new strategies for reaching MEVs and for timely reporting of patients with certain symptoms from remote communities using syndromic surveillance.

b. Surveillance and Response

11. Several disease reporting systems are in place which are not linked, do not reach communities, and do not provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, thereby also limiting the efforts to improve disease control and community prevention and preparedness. In addition, through workshops and other knowledge management activities, specific strategies for disease control and system strengthening will be developed. Workshops will be comprised of carefully prepared participatory learning and strategic planning events with monitoring of follow up actions by the regional coordination unit. Through bilateral agreements with the neighboring border countries, the Project will explore strategies to reach various MEVs who are more likely to be exposed to different types of diseases.

c. Laboratory services and Hospital Infection Prevention and Control

12. In Cambodia, much of the efforts in improving laboratory services have gone into strategic planning, provision of equipment and setting up laboratory services in the larger regional hubs often using mentoring, quality control at central level, and, more recently, also multiple initiatives to improve biosafety. However, as laboratory services are complex requiring some 20 subsystems to be in place, the support for the subsystems have received much less attention such as support for: undergraduate education; laboratory management, facilities, registration and inspection/audit; medical-laboratory linkages; and transport and maintenance systems. It is necessary to address these gaps that will ensure better use of past investments in staff and equipment.

13. Hospital and health centers are the most likely points of contact for newly emerging diseases, and also pose a major concern in terms of spreading these diseases. In addition, health facilities are a source of HAI or nosocomial infections and drug resistance. Current equipment and practices in health facilities for infection prevention and control, and waste disposal are sub-standard and unsafe, and would not meet IHR or APSED obligations. Realizing this, Cambodia is currently launching a new IPC plan and, based on the WHO guidelines, is

rolling out a

comprehensive IPC program that requires strong MOH commitment and more investments in IPC scholarships, infection control management, and hospital equipment and hygiene supplies.

C. Project Location

14. The Project in Cambodia will cover 13 border provinces along its border with Lao PDR, Vietnam, Thailand and Myanmar. The proposed provinces include: at the northeast border with Lao PDR and Viet Nam: Preah Vihear, Stung Treng, Ratanakiri, Mondulkiri and Kratie; at the northwest border with Thailand: Battambang, Pailin, Banteay Meanchey; and at the southeast border with Viet Nam: Kandal, Kampot, Prey Veng, Svay Rieng and Tbong Khmum. These are poor border provinces not supported by other projects with a large proportion of ethnic groups. The main focus will be on the border districts

D. Project Outputs

Output 1: Strengthening regional, cross-border, and inter-sectoral CDC

15. MOH has made progress with regional information sharing and inter-sectoral and cross-border cooperation for CDC. In border areas, MEVs are more likely to get and spread infectious diseases and are less using formal health services. Under this component, it is proposed that the Project supports (i) regional, cross-border, and inter-sectoral information sharing and coordination of outbreak control among GMS countries, (ii) regional capacity for evidence-based CDC, (iii) development of better disease control strategies for MEVs in border areas, and (iv) increased CDC for MEVs in hotspots along economic corridors in targeted border areas. Support is needed for information exchange, simulation exercises, joint outbreak control, strategic planning for MEV disease control strategies in border areas, outreach to MEVs, and improving access of MEVs to CDC.

Output 2: Strengthening national disease surveillance and outbreak response

16. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong. However, the system needs to be further computerized, extended to reach all health centers and communities by employing syndromic reporting, and data management has to be improved. Linkages or integration among surveillance systems with HMIS/DHIS will also be considered. MOH also needs to improve capacity for risk analysis, community preparedness, and disease outbreak response. Under this component, it is proposed that the Project supports: (i) syndromic reporting at community level; (ii) web-based reporting including information technology support; (iii) linking of disease surveillance systems, including linking clinical and laboratory surveillance; (iv) improving capacity for risk analysis, risk communication, and community preparedness; (v) improving capacity of outbreak response teams including transport; and (vi) improving screening and quarantine capacity at border points of entry and quarantine centers. Support is needed for system design, training information technology equipment, vehicles, training, and equipment for screening and outbreak control.

Output 3: Improving laboratory services and hospital infection prevention and control

17. District facilities are unable to comply with internationally acceptable levels of biosafety or

to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance systems are in a nascent stage, and there are no national laboratory audit systems. Nosocomial or hospital-acquired infections (HAI) are becoming a major public health threat. Under this component, it is proposed that the Project supports improving biosafety and quality of laboratory services and expanding services for CDC. Inputs will be (i) staff training for provincial and district hospitals for internal quality improvement, (ii) preparing standard operating procedures, (iii) providing basic equipment, supplies and minor repairs for laboratories and schools, (iv) setting up external quality assurance and audit system for compliance with national biosafety and quality guidelines, and (v) setting up a laboratory network. For infection control in hospitals, the Project will support roll out of IPC through training in hospital hygiene and special case management, provision of basic equipment and minor repairs of wards.

E. Project Outputs of Environmental Concern

18. The requirement for an environmental impact assessment is linked to the following Project Subcomponents: (1) Sub-component 2-5, Component 2, **Output 2** and (2) Sub-component 3-4, Component 3, **Output 3** of the above project summary, namely:

Sub-Component 2-5: **improve capacity of outbreak response teams including transport**

Sub-Component 3-4: **provide laboratory equipment and training for infection prevention and control, including laundry services and waste disposal**

19. The above sub-components will require screening of potential environmental impacts and a discussion of mitigating or enhancement measures as a result of the impacts because the activities involve public health risks and potential accidents, minor repair and improvement works, the installation and commissioning of laboratory equipment and related devices, and the operation of the target provincial/district hospitals' existing medical waste management and waste water treatment facilities – all of which impact the project's environmental setting and require environmental safeguards.

20. The screening addresses the potential impacts of the relevant project activities under the loan program, which are re-defined for purposes of the IEE, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; (iii) operation of the existing solid waste management facilities and (iv) operation of the existing wastewater treatment facilities described as follows:

- **Project Activity 1 – Minor repair and improvement works.** This activity includes the minor repair and improvement works of the hospital facilities specifically affected by the provision of access, accommodation, modification and installation of new or upgraded laboratory equipment and auxiliary devices, IPC equipment and devices including laundry equipment, computer systems, etc.
- **Project Activity 2 – Laboratory equipment commissioning including IPC services.** This activity includes the mobilization, equipment installation, commissioning, demobilization, recurrent maintenance checks by the suppliers/contractors, and the operation from installation and during the life of the equipment. The equipment means the totality of the laboratory equipment,

auxiliary equipment, laundry and washing/drying equipment, and relevant IPC devices and supplies, laundry equipment including the transport vehicles for the transport of laboratory specimen procured under the Project.

- **Project Activity 3 - Solid Waste Management facilities.** The collective activity assumes existing activities that include: (1) the storage and segregation (as applicable) of medical infectious/hazardous and non-infectious/non-hazardous wastes; (2) collection and transfer for disposal or recycling (as applicable); (3) internal and external transportation of medical waste; recycling or composting of non-hazardous wastes; and (4) disposal at: (i) an approved and dedicated disposal facility such as a provincial hospital; (ii) permanent burial in specially designed, secure landfills which will incorporate lining and leachate management systems; (iii) sterilization using either chemicals or steam; and (iv) incineration using an approved incinerator designed to mitigate hazardous emissions. The operational activities will vary according to the type of facility but will include receipt of waste, burial of waste, burning of waste, general site maintenance, and odor and vermin control.
- **Project Activity 4 - Wastewater treatment facilities.** The collective activity assumes the existing operations of wastewater treatment facilities that are installed at the target hospital facilities to treat effluent to meet relevant environmental standards prior to discharge to waterways or municipal wastewater systems. The scale of operation activities will vary according to the type of facility but includes wastewater treatment process control, site maintenance, and odor control.

21. Since the project does not involve civil works construction, the stages of the project cycle during which screening is to be conducted and into which the temporal boundaries of the activities have been divided are: the **pre-procurement stage**, the **procurement (including the commissioning) stage**, and the **operation stage** from the viewpoint of the hospital facilities.

22. The Project will finance the procurement of laboratory equipment and supplies, transport vehicles, laundry and other infection prevention and control equipment, computer systems and devices for the newly-improved hospitals and other institutions identified by provincial authorities serving as the target populations. A total of 12 target provinces will comprise the beneficiaries of the project. Equipment purchases will be in accordance with established MOH standards and will replace old and non-functioning equipment, upgrade technology for existing procedures, or provide new services. The Project will also support the purchase of an initial inventory of reagents and other supplies needed to properly utilize the new equipment. Procurement and supply of equipment will be closely coordinated with the other components of the project implementation.

23. Once completed, the newly improved and renovated laboratory facilities and supplies, IPC equipment and related devices, computers and related systems, and transport vehicles that are part of the Project need to be properly maintained to realize benefits and justify investments. The Project will ensure that hospital personnel are properly trained to use the equipment and operating manuals are supplied in the Cambodian language. The Government of Cambodia shall support the preparation of guidelines for preventive maintenance and training of hospital personnel in preventive maintenance procedures.

24. The Government of Cambodia has also assured that the supplies needed to operate the equipment, as well as the costs of maintenance will be provided during and beyond the project

period through recurrent costs and adequate increases in operation and maintenance budgets.

25. Moreover, while this project does not include civil works and medical waste management and waste water treatment equipment, the investments will be made with the assurance from the Government of Cambodia that all facilities included in this Project have adequate safe water, sanitation, and medical waste management systems, including waste water systems, proper containers to segregate contaminated and hazardous waste, proper collection and storage facilities, and access to modern medical waste incineration and/or non-burn treatment and disposal facilities in compliance with the country's environmental laws and the safeguards policy of the ADB. It is incumbent upon the Government of Cambodia that hospital personnel in all facilities covered by the project will be trained in the theory, methodologies, and supervision of modern medical waste and waste water management practices. In addition, the Project will support consulting assistance to work with authorities in each target province to develop a province-wide plan for the management of medical waste.

F. Project Category

26. For purposes of this IEE, the hospitals surveyed will be indicative and representative of the extent of environmental impact assessment and review that shall have to be performed for the other remaining provinces and districts in accordance with ADB guidelines as the project progresses.

27. The project is initially categorized as B for environment based on ADB's *Safeguard Policy Statement* (2009) as the project involves components dealing with laboratory bio-hazards and hospital solid and liquid waste management. An IEE has been prepared based on a field survey of a provincial hospital and a district hospital in one border province and data obtained from interviews with key officials of the MOH and the Ministry of Environment (MOE) dealing with environmental impact assessment, the regulation of hazardous substances, pollution control and solid waste management. WHO (2015) data were also obtained regarding the status of health care waste management in Cambodia. The findings on the practices in hospital safety and sanitation, infection prevention and control, and risk of accidents and spills during storage, transfer, transport and containment of bio-hazards, and the rapid environmental assessment confirmed the project to be Category B. Each of the participating provinces will prepare EMPs covering all project activities during implementation and in accordance with the environmental laws of the Government of Cambodia.

III. DESCRIPTION OF THE ENVIRONMENT

A. Physical Resources

1. Topography and Soils

28. Cambodia lies in the southwestern part of the Southeast Asian peninsula and has a land area of 181,035 km^2. International borders are shared with Thailand to the west, the Lao People's Democratic Republic to the north, and the Socialist Republic of Viet Nam on the east and southeast. The country has a coastline of 440 km. There are three distinct topographic regions: the central plains, the flat coastal areas, and the mountain ranges with high plateaus. Two-thirds of the country's population live in the central lowlands.

2. Climate and Air Quality

29. The monsoon dominates the climate and causes distinct wet and dry seasons. The southwest monsoon typically brings the rainy season from May to October. The northeast monsoon brings drier and cooler air from early November to March, then hotter air prevails in April and early May. Relative humidity is high all year, exceeding 90%, and barely below 50% in the dry season. Temperatures are uniform throughout the country and average 28 degrees Celsius. Wind velocity is on average at less than 3m/s.

3. Drainage Network and Surface Water and Groundwater Quality

30. Groundwater in Cambodia is plentiful but water quality is important as current and future development projects include accessing groundwater resources for drinking and irrigation. Additionally, various chemicals present in the groundwater can cause serious health problems or water that tastes unpleasant. Since 2005, RDI has tested over 10,000 wells as part of a program to characterize water quality throughout Cambodia. More than fifty percent of Cambodians rely on groundwater for drinking in the dry season (2008 census).

4. Water Resources

31. In rural area of Cambodia, people traditionally use rivers, lakes, ponds and shallow dug wells for their domestic water needs. In the rainy season, people mainly use rainwater for drinking and cooking. Access to clean water drinking (pipe water supply) varies significantly throughout the country. From socio-economic survey of NR56, 2012 shows that 37% sourced their drinking water from ponds or lakes while 34% have piped water supply and 16% fetched their drinking water from tube wells. Others 13% use river/canal or buy or catch rainwater for their daily consumption. Generally, in Cambodia only 30% of rural populations have access to safe drinking water.

B. Ecological Resources

32. Cambodia maintains roughly 58% forest cover, compared with 73% prior to the civil war, and is rich in biodiversity. Threats to Cambodia's forest landscapes and biodiversity include clearing and degradation, overexploitation of key species, and undervaluing of ecological services such as carbon sequestration. Industrialized agriculture and mine exploration continue to degrade forests significantly.

C. Reference Baseline Data for Health Care Waste Management in Cambodia

33. A key component of the project is the improvement of health care waste management practices in the project area. The results of a review of existing health care waste management practices in the project area are summarized below.

1. Healthcare waste generation

34. Healthcare waste (HCW) generated from hospitals includes both non-hazardous waste and hazardous waste. No quantification of non-infectious and infectious waste components of HCW has been available in the project areas surveyed. WHO estimates that about 85% of the HCW from developing countries is non-infectious or generally risk-free healthcare waste, which is comparable to domestic waste. The remaining 15% of healthcare waste is regarded as hazardous and may create a variety of health risks. The MOH in Cambodia states that about

80% of the HCW generated in a health care facility is general waste while the remaining 20% comprises wastes that contain harmful microorganisms that can cause infections and outbreaks while other hazardous substances can affect human/animal lives and cause toxicity and environmental pollution, respectively. Hazardous healthcare waste can be classified into the following categories: infectious waste, highly infectious waste, sharps, pathological/anatomical waste, pharmaceutical waste, genotoxic waste, chemical waste, waste with high content of heavy metals, pressurized containers, and radioactive waste.

35. The amount of HCW generated depends on the hospital size and its scope of services. There has been no data recorded of HCW generation rates in Cambodia. According to surveys on HCW management conducted by the MOH in Vietnam and WHO, a provincial general hospital typically generates 0.64 kg/bed/day of general HCW and 0.14 kg/bed/day of hazardous HCW, while a district hospital typically generates 0.62 kg/bed/day of general HCW and 0.11 kg/bed/day of hazardous HCW. In terms of the relative proportion of hazardous waste generated, infectious waste and pathological waste represents about 15%, sharps represent about 1%, chemical and pharmaceutical waste represents about 3%, other waste such as waste with high content of heavy metals, and pressurized containers share represent less than 1%.

2. Healthcare waste minimization

36. Waste minimization is defined as the prevention of waste production and/or its reduction. This is not regularly practiced by healthcare establishments in the region such as in Cambodia. Minimization measures such as source reduction (modification of purchasing procedures, control of inventory, and production of less toxic materials), good management and control practices applied particularly to the purchase and use of chemicals and pharmaceuticals, and using of recyclable materials are not typically implemented.

37. Healthcare waste contains quantities of valuable and recyclable materials such as plastic, metals, paper and carton. However, waste recycling is not centrally implemented at hospital level despite the fact that it is carried out unofficially by the different offices.

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3. Healthcare waste segregation

38. Cambodia has not formally implemented segregation of wastes into color-coded bags or containers. Within the hospitals that received support, basic segregation has been introduced but without standard operating procedures or regular training provided. Other countries like Vietnam, for example have institutionalized the segregation of three separate containers into different colors: general waste in green bags, clinical waste in yellow bags, and toxic wastes in black bags. The MOH has started to develop its own system, contained in their National Guideline on Health Care Waste Management under the leadership of the MOH and in coordination with the relevant regulations by the MOE as the regulatory body. In other developing countries, sharps are segregated and placed into rigid containers with certain specifications to avoid accidental punctures or spillage during handling. In Cambodia, the provincial hospitals who were interviewed have been owning to being generally responsible for the sharps. However, their treatment and ultimate disposal has not progressed into something environmentally acceptable. The provincial hospitals after collecting the hazardous wastes from the district hospitals, either incinerate them using low-temperature open incinerators or bury them at unsecured waste pits within their property boundaries. The successful practice of waste segregation and disposal is one of the biggest challenges in HCW management in most developing countries such as Cambodia. There are limitations reported, as follows:

(i) Knowledge, attitude and practices among waste generators including hospital staff, patients and visitors are unsatisfactory
(ii) Supply of equipment for waste segregation, especially sharp containers is insufficient in both the district hospitals and health centers as a consequence of inadequate funding
(iii) No system has been generally introduced as a policy by the relevant authorities for enforcement

3. Healthcare waste collection

39. Of the district hospitals surveyed, the staff assigned to be responsible for collecting healthcare waste from the generation point to interim storage points in the departments have been generally on an ad-hoc basis. No institutionalized committees have been formed to take on the function. Some weaknesses in collection have been observed in the region as follows:

(i) Provision of equipment, waste containers in different sizes are not sufficient
(ii) There is no budget appropriation for staff nor equipment and materials to meet these recurring needs
(iii) Design of hazardous waste containers do not meet requirements
(iv) Codification and labeling, waste bags and containers, especially those for clinical waste and chemical waste are not properly color-coded and labeled

4. Healthcare waste transportation

40. Some primary health care workers are made responsible for internal collection from the district hospitals. All of the district hospitals visited lack specialized devices for waste transportation. Hazardous waste is often transported by hand causing spillage and spread of disease throughout the hospital. Internal transportation plans in which the timetable and route of transportation are clearly identified are not available.

41. No private contractors or responsible government agency transports general waste out of the hospitals to a disposal facility. The district hospitals themselves manage their HCW internally, except for donor-provided sharps safety boxes and certain anatomical wastes that the districts send to the provincial hospitals for disposal.

5. Healthcare waste storage

42. All of the visited district hospitals do not have a formally designated place to store healthcare waste except for different cans and bags of different sizes and materials. Most of the storage containers in district hospitals, do not meet design and operating regulations because of the following shortcomings:

(i) The storage areas do not incorporate separate places for different categories of healthcare waste. As a result, general waste and clinical waste that were segregated at sources and separately collected and transported are mixed again at storage places. Chemical waste is not collected and centrally stored. Liquid wastes are disposed of in the sinks although some of the hospitals have separate septic vaults for liquid wastes for wastes are disposed
(ii) The storages do not have roofs and locks. Unauthorized people, animals, rodents and inserts can easily access hazardous waste causing risks of spillage and disease spread.

(iii) Storage duration often exceeds 24 hours in hot weather.

6. Healthcare waste treatment

43. No models for health care waste treatment were observed in the district hospitals visited.

44. Healthcare waste treatment technologies applied in the region are (i) medium temperature incineration, (ii) low temperature incineration, (iii) waste burial, (iv) steam autoclave, (v) chemical disinfection;

(i) Medium temperature incineration: Pyrolytic incinerators that incinerate waste at 800 – 900°C are reported to be used at the provincial hospitals but these have not been confirmed by actual visits. The emissions from incinerators have not been monitored since they were installed, but polluting gas emissions and high operating costs are reported.

(ii) Low temperature incineration: Drum incinerators, brick incinerator or one-chamber, open incinerators are still common in district hospitals even though their design is out of date. Because of low effectiveness and high environmental impacts, such incinerators are no longer recommended. The gas emissions from these incinerators have reportedly been very pollutive.

(iii) Waste burial: District hospitals bury healthcare waste on their premises. Safe burial of healthcare waste is recommended by WHO. However, in comparison with requirements of sanitary landfill, the bury pits observed in hospitals often have the following shortcomings: (i) inadequate sealing of base and sides to minimize the movement of wastewater or leachate off site, (ii) no presence of site personnel capable of effective control of daily operations, (iii) no surface water collection, (iv) access to site and working areas difficult for waste delivery and site vehicles, (v) lack of surface water collection trenches around site boundaries, (vi) lack of a final cover to minimize rainwater infiltration when each phase of the landfill is completed

(iv) Wet thermal disinfection: Stream autoclaves are commonly used by hospitals to primarily treat highly infectious waste. Although wet thermal disinfection has been introduced in Cambodia at present, application of autoclave for healthcare waste treatment is still limited to microbiological laboratories where highly infectious waste is mostly generated.

(v) Chemical disinfection: Using disinfectants to treat contaminated materials is very common in provincial and district hospitals. However, application of chemical disinfection for healthcare waste treatment, particularly for highly infectious waste treatment is still limited to microbiological laboratories and in areas of infectious disease outbreaks.

7. Wastewater collection and treatment

45. Hospital wastewater includes rainwater, wastewater generated from healthcare activities and wastewater from toilets. Old hospitals often have a collection system for storm water, a collection system and septic tanks for wastewater from toilets but only a few of those visited have separate collection lines and separate septic tanks for wastewater generated from healthcare activities. In consequence, wastewater from healthcare activities with a high content of pathogens and certain amount of pharmaceuticals and chemicals is discharged into the storm water system line or discharged onto the land without any treatment. Beside these weaknesses in design, there are weaknesses in operation and maintenance in terms of wastewater collection

and treatment as follows:

(i) Hospital staff often discharge chemical and pharmaceutical waste into wastewater collection systems. This practice can harm the wastewater treatment plant, if any.

(ii) In the district hospitals areas visited, staff and patients do not know how to properly maintain toilet and sanitary facilities in the hospitals. This often results in blockages
of the wastewater collection system. Regular and corrective maintenance of wastewater collection system is rarely carried out.

IV. SCREENING OF POTENTIAL ENVIRONMENTAL IMPACTS AND MITIGATION MEASURES

A. Rapid Environmental Assessment

46. In order to identify potential environmental impacts of the project components, the initial environmental screening was first carried out using the ADB rapid environmental assessment forms (REAs) to screen the proposed activities required for the installation of new or improved laboratory facilities/equipment such as minor repair and improvement works on the provincial and district hospitals at border provinces, districts and towns as the case may be. (Please see Appendix 2 for the form used). While the district and provincial hospitals are all existing facilities and whatever improvements are introduced bring mostly positive impacts for the environment, the REAs categorized most of the project activities as Category B because the project involves the management of infectious, hazardous, medical solid waste and wastewater and the risks inherent in the handling of laboratory wastes, and the diagnostic activities in managing highly infectious diseases at the border towns of the target border district and provincial hospitals.

47. The ADB safeguard policies require that the project's activities need to be carefully considered to avoid and/or to minimize the negative impacts on the natural environment and social environment (including environmental public health and occupational health), and provide the appropriate measures to mitigate such impacts. In accordance with the ADB guidelines, the potential impacts of medical solid and liquid wastes including laboratory wastes, being hazardous along with deficient sanitation and laundry facilities and the lack of effective wastewater equipment and treatment systems categorizes the health facilities as having significant potential negative environmental impacts that need to be mitigated.

B. Environmental Assessment Methodology

48. A survey was conducted by the Consultant and the MOH team in one district hospital (Pea Reang District Hospital) and one provincial hospital (Prey Veng Provincial Hospital) as met with the officials of an Operational District office at one border province to be representative of the other targeted provinces. The main objectives of the survey were to:

(i) Assess the current practices and environmental conditions focused on the medical waste (solid and liquid) management of the health care facilities (provincial and district hospitals);
(ii) Organize meetings with the provincial agencies of MOH, the PHDs to consult them about their needs and plans about the environmental management of the

sub-components of the health security project to institute environmental safeguards from the impacts of laboratory waste, infectious disease bio-hazards, hospital safety and hygiene for infection prevention and control, and medical solid and liquid waste management; and

(ii) Collect environmental baseline data of the representative provinces included in the target border areas.

49. During the time allotted, the site surveys were carried out by a combination of methods i.e. observation, photo-documentation, data/document review and analysis, and interview or focus group discussions with key informant officials. The survey team earlier developed sets of Rapid Environmental Assessment (REA) checklists for health care facilities. The data and information on environmental issues (focused on medical solid and liquid waste management and hospital safety and hygiene for infection prevention and control) of the selected provinces under the project areas were collected from MOH, MOE and relevant provincial agencies.

50. The Consultant and the MOH/provincial team conducted the meetings with the provincial staff, Provincial Hospital Director, Operational District Director and Laboratory staff were held with participation of the relevant staff to discuss the environmental situation in their respective areas focusing on the medical and laboratory waste management. Similar meetings and consultations at the district hospital visited were also held with participation of the district hospitals staff to discuss the environmental situation of the district hospitals respectively and open discussions about their views about the project, on the medical waste management and hospital safety and hygiene for infection prevention and control, and on medical solid waste management and wastewater treatment facilities.

C. Potential Environmental Impacts and Mitigating Measures

51. For the purposes of the assessment, the following categories of impacts have been developed:

i. **NO IMPACT:** The potential impact of the project is assessed as NO IMPACT if the project activity is physically removed in space or time from the environmental component, or if the impact is so small as to be un-measurable (i.e. negligible).

ii. **MAJOR IMPACT – POSITIVE OR NEGATIVE:** An impact is said to be MAJOR if the project has the potential to affect an environmental component. The following criteria were used to determine whether a given impact is MAJOR:

   a. spatial scale of the impact (site, local, regional, or national/ international);
   b. time horizon of the impact (short, medium, or long term);
   c. magnitude of the change in the environmental component brought about by the project activities (small, moderate, large);
   d. importance to local human populations;
   e. compliance with international, national, provincial, or district environmental protection laws, standards, and regulations;
   f. compliance with ADB guidelines, policies, and regulations.

iii. **MINOR IMPACT – POSITIVE OR NEGATIVE:** If an impact occurs but does not meet the criteria for a Major Impact it is assigned the category MINOR. Minor impacts occur along a spectrum ranging from those impacts that are close to being major impacts to those that are close to being negligible impacts. The

judgments made in relation to the position of specific impacts along this spectrum are discussed in the text accompanying the environmental screening.

iv. **UNKNOWN IMPACT:** The potential impact of the project will be assessed as being UNKNOWN if the magnitude of the effect cannot be predicted for any of the following reasons:

a. the nature and location of the project activity is uncertain;
b. the occurrence of the environmental component within the study area is uncertain;
c. the time scale of the effect is unknown;
or
d. the spatial scale over which the effect may occur is unknown.

52. These categories have been applied to other ADB infrastructure projects and have been adapted from ADB, *1997 Environmental Impact Assessment in Developing Countries.*

D. Screening of Environmental Impacts of Project Components

53. The purpose of this section is to undertake further screening of typical environmental impacts of the project components/sub-components. The screening addresses the potential impacts of the structural processes to be implemented and relevant activities under the loan program, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; iii) operation of the existing solid waste management facilities and (iv) operation of existing wastewater treatment facilities. Since the project does not involve civil works construction, the environmental assessment covers the pre-procurement, procurement (including the commissioning stage), and the operation stage of the project as described fully in Section II-G. Only potential impacts that have direct and relevant significance are listed in the environmental screening (Appendix 1).

54. The following key is used in the environmental screening.

NO impact	O
MINOR NEGATIVE impact	X
MAJOR NEGATIVE impact	XX
MINOR POSITIVE impact	+
MAJOR POSITIVE impact	++
UNKNOWN impact	?

E. Findings of the Environmental Assessment

55. The TOR initially categorized this project as requiring an Initial Environmental Examination (IEE) Report and an Environmental Management Plan both of which are required for a Category B Project. It is understood that this project was tentatively classified as a

Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document. This categorization was examined through the representative visits to the different project sites and the proposed project component descriptions and how the project proponent intends to mitigate the potential negative environmental impacts of the project.

56. In accordance with the ADB's *Environment Policy (2003),* Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or significance than those for Category A projects that require a full-blown Environmental Impact Statement arising from major adverse impacts on the environment. For a Category B project, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

57. In Cambodia, the final list of target district hospitals from the border provinces and districts are still being finalized by Government through the MOH, and their respective environmental assessments have not been prepared. The project is expected to have positive environmental impacts based on the level of investments in laboratory equipment to improve diagnostics of emerging diseases in support of communicable diseases control. On the other hand, this project is not supporting civil works construction for waste management. It is expected that the existing SWM equipment and wastewater treatment facilities will not be able to meet the environmental standards consistently.

58. During the project's life, the environmental assessment will continue particularly for the medical solid waste and the wastewater treatment facilities. If not upgraded or properly maintained, there will be a good chance that the assessment will also continue to have negative environmental impacts. It is very important therefore to have an environmental management plan in place. Within the plan should be a monitoring framework.

59. Separately, the projects will undergo environmental impact assessment in accordance with the relevant Cambodia legislation on environmental pollution laws, medical solid and liquid waste management, wastewater treatment facilities, and environmental health and safety.

V. INSTITUTIONAL REQUIREMENTS AND ENVIRONMENTAL MONITORING PLAN

A. Institutional Arrangements

60. Table 5.1 summarizes the proposed environmental management responsibilities of key parties involved in the project.

Table 5.1: Environmental Management Institutional Arrangements

Agency	Environmental Management Responsibilities
ADB	Sign grant agreement with Government of Cambodia including environment-related covenants Review of site specific EAs and environmental monitoring reports

Agency	Environmental Management Responsibilities
MOH PCU	Responsibility for overall project implementation, including environmental management activities and implementation of EARPs Coordination of environment-related activities of PIAs including implementation of aspects of EARPs
MOH	Responsibility for project operation including operation stage environmental performance Allocation of staff with responsibility for environmental issues during operation
PIAs	Responsibility for province level project implementation Responsibility for implementing EARPs including preparation of environmental assessments - and obtaining environmental approvals for works within province Responsibility for pre-construction stage and construction stage environmental management, monitoring and reporting
MOE	Provision of advice to PIAs as required on environmental issues
MOE and ADB	Approval of EMPs for works within districts
Suppliers/contractors	Implementation of environmental management commitments contained in site specific EMPs Monitoring and reporting of environmental performance

61. Responsible personnel assigned by the MOH would have primary responsibility for environmental issues and activities during project implementation.

B. Environmental Mitigation Plan

62. Table 5.2 contains the proposed typical environmental mitigation plan for the pre-procurement, procurement and operation stages of selected project sub-components as assessed. During project implementation, the EMPs for the site specific project sub-components will be validated as a continuing process. Reference will be made to new site information obtained to update site specific mitigation measures for inclusion in the EMP.

Table 5.2 Typical Environmental Mitigation Plan

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Procurement Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/ Contractor
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/ Contractor
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/ Contractor
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/ Contractor
Risks to public and worker health and safety	Minimize risk of accidents to public and workers	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	Supplier/ Contractor
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Operation Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Ensure compliance with relevant Cambodia air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Cambodia on air quality, particulates and odor	MOH and MOE
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the labs Regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	MOH
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours Notify nearby community of schedule and duration of activities	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Cambodia and MOE regulations.	MOH and MOE
		Ensure that wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal. Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Cambodia and MOE regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable MOE standards for medical wastewater.	MOE

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos, if any Provide safety equipment to construction workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Viet Nam regulations on SWM and wastewater discharge are complied with.	MOH and MOE
Emissions generation	Comply with relevant Cambodia Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MOE
Issue	**Performance Objective**	**Mitigation Measure**	**Responsibility for Implementation**
Operation Stage			
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Cambodia standards prior to discharge Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH and MOE

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities	MOH
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	ensure that the applicable laws and regulations on SWM and wastewater treatment particularly on best practices and safety are complied with.	MOH and MOE
Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
		Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

C. Environmental Monitoring Plan

63. Tables 5.3 and 5.4 contain the proposed environmental monitoring plan for the pre-construction, construction and operation stages of the project components. Two types of environmental monitoring are proposed to be implemented:

(i) Environmental effects monitoring is conducted to estimate the impacts of the sub-project on ambient environmental conditions.

(ii) Project environmental performance monitoring is conducted to evaluate compliance with environment-related operating procedures, national standards, and/or contractor specifications including the requirements of the EMP.

64. The following plan identifies the relevant site specific monitoring measures for inclusion in the EMP.

Table 5.3 Environmental Effects Monitoring Plan

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / MOH
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier / MOH
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier / MOE
Operation					
Mitigation Measure	**Parameters**	**Location**	**Methods**	**Frequency**	**Responsibility**
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified in Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOE
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOE

Table 5.4: Environmental Performance Monitoring Plan*

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Covering of equipment and fixtures and use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / MOE
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier / MOE
Operation					
Air emissions control	All criteria in Cambodia - Air quality – odor from solid waste matter - Permitted level.	At solid waste facilities and autoclaves	As specified in Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOE
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOH

D. Environmental Monitoring and Reporting

65. Table 5.5 contains the proposed environmental monitoring and reporting system for the pre-construction, construction and operation stages of the project.

Table 5.5 Environmental and Monitoring Reporting Requirements

Project Phase	Type of Monitoring	Description	Responsibility	Reporting Requirements
Procurement	Supplier/ Contractor's Environmental Performance Monitoring	Self-monitoring of environmental effects of minor repair and improvement works in terms of environmental performance monitoring requirements identified in EMP. Undertaken on an ongoing basis throughout the procurement process with regular monitoring frequencies.	Supplier/ contractor	Commissioning reports to MOH/MOE

Project Phase	Type of Monitoring	Description	Responsibility	Reporting Requirements
	EMP Compliance Monitoring	Monitoring of Supplier/Contractor's compliance with EMP requirements. Undertaken during commissioning of equipment. Monitoring based on combination of observation and review of supplier's environmental performance monitoring results.	PIAs	Commissioning reports to MOH/ ADB
Operation	Operation Environmental Monitoring	Monitoring of performance of project operation. Undertaken on a regular basis over life of project and self-reporting of compliance with EMP operation stage commitments.	MOH	1st year: 3 monthly reports to ADB and MOE Subsequent years: 6 monthly reports to MOE

E. Environmental Management Budget

66. Environmental management costs include costs both at the level of individual project sub-components as well as project component-wide environmental management costs. An environmental management budget to cover costs for management and monitoring both at the level of the district hospitals and the health centers will be established. A certain percentage of the total project costs can be allocated for this fund upon agreement with the MOH.

67. The EMP budget will include the following components:

(i) Marginal costs for implementation of environmental mitigation measures during pre-procurement, procurement and operation stages
(ii) Marginal costs for implementation of environmental monitoring measures during pre-procurement, procurement and operation stages

VI. PUBLIC CONSULTATION AND INFORMATION DISCLOSURE

A. Public Consultation Undertaken to Date

68. Consultation undertaken to date on the project has involved the following:

(i) Meetings and consultations with Provincial Health Department directors, laboratory and infection control and prevention staff representatives in the sampled project province to inform them about the need for rapid environmental assessments and obtain the current status of the district hospital facilities and health centers and the upgrades or improvements that they are proposing based on their own diagnosis.

(ii) Meetings and consultations with the District Health Office Director and/or Hospital Director together with their management and staff, laboratory and infection control and prevention staff representatives in the sampled project province to brief them about the environmental assessments that each hospital has to undertake to

identify the current status of environmental conditions in the vicinity of the health facilities and identify the scope of required project interventions.

69. The initial public consultations showed a high level of acceptance of the project as the project will improve the hospitals' and health centers' current state and capability for improved laboratory services and infection prevention and control. Some suggestions were forwarded regarding the laboratory equipment needed, waste management containers, disposal technologies that are non-burn. Representatives of INGOs were concerned about the health effects of incinerators. Some of the related environmental concerns included the lack of proper management of health care waste, the lack of adequate staff for operations and maintenance of the facilities, and the basic lack of medical and non-medical equipment. Such concerns will be incorporated in the mitigation and monitoring plans during project design and implementation. Public consultation is an on-going process and the consultations will continue with the project affected communities and relevant NGOs, if any, during the detailed design and implementation phases of the project.

B. Future Public Consultation and Disclosure

70. In order to ensure that future project activities are conducted in a participatory sense and that community concerns and opinions about potential environmental impacts are taken into account during subcomponents of procurement and operation, a range of public consultation and disclosure activities will be implemented throughout activity preparation, implementation and operation. These activities, which have been developed to meet the requirements of both Government of Cambodia and ADB safeguards requirements, are summarized in the following sections.

71. The following consultation activities will be implemented during the finalization of the detailed design of project activities:

(i) District level workshops in each district contained in the project area to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops will include stakeholder agencies, mass organizations (Women's' Union, Youth Union and Farmers Association), other relevant district level organizations such as the District Committee for Ethnic Minorities and CPC and other relevant stakeholder representatives.
(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required particularly for the quarantine and border area outbreak response facilities.

72. The public consultation activities carried out and the subsequent outcomes will be documented in the environmental assessment documents to be prepared for each site and records of the public consultation appended to the document as outlined in the Environmental Assessment and Review Procedures for the project.

73. To ensure ongoing community involvement during project procurement and operation, the following activities will be carried out for each project activity.

(i) Community information on procurement and operational activities and details of any expected impacts and measures to control them by means of newspaper and

loudspeaker announcements and direct communication by local authorities to affected households

(ii) Establishment of a grievance redress mechanism to allow community members to report concerns regarding operational activities including environmental pollution concerns.

74. The requirements for future consultation activities during procurement and operation will be documented in the site specific environmental assessments to be prepared during project implementation.

VII. ENVIRONMENTAL CRITERIA FOR PROJECT SUB-COMPONENT SELECTION

75. The following environmental criteria have been developed for the purposes of future project sub-component selection[3]. All project sub-components must:

(i) Avoid direct or indirect significant, negative impacts on protected areas defined by Law on Nature Protection Area (Protected Areas Law) 080104, February 2008 or other known areas of ecological sensitivity including those areas identified in Section III of the IEE

(ii) Avoid loss of significant areas of vegetation or permanent, negative impacts on a known rare or endangered flora or fauna species

(iii) Avoid pollution of waterways, surface waterbodies or groundwater resources with ecological values or which are used for domestic or agricultural water supply

(iv) Avoid direct or indirect significant, negative impacts on important items of cultural heritage, including those sites identified in Section III of the IEE

(v) Not cause any other environmental impacts that would trigger categorization as a 'Category A' project in accordance with the ADB's *Environmental Policy, OM.20 Environmental considerations in ADB operations* and *Environmental Assessment Guidelines* (2003)

76. Once project components have been selected using the defined criteria, they will be subject to further environmental analysis through implementation of the environmental assessment and review procedures (EARPs) presented in Section VIII.

VIII. ENVIRONMENTAL ASSESSMENT AND REVIEW PROCEDURES

A. Introduction

77. The following Environmental Assessment and Review Procedures (EARPs) document the procedures for the environmental assessment of the project sub-components that will be implemented under Components 2 and 3 of the project. The EARPs have been harmonized with the GOV's environmental assessment requirements as far as possible to ensure a streamlined environmental assessment process for project loan activities. The EARPs have been developed to comply with the ADB's *Environmental Assessment Guidelines* (2003).

[3] Environmental criteria apply only to the following structural project sub-components: Minor repair and improvement works; laboratory equipment installations; solid waste management facilities and wastewater treatment facilities.

B. Overview of Types of Project Sub-Components to be Assessed

78. The project targets border districts of 12 provinces along Cambodia's borders with Lao PDR, Viet Nam and Thailand, and some districts along the economic corridors. The selection of the final provinces and districts would be based on:

(1) economic status of the province
(2) health and health service statistics
(3) regional risks and priority clusters
(4) existing support from other partners

79. All project sub-components at one location will be grouped together to form a 'project activity for the purposes of the application of the EARPs.

C. Cambodia's Environmental Assessment and Review Procedures

80. Environmental legislation and associated regulatory instruments in Cambodia that are relevant to the selection of future project/sub-project components are given below. The Government of Cambodia's environmental safeguards procedures are set out in the following, but not limited to the following instruments:

(i) Sub-Decree on Environmental Impact Assessment Process (No: 72. ANRK.BK), August 11,1999
(ii) Sub-decree on Solid Waste Management (MOE 1999
(iii) Directive on Industrial Hazardous Waste Management (MOE May 26, 2000)
(iv) Directive on Industrial Hazardous Waste Management (MOE Oct 9, 2000)
(v) The Joint Prakas 19 on Solid Waste Management in Cities and Provinces made between the MOE and the Ministry of Interior (MOI)
(vi) Law on Nature Protection Area (Protected Areas Law) 080104 (February 2008
(vii) Directive on Managing Health Waste in the Kingdom of Cambodia (MOH 2008)
(viii) Prakas (Regulation) on Health Care Waste Management in Cambodia, MOH Dept. of Hospital Services, 2009
(ix) Infection Prevention and Control Guidelines for Health Care Facilities. MOH 2010
(x) National Guideline on Health Care Waste Management, (MOH 2012)

81. The Government of Cambodia legislation does not require sector level environmental assessments to be carried out for projects such as this project. Thus, unlike the ADB process, there will not be one overarching environmental document for the project prepared under the Government of Cambodia environmental assessment framework. Investments financed by the loan will be evaluated by the Government on a site by site basis. All sub-components at one site will be grouped together to form a 'project activity' for and for each project activity, an environmental assessment report will be required to be prepared. The type of environmental assessment report required will depend on the nature, scale and location of the investment.

D. Specific Procedures to be used for Project Sub-components under the Sector-type Loan

1. Responsibilities and Authorities

82. Table 8.1 sets out the responsibilities and authorities of key organizations involved in the implementation of the EARPs.

Table 8.1 Responsibilities for EARP Implementation

Organization	EARP Implementation Responsibilities
PMU	Check environmental selection criteria have been applied in selection of project sub-components Provide advice to PIA on environmental assessment (EA) preparation Review and provide "no-objection" on EAs submitted by PMUs Submit EA to ADB for review and approval
PMU	Overall responsibility for EA preparation and submission for approval including engagement of consultants if required to prepare EIAR Apply environmental selection criteria to identify future project sub-components
MOH	Ensure that the PMU is adequately resourced to properly manage project sub-components including safeguards issues Appraise and approve EIARs
MOE	Provide advice and guidance on environmental issues during project sub-component preparation
MOH	Approval of project subcomponent CEP/EMPs
ADB	Receipt and review of EA for each project sub-component

83. Institutional strengthening for organizations involved in EARP implementation would be carried out as follows:

(i) **Environment Support Consultants:** A national consultant would be engaged to work with the PMU and MOE Environment Officers and MOH staff to establish systems and tools to implement their project responsibilities and to provide technical on-the-job training and support. Such systems and tools would include example EA documents and templates for use throughout project implementation and organisation of forums to share lessons learnt between PMUs. These positions would be implemented intermittently throughout project implementation.

(ii) **PMU Environment Officer:** The PMU Environment Officer would be the main point of contact for environmental safeguards issues at the central level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iii) **PHD Environment Officer:** The PHD Environment Officer would be the primary point of contact for environmental safeguards issues at the province level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iv) **MOH Environment Officer:** An existing staff member within the MOH would be allocated to have responsibility for environmental issues during project operation. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

2. Environmental Criteria for Future Project Sub-component Selection

84. The environmental criteria for future project sub-component selection are documented below:

(i) Sub-Decree on Environmental Impact Assessment Process (No: 72. ANRK.BK), August 11,1999
(ii) Sub-decree on Solid Waste Management (MOE 1999
(iii) Directive on Industrial Hazardous Waste Management (MOE May 26, 2000)
(iv) Directive on Industrial Hazardous Waste Management (MOE Oct 9, 2000)
(v) The Joint Prakas 19 on Solid Waste Management in Cities and Provinces made between the MOE and the Ministry of Interior (MOI)
(vi) Law on Nature Protection Area (Protected Areas Law) 080104 (February 2008
(vii) Directive on Managing Health Waste in the Kingdom of Cambodia (MOH 2008)
(viii) Prakas (Regulation) on Health Care Waste Management in Cambodia, MOH Dept. of Hospital Services, 2009
(ix) Infection Prevention and Control Guidelines for Health Care Facilities. MOH 2010
(x) National Guideline on Health Care Waste Management, (MOH 2012)

3. Procedures for Environmental Assessment of Project Sub-components

a. Environmental Categorization

85. The first step in the EARPs will be the determination of the environmental categorization for each subproject in terms of both ADB and Government of Cambodia requirements.

86. In terms of ADB environmental categorization, the environmental selection criteria that have been developed for subprojects will ensure that all subprojects will be classified either as:

(i) Category B in accordance with the ADB's *Environmental Assessment Guidelines* and thus subject to preparation of an IEE; or
(ii) Category C in accordance with the ADB's *Environmental Assessment Guidelines* and thus not subject to formal environmental assessment.

87. The determination of whether a subproject is Category B or Category C will be made by the PMU (with advice from the MOH as necessary) using guidance from the ADB's *Environmental Assessment Guidelines.*

88. In terms of the Government of Cambodia's environmental categorization, reference to Annex 1 of Decree 80 indicates that some subprojects may require one of the following levels of environmental assessment:

(i) **Preparation of EIAR:** A small number of project activities may trigger consideration of the EIA decree for a detailed EIAR. Types of activities that may be subject to EIARs include hospitals with more than 50 beds; incinerators or WWTPS with capacity greater than 1000m^3/day.

(ii) **Preparation of CEP**: Project activities that do not trigger an EIAR will require a less detailed environmental assessment in the form of a CEP.

(iii) **No environmental assessment:** Some subprojects involving very minor upgrading or improvement works may not require any assessment under the Government of Cambodia's safeguards requirements; however, there is no clear guidance provided in the Government legislation as to when no assessment is required and this determination will be made on a case by case basis by MOE and/or PHD in consultation with the PMU during the environmental categorization process.

89. The determination of the appropriate environmental categorization of each subproject in accordance with Government of Cambodia's safeguards requirements will be made by the PHD, based on advice from PMU and the relevant MOE. at the outset of the environmental assessment process with reference to the EIA decree pertaining to environmental categorization by screening.

b. Preparation of Environmental Assessment Documents

90. For all project activities[4] an environmental assessment document will be required to be prepared that will incorporate the following elements:

(i) Required contents of EIAR or CEP document as established in the Government of Cambodia's EIA decree

(ii) Appendix containing a site specific Environmental Management Plan (EMP) prepared following the format and structure contained in Section V

(iii) Appendix containing the results of public consultation and information disclosure activities

91. The information required to be included in the appendices of the EA document are consistent with, but represents a strengthening of the Government of Cambodia's requirements for addressing environmental management issues and public consultation activities in environmental assessment documentation.

c. Requirements for Environmental Management Plans

92. The EA will be required to include an Environmental Management Plan (EMP) for each project sub-component. The EMP will address environmental mitigation and monitoring activities, institutional arrangements and strengthening requirements, public consultation activities during project implementation and operation and environmental monitoring and reporting requirements.

[4] For the purposes of the EARPs a 'project activity' is defined as all project sub-components being carried out at a particular location.

93. Table 8.2 summarizes the potential impacts and proposed mitigation measures for the project activities that will form the basis of the EMP for each project sub-component.

Table 8.2 Project Environmental Impacts and Mitigation Measures

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Procurement Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/ Contractor
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/ Contractor
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/ Contractor
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/ Contractor
Risks to public and worker health and safety	Minimize risk of accidents to public and workers	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	PHD

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	PHD
Operation Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Ensure compliance with relevant Cambodia air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Cambodia on air quality, particulates and odor	PHD
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the laboratory. Regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	PHD
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours Notify nearby community of schedule and duration of activities	PHD

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Cambodia and MOE regulations.	PHD
		Ensure that wastewater from the laboratories will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal. Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Cambodia and MOE regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable MOE standards for medical wastewater.	PHD

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos. Provide safety equipment to construction workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Viet Nam regulations on SWM and wastewater discharge are complied with.	MOH
Emissions generation	Comply with relevant Vietnam Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MONRE
Operation Stage			
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Cambodia standards prior to discharge Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities	MOH
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	Ensure that the applicable regulations on SWM and wastewater treatment particularly on best practices and safety are complied with.	PHD
		Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

94. Tables 8.3 and 8.4 summarize the proposed monitoring measures for the project activities that will form the basis of the EMP for each project sub-component.

Table 8.3 Environmental Effects Monitoring Plan[5]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / PPMU
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier / PPMU
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier / PPMU
Operation					
Mitigation Measure	**Parameters**	**Location**	**Methods**	**Frequency**	**Responsibility**
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOH

[5] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table

Table 8.4 Environmental Performance Monitoring Plan[6]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Covering of equipment and fixtures & use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / PHD
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier / PHD
Operation					
Air emissions control	All criteria in Cambodia - Air quality – odor from solid waste matter - Permitted level.	At solid waste facilities and autoclaves	As specified in Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified in Cambodia standards	Weekly for first 6 months and then monthly thereafter	MOH

d. Requirements for Public Consultation and Disclosure

95. There is a requirement that public consultation and information disclosure takes place for each project activity during preparation of the EA. The following minimum requirements for public consultation and disclosure must be met for each project activity.

96. At the outset of the preparation of the EA, local authorities and community representatives in the vicinity of, or who are likely to be affected by, the project should be informed of the project activity and given an opportunity to provide feedback on potential environmental issues or required management measures. The following activities will be carried out for each project activity:

(i) District level workshops in each district contained in the project area to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops with include

[6] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table

stakeholder agencies, mass organizations (Women's Union, Youth Union and Farmers Association), other relevant district level organizations such as the District Committee for Ethnic Minorities, commune committees and representatives.

(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required.

97. In addition, information on the project activity and consultation activities will be provided to the local community through newspaper notices and/or public announcements.

98. Following approval of the environmental assessment document, a copy of the approval and a summary of the environmental assessment document will be sent to all relevant DPCs and CPCs. Information regarding the approved project and the proposed environmental management measures will be posted at suitable locations on the project site.

99. The public consultation activities carried out and the subsequent outcomes must be documented in the EA and the records of the public consultation appended to the document.

e. Review of Environmental Assessment Documents by GOL and ADB

100. At the same time that the EA is submitted to the relevant GOL authorities (in Lao language), it will be submitted by the CPMU (in English language) to the ADB. The ADB will review the document for compliance with its environmental safeguards requirements.

101. All environmental assessment documents prepared using these EARPs will be reviewed and approved by the GOL. The approval process that will be implemented by the GOL as set out in the relevant decree.

102. For sub-projects with a value of more than $1million, approval of environmental assessment documents will be required from the ADB prior to the commencement of construction works.

f. Monitoring and Reporting of EARP Implementation

103. Monitoring and reporting of EARP implementation will be undertaken to ensure that the procedures are being adequately implemented and to identify any modifications or corrective action that may be required to improve the efficiency of the EARPs throughout the project implementation process. The monitoring of EARP implementation will be incorporated into the overall project monitoring and evaluation and reporting system. EARP implementation will be monitored at the province and central levels.

104. Reporting of EARP implementation will take place on a 6 monthly basis. Each PPMU will report to the CPMU on the monitoring parameters contained in Table 8.2, and the CPMU will consolidate these reports, together with the results of the central level monitoring for submission to the ADB.

105. Table 8.5 summarizes the monitoring processes that will be carried out for EARP implementation.

Table 8.5 Monitoring of EARP Implementation

<table>
<tr><th>Monitoring Parameter</th><th>Monitoring Method</th><th>Frequency of Monitoring</th><th>Responsibility for Monitoring</th></tr>
<tr><td rowspan="3">Verification of EA preparation and approval before commencement of project component construction</td><td rowspan="3">Verification of: (i) EA document produced, (ii) GOV certificate issued, (iii) ADB no-objection issued</td><td>Each project sub-component before commencement of construction</td><td>PHD</td></tr>
<tr><td>Random checks of at least 15% of project sub-components</td><td>PMU</td></tr>
<tr><td>Random check of small number of project sub-components</td><td>PMU</td></tr>
<tr><td>Adequacy of public consultation / disclosure activities to meet EARP requirements</td><td>Number and type of public consultation and disclosure events and key issues raised</td><td>For all project sub-components</td><td>PHD</td></tr>
</table>

E. Confirmation that the Environmental Assessment and Review Procedures conform to ADB's Requirements

106. The EARPs presented in this section have been developed to take account of the ADB's environmental safeguards requirements. Specifically, the EARPS require development of environmental mitigation and monitoring plans and institutional arrangements, and implementation of public consultation activities to meet the ADB's requirements.

107. The review of the environmental assessment documents for each project activity that will be carried out by the ADB will ensure compliance of the products of these EARPs with ADB safeguards requirements.

F. Staffing Requirements and Budget for EARP Implementation

108. Table 8.6 summarizes the estimated staffing requirements and budget for EARP implementation for each project activity.

Table 8.6 Staffing Requirements and Budget for EARP Implementation

Organization	Responsible Personnel	Human / Financial Resources for EARP Implementation assuming EIAR Level Assessment	Human / Financial Resources for EARP Implementation assuming CEP Level Assessment
PMU	PMU Environment Officer	3 person weeks	1-person week
PHD	PHD Environment Officer	4 person weeks $20,000	3 person weeks $5,000

IX. FINDINGS AND RECOMMENDATIONS

A. Findings

109. The terms of reference initially categorized this project as requiring an Initial Environmental Examination (IEE) report and an Environmental Management Plan (EMP) both of which are required for Category A and B projects. It is understood that this project was tentatively classified as Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document. This categorization was examined through the respective visits to the different project sites and the proposed project component descriptions and how the project component intends to mitigate the potential negative environmental impacts of the project.

110. In accordance with the ADB's *Safeguard Policies Statement (2009)*, Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or significance than those for Category A projects that require a full Environmental Impact Assessment (EIA) arising from major adverse impacts on the environment. For Category B projects, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

111. The final list of the project's subcomponents and the project descriptions for their implementation have indicated that the project will be a Category B. The negative impacts expected to occur during operation stages of the project, namely:

(i) **During the procurement stage**: Probably some structures of the laboratories and/or other structures of the hospitals need to be repaired and upgraded before assembly of the equipment. However, the negative impacts during this phase will be negligible due to the scale of the activities are limited and these negative impacts will be localized and temporary. Such impacts include generation of noise and dust, deterioration of water quality through sediment laden runoff and will be readily managed to acceptable levels through implementation of standard environmental management practices.

(ii) **During operation stage**: Liquid and solid waste generated by the operation of the laboratories as well as the hospitals as a whole are likely to be the sources of negative impacts on the environment if they are not managed properly. Such pollution sources will include infectious specimens, chemicals for testing, wastewater and emission of the laboratories. These pollution sources are long-term and consecutive, and therefore, mitigation measures should be considered adequately through both structural measures (the technical systems for collection and treatment the wastewater, hazardous waste, infectious waste and emission generate from the laboratory should be equipped synchronously) and management measures (application procedure of separation of wastes at source, procedure of management, collection and treatment of hazardous/infectious wastes, etc.). During the Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices particularly in relation to solid waste and wastewater treatment facilities.

B. Recommendations

112. It is recommended that the Project should ensure that for the selected health facilities the laboratories should be well-managed with trained staff. Based on the field assessment and the project proposals, most of laboratories have standardized biosafety level 3 for the provincial health facilities (provincial hospitals) and standardized biosafety level 2 for the district health facilities (district hospitals and selected health centers). However, most of laboratories in the provinces visited are not equipped with the collection and treatment systems for the waste emissions generated and the wastewater from the laboratories are not treated according to the environmental standards. Therefore, the implementing agencies need to consider the appropriate equipment and structures for further investments to ensure that the operation of the health facilities are sound and will not cause significant impacts to the environment. The mitigation measures will also be managed by the provinces and made part of their operational plans for the health facilities invested.

113. Separately, the project will undergo environmental impact assessment in accordance with Cambodia's laws on environmental impact assessment. The Environmental Impact Assessment is required for all newly improved hospital projects. For the repair, renovation and upgrade of the hospitals, depending on the scale of the construction activities, an EIA or Environmental Protection Scheme have to be prepared in the next phase of the project in accordance with Government of Cambodia's regulations.

X. CONCLUSIONS

114. The project activities are expected to have a range of benefits on the natural and social environment, and only minor or negligible negative environmental impacts. The majority of minor negative impacts are expected to occur during the procurement phase and operation phase. These will be localized, minor and temporary and will be readily managed to acceptable levels through the implementation of the appropriate solid waste, wastewater, and environmental management practices. Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices.

115. This IEE Report includes an Environmental Management Plan (EMP) defining the types of environmental mitigation and monitoring measures required to offset potential negative environmental impacts. The development of the EMP takes into account the likely level of technical, financial and human resources available for each of the subproject components. The EMPs will be updated as project implementation progresses beginning with the detailed design. Site-specific conditions may change the nature of the assumptions on the EMPs as the details of the upgrades and improvement projects of the hospitals and health centers become more precise and sensitive to the prevailing environmental conditions of the different project locations.

116. Based on the findings of the environmental assessment, it is concluded that that the project will not have a significant effect on the environment. The investments in the health security project, overall, will bring forth more positive than negative environmental impacts and greater health security particularly in the border provinces. In view of this, an EIA is not required to be prepared for this project. Individual project activities will be assessed following the Environmental Assessment Review Procedure as prescribed by ADB for the other sub-

project component activities while site-specific environmental mitigation and monitoring

measures will be developed and implemented accordingly as set out in the EMPs.

XI. REFERENCES

ADB. 2009. Safeguard Policy Statement
ADB. 2002. Environmental Policy and Operations Manual 20
ADB. 2003. Environmental Assessment Guidelines, Manila
ADB. 1997. Environmental Impact Assessment in Developing Countries

Appendix 1. ENVIRONMENTAL SCREENING OF PROJECT SUB-COMPONENTS

POTENTIAL IMPACT	PRE - PROCUREMENT	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Impacts on the Natural Environment				
Dust generation and air emissions	O	X	O	**Minor Repair and Improvement Works** During minor repair and improvement work, localized, temporary negative impacts may result from dust generation from removal and installation of existing equipment, frames, cabinets, and supports to clear the way for new laboratory improvements and equipment. Mitigation measures will include use of wet rags and vacuum cleaners for dust suppression, containment and minimization of work areas, and utilizing temporary protective curtains on existing facilities and equipment. No impacts are expected during the operation stage.
	O	X	++	**Laboratory Equipment Commissioning including IPC Services** Negative Impact as above for dust emissions. As a mitigating and control measure, emissions from the labs will be collected and treated to ensure the compliance with relevant the environmental standards of Cambodia as current regulations on air (poison gases and odor) IPC "standard precautions" to be implemented to enhance positive impact during operations. Standard precautions include: use of PPE and environmental cleaning.
	O	O	X	**Solid Waste Management Facilities** Negative impact as above for dust emissions. For IPC, autoclaves will be designed and controlled to ensure compliance with relevant Cambodia air quality emissions standards namely criteria contained in MOE regulations on: air (odor and particulates) and water quality – for steam condensate of medical liquid waste from autoclaves permitted level. Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Cambodia on air quality, particulates and odor.
	O	O	O	**Wastewater Treatment Facilities** No impact
Odor generation	O	O	O	**Minor Repair and Improvement Works** No impact
	O	O	X	**Laboratory Equipment Commissioning including IPC Services** During operation improper use or maintenance of lab facilities and equipment may result in minor, localized impacts from odor generation. Mitigation measures will include development and implementation of guidance and action for operation of the labs and training of personnel in proper operation of the labs.
	O	O	X	**Solid Waste Management Facilities** During operation improper use or maintenance of waste storage areas may result in minor, localized impacts from odor generation. Mitigation measures will include development of operational procedures for temporary and

POTENTIAL IMPACT	PRE - PROCUREMENT	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
				permanent waste storage areas, regular removal of waste from temporary storage areas and training of personnel in proper waste management practices.
	O	O	X	**Wastewater Treatment Facilities** During operation improper use or maintenance of wastewater treatment facilities may result in minor, localized impacts from odor generation. Mitigation measures will include development of appropriate operational procedures and training for personnel.
Noise generation	O	X	O	**Minor Repair and Improvements Works** During minor repair and improvement work, minor, localized, temporary impacts may result from noise generation from use of tools and installation equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of tools and equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected rooms of the duration and extent of installation works. No impacts are expected during the operation phase of the works.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** Minor negative impacts and mitigating measures as above.
	O	O	X	**Solid Waste Management Facilities** During collection, transport and disposal operations, minor, localized, temporary impacts may result from noise generation from use of containers, vehicles and equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected areas of the duration medical waste management activities.
	O	O	X	**Wastewater Treatment Facilities** Minor negative impacts and mitigating measures during operations as above
Surface water quality deterioration	O	X	0	**Minor Repair and Improvement Works** Minor negative impacts on surface water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from the drainage ways.
	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, surface water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.

POTENTIAL IMPACT	PRE - PROCUREMENT	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Solid Waste Management Facilities** During operation stage, surface water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect waterways. Discharge from solid waste facilities will comply with criteria contained in the applicable Cambodia MOE and MOH regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable MOE standards for medical wastewater.
Ground water quality deterioration	O	X	O	**Minor Repair and Improvement Works** Minor negative impacts on ground water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation that will seep through ground water sources or wells. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from ground water sources.
	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, ground water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include protecting groundwater sources permanently and the development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to the environment.
	O	O	X	**Solid Waste Management Facilities** During operation stage, ground water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect ground water sources. Discharge from solid waste facilities will comply with criteria contained in the applicable Cambodia MOH and MOE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect ground water quality. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable MOE standards for medical wastewater.
Soil Contamination	O	X	O	**Minor Repair and Improvement Works** During operation, minor impacts of cleaning activities resulting in contamination of soils with cleaning chemicals and agents from repair and improvement activities. Mitigation measures will include ensuring that a barrier between the working surfaces and the soil are used to avoid contamination during the works.

POTENTIAL IMPACT	PRE - PROCUREMENT	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	0	0	O	**Laboratory Equipment Commissioning including IPC Services** No impacts.
	O	O	X	**Solid Waste Management Facilities** During operation stage, soil could be adversely affected by improper disposal of solid waste particularly for hospitals that bury medical wastes into their own grounds. Mitigation measures will include ensuring sealing and containment of burial pits or dumping grounds prior to external municipal disposal Discharge from solid waste facilities will comply with criteria contained in the applicable Cambodia and MOE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect surrounding soils. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable MOE standards for medical wastewater.
Impacts on the socio-economic environment				
Amenity of surrounding land use	O	X	O	**Minor repair and improvement works** During procurement very minor, localized and temporary impacts to amenity of surrounding land use may occur in the form of dust and noise generation. Such impacts will be readily mitigated through the range of measures previously described on dust, odor and noise.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** Same as above during procurement**,** the laboratories may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Solid Waste Management Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Wastewater Treatment Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.
Impacts on Public Health and Safety				
Risks to public health and safety	O	X	0	**Minor Repair and Improvement Works** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks in public safety for nearby receivers if not properly managed. Mitigating measures include adopting and ensuring that the suppliers comply with safety guidelines established by the provincial and district hospitals.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services**Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.

	O	O	X	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Cambodianregulations on SWM are complied with.
	O	O	X	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Lao PDR regulations on wastewater discharge are complied with.
Risks to health and safety of workers	O	X	0	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals. Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services**Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.
Risks to health and safety of workers	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to the hospital workers. Mitigating measures include ensuring that the applicable Cambodia regulations on SWM are complied with.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff. Mitigating measures include ensuring that the applicable Cambodia regulations on wastewater discharge are complied with.
	O	X	O	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals.
Increase in illness due to	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.

environmental pollution such as: dust, air, water supply contaminants, solid and hazardous wastes, untreated sewage surface water runoff, and wastewater	0	0	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Cambodia regulations on SWM are complied with. Also sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions. Implement solid and hazardous waste management plans. Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.
	0	0	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff and the public. Mitigating measures include ensuring that the applicable Cambodia regulations on wastewater discharge are complied with.
Accidents and injury	0	X	0	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for accidents and injury Mitigating measures include adopting and ensuring that the hospital's safety guidelines are established and practiced by the provincial and district hospitals. Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.
	0	0	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.
	0	0	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks of accident and injury. Mitigating measures include ensuring that the applicable Cambodia regulations on SWM particularly on best practices and safety are complied with.
	0	0	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks the risks of accident and injury. Mitigating measures include ensuring that the applicable Cambodia regulations on wastewater discharge are complied with and safety practices are always observed,

Appendix 2. RAPID ENVIRONMENTAL ASSESSMENT FORM (MODIFIED)

Instructions:

- This checklist focuses on environmental issues and concerns. To ensure that social dimensions are adequately considered, refer also to ADB checklists and handbooks on (i) involuntary resettlement, (ii) indigenous peoples planning, (iii) poverty reduction, (iv) participation, and (v) gender and development.
- Answer the questions assuming the "without mitigation" case. The purpose is to identify potential impacts. Use the "remarks" section to discuss any anticipated mitigation measures.

Project Title: Greater Mekong Subregion Health Security Project
Location: Cambodia
Proposed Environmental Category: B

SCREENING QUESTIONS	Yes	No	REMARKS
A. PROJECT SITING IS THE PROJECT AREA:			
DENSELY POPULATED?		X	
HEAVY WITH DEVELOPMENT ACTIVITIES?		X	
ADJACENT TO OR WITHIN ANY ENVIRONMENTALLY SENSITIVE AREAS?		X	
CULTURAL HERITAGE SITE		X	
PROTECTED AREA		X	
WETLAND		X	
MANGROVE		X	
ESTUARINE		X	
BUFFER ZONE OF PROTECTED AREA		X	
SPECIAL AREA FOR PROTECTING BIODIVERSITY		X	
BAY		X	
B. POTENTIAL ENVIRONMENTAL IMPACTS WILL THE PROJECT CAUSE…			

SCREENING QUESTIONS	Yes	No	REMARKS
impacts on the sustainability of associated sanitation and solid waste disposal systems and their interactions with other urban services?	X	☐	
deterioration of surrounding environmental conditions due to rapid urban population growth, commercial and industrial activity, and increased waste generation to the point that both manmade and natural systems are overloaded and the capacities to manage these systems are overwhelmed?	☐	X	
degradation of land and ecosystems (e.g. loss of wetlands and wild lands, coastal zones, watersheds and forests)?	☐	X	
increase in soil erosion and siltation?	☐	x	
increase in peak and flood flows?	☐	x	
loss of downstream beneficial uses (water supply or fisheries)?	x	☐	Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to stream sources of water. Target district hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with MOE emission standards
unnecessary loss of ecological value and decreased biodiversity by replacement of natural forest with plantation with limited number of species?	☐	x	
dislocation or involuntary resettlement of people?	☐	X	
displacement of people or reduce their access to forest resources?	☐	X	
degradation of cultural property, and loss of cultural heritage and tourism revenues?	☐	X	
encroachment into precious ecosystem (e.g. sensitive habitats like protected forest areas or terrestrial wildlife habitats?	☐	x	
occupation of low-lying lands, floodplains and steep hillsides by informal settlers and low-income groups, and their exposure to increased health hazards and risks due to pollutive industry?	☐	X	
water resource problems (e.g. depletion/degradation of available water supply, deterioration for surface and ground water quality, and pollution of receiving waters?	X	☐	Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to boreholes/wells used as groundwater source. Target district hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with MOE emission standards

SCREENING QUESTIONS	Yes	No	REMARKS
air pollution from fuel gas discharged into the atmosphere?	☐	X	
social conflicts between construction workers from other areas and local workers?	☐	X	
road blocking and temporary flooding due to land excavation during rainy season?	☐	X	
noise and dust from construction activities?	X	☐	Potential impacts from minor repair and improvement works in laboratories
traffic disturbances due to construction material transport and wastes?	☐	X	Only minor repair and improvement works for laboratories are anticipated
increased road traffic due to interference of construction activities?	☐	x	
hazardous driving conditions where construction interferes with pre-existing roads?	☐	x	
short-term soil erosion and silt runoff due to construction?	☐	X	
hazards to public health due to ambient, household and occupational pollution, thermal inversion, and smog formation?	☐	X	
short-term construction impacts (e.g. soil erosion and silt runoff, deterioration of water and air quality, noise, dust and vibration from construction equipment?	X	☐	Potential minor impacts from repair and improvement works of laboratories within existing hospital building facilities
overdrawing of ground water, leading to land subsidence, lowered ground water table, and salinization?	☐	X	
contamination of surface and ground waters due to improper waste disposal?	X	☐	Potential impact for hospitals with deficient and substandard medical solid waste management systems especially if the hospital grounds are used as temporary waste transfer stations. Target district hospitals should mitigate by ensuring that an operational medical waste management system is in place including treatment facilities that comply with MOE emission standards.
contamination of soil and groundwater from solid wastes from water treatment sludges, cafeteria or lunchroom wastes, ashes and incineration residues, etc.?	x	☐	Same as above
contamination of air quality from incineration (if incinerator is present at the facility)?	x	☐	Potential impact for hospitals with deficient and substandard incinerators that produce emissions that are not compliant with air emission standards. Target district hospitals should mitigate by ensuring that an operational medical waste disposal system is in place that complies with MOE air emission standards.

SCREENING QUESTIONS	Yes	No	REMARKS
health and safety hazards to workers from toxic gases and hazardous materials present in the facility?	x		Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management
water pollution from discharge of liquid effluents?	x		Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management
pollution of receiving waters resulting in amenity losses, fisheries and marine resource depletion, and health problems?		x	
public health and safety hazards due to solid waste disposal in sanitary landfills?	x		Potential impact by hospitals operating without medical solid waste treatment facilities. Mitigate by ensuring that a compliant disposal system is in place or is worked out with the municipality and no open dumping is allowed at the hospital grounds.
poor sanitation and solid waste disposal in construction camps and work sites, and possible transmission of communicable diseases from workers to local populations?		x	Work is within existing premises
increased noise and air pollution resulting from traffic volume?		x	
creation of temporary breeding habitats for mosquito vectors of disease?	x		Potential impact from hospitals that have deficient and substandard drainage facilities. Mitigating measure is to upgrade, maintain and ensure that no ponding from drainage systems occurs.

Initial Environmental Examination

May 2016

Lao PDR: Greater Mekong Subregion Health Security Project

Prepared by Conseil Santé for the Ministry of Health and the Asian Development Bank.

CURRENCY EQUIVALENTS
(as of March 2016)

Currency Unit	–	Lao Kip (LAK)
$1.00	=	7,950 LAK

WEIGHTS AND MEASURES

Ha	–	Hectare
Kg	–	Kilogram
Km	–	Kilometer
L / l	–	Liter
m	–	Meter
mg	–	Milligram
μg	–	Microgram

NOTE

In this report, "$" refers to US dollars

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ABBREVIATIONS

ADB	–	Asian Development Bank
AIDS	–	Acquired Immune Deficiency Syndrome
APSED	–	Asia Pacific Strategy for Emerging Diseases
BOD	–	Biological oxygen demand
CDC	–	Communicable Diseases Control
CLMV	–	Cambodia, Lao PDR, Myanmar and Viet Nam
COD	–	Chemical oxygen demand
CPMU	–	Central Project Management Unit
CPC	--	Commune Peoples Committee
DHIS	–	District Health Information system
DHO	–	District Health Office
DOH	–	Department of Health
DONRE	–	Department of Natural Resources and Environment
DPC	–	District Peoples Committee
DPIC	–	Department of Planning and International Cooperation
EA	–	Environmental assessment / Executing Agency
EARF	–	Environmental Assessment and Review Framework
EARP	–	Environmental Assessment and Review Procedures
EHF	–	Ebola Hemorrhagic Fever
EIA	–	Environmental Impact Assessment
EIAR	–	Environmental Impact Assessment Report
EID	–	Emerging Infectious Diseases
EMP	–	Environmental Management Plan
EU	–	European Union
GOL	–	Government of Lao People's Democratic Republic
GMS	–	Greater Mekong Subregion
HAI	–	Hospital acquired Infection
HCWM	–	Health Care Waste Management
HMIS	–	Health Management Information System
HSDP	–	Health Sector Development Program
HIV	–	Human Immunodeficiency Virus
IA	–	Implementing Agency
IEC	–	Information, Education and Communication
IEE	–	Initial Environmental Examination
IHR	–	International Health Regulations
INGO	–	International non-government organization
IOM	–	International Organization for Migration
IP	–	Indigenous peoples
IPC	–	Infection Prevention and Control
ISWM	–	Integrated Solid Waste Management
JICA	–	Japan International Cooperation Agency
Lao PDR	–	Lao People's Democratic Republic
MERS	–	Middle East Respiratory Syndrome
MEVs	–	Migrants and mobile populations, ethnic minorities, and other vulnerable group
MMPs	–	Migrant and mobile populations
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MONRE	–	Ministry of Natural Resources and Environment
MPI	–	Ministry of Planning and Investment
NGO	–	Non-government organization
PAH	–	Project affected household
PAM	–	Project Administration Manual
PCU	–	Project Coordination Unit

PM	–	Particulate matter
PHO	–	Provincial Health Office
PIA	–	Provincial Implementing Agency
PPC	–	Province Peoples Committee
PPE	–	Personal Protective Equipment
PPMC	–	Provincial Preventive Medicine Center
PPMU	–	Provincial Project Management Unit
PPTA	–	Project Preparatory Technical Assistance
REA	–	Rapid Environmental Assessment
RCU	–	Regional Coordination Unit
SWM	–	Solid Waste Management
VHC	–	Village Health Committee
VHW	–	Village Health Worker
WB	–	World Bank
WHO	–	World Health Organization
WHS	–	World Heritage Site
WREA	–	Water Resources and Environment Administration
WWTP	–	Wastewater treatment plant

I. INTRODUCTION

A. Background of the Project

1. The Greater Mekong Subregion (GMS) comprises Cambodia, China (Yunnan and Guangxi), Laos, Myanmar, Thailand, and Viet Nam, with a population of about 326 million people. The region has gone through rapid economic development, with overall GDP growth of 5-10% per year during the past decade. The major demographic, economic and technological differences among the GMS countries, combined with improved connectivity and trade facilitation, bring about substantial business dynamics. Regional investments have increased rapidly, stimulated by regional security, low cost labor, and improved connectivity. Better roads, ports and trade agreements facilitate participation in the global market. Regional tourism has also increased dramatically. GMS Countries are industrializing rapidly, resulting in a rapid increase in migrant workers, mostly internally, but also externally. Urbanization is increasing rapidly, and creating new challenges that require major investments. This has also increased the risk of the spread of communicable diseases associated with increased connectivity, employment, and social and physical living environment.

2. Under the GMS economic development program, the Governments of Cambodia, Lao People's Democratic Republic (Lao PDR), Viet Nam and Myanmar, and the Asian Development Bank (ADB) aim to achieve core capacities for the control of emerging infectious diseases (EIDs) and other major public health threats based on international standards of the World Health Organization (WHO). A GMS Health Security Project (the Project) of $132 million has been proposed for 2016 including a contribution of $125 from ADB's Special Funds resources, and government counterpart funds of $7.0 million. The Project follows other health projects for communicable diseases control (CDC), HIV, Malaria, and related regional technical assistance.[1]

B. Purpose and Structure of the Report

3. The project is categorized as a Category B project in accordance with ADB's *Environment Policy*. The Initial Environmental Examination (IEE) presented in this report is to comply with the requirements of ADB in relation to environmental assessment of ADB financed projects. In particular, the IEE has been prepared to fulfill the requirements of the ADB's *Environmental Policy* and *Operations Manual (OM) 20: Environmental Considerations in ADB Operations*. The IEE has been based on the guidance contained in the ADB's *Environmental Assessment Guidelines* (2003).[2] The following methodology has been implemented in the preparation of the IEE:

- (i) Review of project-related documents and literature relevant to the project areas initially surveyed
- (ii) Site visits to view the environmental conditions in representative project areas and the general location of the projects
- (iii) Consultation with local and national authorities to source information on project area characteristics and potential project impacts
- (iv) Identification of existing environmental and socio-economic characteristics to develop project baseline data

[1] Including Community Action for HIV Prevention in 2001; GMS Regional Communicable Diseases Control Project in 2004; Second GMS Communicable Diseases Control Project in 2010; GMS Capacity Building for HIV/AIDS Prevention Project in 2012; Japan Fund for Poverty Reduction projects such as for Model Healthy Village; and technical assistance for malaria and dengue control, health education, e-Health, and related areas.

[2] ADB. 2003. *Environmental Assessment Guidelines.* Manila.

(v) Analysis of typical environmental impacts of project components and identification of suitable typical mitigation measures to ameliorate potential impacts
(vi) Development of institutional arrangements for implementation of environmental management and monitoring
(vii) Development of a set of environmental criteria for future project activity selection
(viii) Development of environmental assessment and review procedures (EARPs) for future project sub-components.

4. For purposes of this IEE, the hospitals surveyed will be indicative and representative of the extent of environmental impact assessment and review that shall have to be performed for the other remaining provinces and districts in accordance with ADB guidelines as the project progresses.

II. DESCRIPTION OF THE PROJECT

A. Project Rationale

5. The Greater Mekong Health Security Project will complement existing projects, focusing on CDC, HIV/AIDS and Malaria in one single intervention aimed at strengthening health security in Cambodia, Lao PDR, Myanmar, and Viet Nam by improving district and provincial health services capacity for diagnostic, response and treatment. The proposed project will (i) strengthen health services capacity to identify and treat communicable diseases, including neglected tropical diseases, HIV/AIDS, tuberculosis, and food borne diseases; and (ii) use the regional knowledge generated during the two previous phases of the project to control emerging and re-emerging diseases. The proposed project will target remote and underserved areas, with high poverty incidence, and MMPs. Geographic targeting will be determined by linking disease incidence with mobile and migrant population data by province. A project modality is proposed for Cambodia, Lao PDR and Myanmar.

B. Project Design

6. The project goal is to strengthen the GMS health security, with the following indicators: (i) zero major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased treatment of vulnerable groups for communicable diseases. The proposed project outcomes are: (i) improved coverage of GMS public health security system and compliance with IHR/APSED; and (ii) CDC coverage increased in vulnerable groups in CLMV border areas, in particular for migrants, ethnic minorities, and other vulnerable groups (MEVs) as prioritized by the Governments. The proposed project outputs are: (i) increased GMS collaboration and MEV access to CDC in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases.

7. In Lao PDR, the proposed project amount is $12.6 million of which the GOL requested a loan of $4.0 million from the ADB Special Funds and a grant of $8.0 million and counterpart funds of $0.6 million. The Department of Planning and International Cooperation (DPIC) represents MOH as the Executing Agency. In summary, the GOL will use the loan to finance hardware (laboratory equipment, computers, transport and other auxiliary devices, and use government resources to finance software (training and workshops). The Department of Planning and International Cooperation (DPIC) represents MOH as the Executing Agency. In summary, the Government will use the loan primarily to finance hardware, and use government resources to finance software (training and workshops.

a. Regional Cooperation and CDC for Vulnerable Groups in Border Areas

8. Regional cooperation is mainly in the form of information exchange and joint outbreak responses. While national level information exchange is affected by lack of leadership, cross-border cooperation is gaining momentum.

9. Sub-groups of MEVs in border areas have unique risk of exposure to particular diseases. The risks may vary by occupation and location. However, there are particular concerns for cross-border migrant workers returning home with HIV or TB, who may not have access to care on their return. HIV-infected youths and pregnant mothers also may have limited access to services and care.

b. Surveillance and Response

10. The project will explore new strategies for reaching MEVs and for timely reporting of patients with certain symptoms from remote communities using syndromic surveillance. In addition, through workshops and other knowledge management activities, specific strategies for disease control and system strengthening will be developed. Workshops will not be talk shops, but carefully prepared participatory learning and strategic planning events with monitoring of follow up actions by the regional coordination unit. Various MEVs in border areas are more likely to be exposed to different types of diseases. The risks may vary by occupation and location. However, there are special issues for cross-border migrant workers returning home with HIV or TB. Sometime unable to continue treatment, this may induce and spread drug resistance. HIV positive under 18 sex workers and pregnant mothers should be prioritized in terms of child rights and provided with free services. The Project design will explore strategies to reach these MEVs such as through a bilateral agreement on continuum of care between Lao and Thailand which is being planned.

c. Laboratory Services and Infection Prevention and Control

11. MOH has a National Policy for Health Laboratories and a National Strategic Plan for Health Laboratories as well as a Health Technology Policy. The World Health Organisation (WHO) has facilitated the translation of the WHO Biosafety Guidelines into Lao MOH, with the assistance of WHO, has developed a draft Lao National Quality Standard that is based on the international standard ISO 15189 *Medical laboratories—Particular requirements for quality and competence*.

12. Hospital and health centers are the most likely point of contact for any emerging disease, and also pose a major concern in terms of spreading these diseases. In addition, health facilities are a source of nosocomial infections and drug resistance. Current equipment and practices in health facilities for infection prevention and control are unsafe and waste disposal would not meet IHR or APSED obligations. Lao PDR MOH, with support of WHO, will roll out an IPC program and the World Bank provides support for waste management infrastructure.

C. Project Location

13. The Project in Lao PDR will cover the border districts of 12 border provinces along its border with Cambodia, Vietnam, Thailand and Myanmar. The proposed project targets 12 border provinces out of a total of 18 provinces in Lao PDR, and 24 border districts, some of which have a district hospital A with laboratory. Proposed project provinces in the north are Phongsaly, Luang Namtha, Bokeo, Udomxay, Xiang Quang and Huaphan; in the center Bolikhamsay and

Khammouane, and in the south Champasack, Attapeu, Saravan, and Sekong. These are poor border provinces not supported by other projects with a large proportion of ethnic groups.

D. Project Outputs of Environmental Concern

14. The requirement for an environmental impact assessment is linked to the following Project Subcomponents: (1) Sub-component 2-5, Component 2, **Output 2** and (2) Sub-component 3-4, Component 3, **Output 3** of the above project summary, namely:

Sub-Component 2-5: **improve capacity of outbreak response teams including transport**

Sub-Component 3-4: **provide laboratory equipment and training for infection prevention and control, including laundry services and waste disposal**

15. The above sub-components will require screening of potential environmental impacts and a discussion of mitigating or enhancement measures as a result of the impacts because the activities involve public health risks and potential accidents, minor repair and improvement works, the installation and commissioning of laboratory equipment and related devices, and the operation of the target provincial/district hospitals' existing medical waste management and waste water treatment facilities – all of which impact the project's environmental setting and require environmental safeguards.

16. The screening addresses the potential impacts of the relevant project activities under the loan program, which are re-defined for purposes of the IEE, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; iii) operation of the existing solid waste management facilities and (iv) operation of the existing wastewater treatment facilities described as follows:

- **Project Activity 1 – Minor repair and improvement works.** This activity includes the minor repair and improvement works of the hospital facilities specifically affected by the provision of access, accommodation, modification and installation of new or upgraded laboratory equipment and auxiliary devices, IPC equipment and devices including laundry equipment, computer systems, etc.
- **Project Activity 2 – Laboratory equipment commissioning including IPC services.** This activity includes the mobilization, equipment installation, commissioning, demobilization, recurrent maintenance checks by the suppliers/contractors, and the operation from installation and during the life of the equipment. The equipment means the totality of the laboratory equipment, auxiliary equipment, laundry and washing/drying equipment, and relevant IPC devices and supplies, laundry equipment including the transport vehicles for the transport of laboratory specimen procured under the Project.

- **Project Activity 3 – Solid Waste Management facilities.** The collective activity assumes existing activities that include: (i) the storage and segregation (as applicable) of medical infectious/hazardous and non-infectious/non-hazardous wastes; (ii) collection and transfer for disposal or recycling (as applicable); (iii) internal and external transportation of medical waste; recycling or composting of non-hazardous wastes; and (iv) disposal at: (a) an approved and dedicated disposal facility such as a provincial hospital; (b) permanent burial in specially

designed, secure landfills which will incorporate lining and leachate management systems; (c) sterilization using either chemicals or steam; and (d) incineration using an approved incinerator designed to mitigate hazardous emissions. The operational activities will vary according to the type of facility but will include receipt of waste, burial of waste, burning of waste, general site maintenance, and odor and vermin control.

- **Project Activity 4 – Wastewater treatment facilities.** The collective activity assumes the existing operations of wastewater treatment facilities that are installed at the target hospital facilities to treat effluent to meet relevant environmental standards prior to discharge to waterways or municipal wastewater systems. The scale of operation activities will vary according to the type of facility but includes wastewater treatment process control, site maintenance, and odor control.

17. Since the project does not involve civil works construction, the stages of the project cycle during which screening is to be conducted and into which the temporal boundaries of the activities have been divided are: the **pre-procurement stage**, the **procurement (including the commissioning) stage**, and the **operation stage** from the viewpoint of the hospital facilities.

18. The Project will finance the procurement of laboratory equipment and supplies, transport vehicles, laundry and other infection prevention and control equipment, computer systems and devices for the newly-improved hospitals and other institutions identified by provincial authorities serving as the target populations. A total of 12 target provinces will comprise the beneficiaries of the project. Equipment purchases will be in accordance with established MOH standards and will replace old and non-functioning equipment, upgrade technology for existing procedures, or provide new services. The Project will also support the purchase of an initial inventory of reagents and other supplies needed to properly utilize the new equipment. Procurement and supply of equipment will be closely coordinated with the other components of the project implementation.

19. Once completed, the newly improved and renovated laboratory facilities and supplies, IPC equipment and related devices, computers and related systems, and transport vehicles that are part of the Project need to be properly maintained to realize benefits and justify investments. The Project will ensure that hospital personnel are properly trained to use the equipment and operating manuals are supplied in Lao language. The GOL shall support the preparation of guidelines for preventive maintenance and training of hospital personnel in preventive maintenance procedures.

20. The Government has also assured that the supplies needed to operate the equipment, as well as the costs of maintenance will be provided during and beyond the project period through recurrent costs and adequate increases in operation and maintenance budgets.

21. Moreover, while this project does not include civil works and medical waste management and waste water treatment equipment, the investments will be made with the assurance from GOL that all facilities included in this Project have adequate safe water, sanitation, and medical waste management systems, including waste water systems, proper containers to segregate contaminated and hazardous waste, proper collection and storage facilities, and access to modern medical waste incineration and/or disposal facilities in compliance with the safeguards policy of the ADB. It is incumbent upon the GOL that hospital personnel in all facilities covered by the project will be trained in the theory, methodologies, and supervision of modern medical waste and waste water management practices. In addition, the Project will support consulting

assistance to work with authorities in each target province to develop a province-wide plan for the management of medical waste.

E. Project Category

22. The project is initially categorized as B for environment based on ADB's *Safeguard Policy Statement* (2009) as it involves laboratory bio-hazards and hospital solid and liquid waste management. An IEE based on the field survey of a provincial hospital and a district hospital verified the data obtained from the MOH/DPIC regarding the current medical waste management and wastewater treatment practices in 8 district hospitals of 5 provinces, 4 of which are border provinces, in Lao PDR. The hospital safety and sanitation, infection prevention and control, and risk of accidents and spills during storage, transfer, transport and containment of bio-hazards observed and the rapid environmental assessment confirmed the project to be Category B. Each of the participating provinces will prepare EMPs covering all project activities during implementation and in accordance with the environmental laws of GOL.

III. DESCRIPTION OF THE ENVIRONMENT

A. Physical Resources

1. Topography

23. Lao PDR's district hospitals and health centers in the northern provinces are scattered across hilly and mountainous terrain, and connected through a system of winding, paved and unpaved roads while in the southern provinces of Attapeu and Salavanh, the health facilities are scattered across plateaus and valley floors and along the Mekong flood plain and connected by comparatively better roads. Many of the remote health centers are not accessible by main road connections and it could take a few hours of travel by motorbike or footpath.

2. Climate

24. Lao PDR has a tropical monsoon climate which features a dry season (November to February) and a wet season (May to October). Rainfall is generally high, averaging 1,600 mm over the country and reaching 3,700 mm, at higher elevations in the south. Sustained high rainfall during the wet season is common particularly during July and August, leading to soil saturation, rendering sloping land vulnerable to landslides. Dry seasons appear to be more pronounced to the southwest of the country but they can be long enough in most parts of the country to cause difficulty in sourcing adequate water for households and other users, and for irrigation despite the high rainfall as a whole. The yearly average temperature is about 28 degrees C, rising to a maximum of 38 degrees C during April and May.

3. Water Resources

25. Due to high rainfall levels over the country and the inflow of the Mekong River, water reserves in Lao PDR are vast, as evidenced by the growing number of major hydropower schemes being built in the country. A constraint on water use, however, is the length of the dry season, potentially affecting town water supplies where there is a high demand for irrigation water. There is considerable scope for the expansion of irrigated land. The extent of groundwater reserves is much smaller but still substantial.

B. Ecological Resources

26. Lao PDR is endowed with considerable forest resources, occurring in a range of forest types that vary according to altitude, rainfall and soil types, and represent habitats of international conservation value. Non-timber forest products are important as a food and tradeable commodity source for many communities. Forest plantations have been established with varying success, due mainly to the standards of planning and management of forest plantations. A number of plant and animal species have high endemism. A National Protected Area (NPA) system has been established, consisting of areas covering nearly 14% of the total land area. Management focuses on conservation, integrating traditional land uses in most cases.

C. Economic Development

1. Economic Structure

27. Lao PDR is a lower-middle income economy with a GNI per capita of $1,600 in 2014. GDP growth averaged 7% over the last decade, with increasing use of the country's natural resources – mostly water, minerals and forests – contributing one third to growth. Construction and services also expanded, with growing regional integration boosting tourism and attracting foreign investment. Growth contributed to lowering the number of poor people to an estimated 23.2% of the population in 2012/13 from 33.5% a decade ago. However, poverty reduction has taken place at a slower pace compared to some regional peers.

2. Land Use

28. Lao People's Democratic Republic (Lao PDR) is a landlocked country with a total area of 236,800 km^2 or 23,680,000 hectares. Urban areas take up less than one percent of the total land area. The country is divided into sixteen provinces, one special zone, and Vientiane Capital City. With a population of about 5.6 million in 2005, the Lao PDR is the second least populated country in the Association of South-East Asian Nations (ASEAN).

29. Lao PDR's mountainous terrain precludes expansive permanent agriculture, with 70 percent of the land area having a slope of more than 20 degrees. The area suitable for intensive agriculture is estimated at nearly 1.9 million hectares, or only 8% of the total land area, which consists of permanent pasture, arable lands and permanent crops. The arable land consists mainly of narrow valleys and the productive silt rich in the flood plain of the Mekong River and its tributaries. The arable land under cultivation is estimated to be 800,000 ha. This comprises 43% of the intensive agricultural land, or only 3.4% of the total land area. Rice is grown on 78% of this.

D. Social and Cultural Resources

1. Administrative Areas

30. Lao PDR is divided into 16 provinces, Vientiane Municipality and Saysomboune Special Zone (administered directly by the armed forces for security reasons). Provinces divide into districts (national total of 141 districts), which are further divide into villages (between 11,000 and 12,000). There is no formal jurisdiction between districts and their constituent villages. But in practice, district administrations tend to group villages into zones or *khet,* which are made up of several villages. Official government documents frequently refer to three regions—northern,

central, and southern—but these are geographical and not administrative units.[3] The profile of administration in the project area is presented in Table 3.2.

Table 3.2: Districts and Villages in Project Provinces

Project Provinces	No. of Districts	Villages			
		Total	Urban	Rural w road	Rural w/o road
Northern Provinces					
Bokeo	5	291	42	212	37
Luangnamtha	5	355	37	271	47
Oudomxay	7	472	49	303	120
Huaphanh	8	727	28	646	53
Phongsaly	7	542	52	347	143
Southern Provinces					
Champasack	10	639	95	383	161
Attapeu	5	150	22	103	25
Sekong	4	235	20	138	77
Saravane	8	612	32	551	29
		Total	Urban	Rural w road	Rural w/o road
Central Provinces					
Bolikhamxay	7	326	56	251	19
Khammouane	9	590	114	368	108
Xieng Khouang	8	509	69	394	46

Source: Lao Social Indicator Survey (LSIS) 2011-2012, Surveys Division, Department of Statistics.

2. Population and Community Structure

31. The total population of the project area is approximately 2.8 million, representing about 40% of the projected national population of 6.9 million (2015). The average population density in Lao PDR is 23 people per square kilometer giving the country the lowest population density in Asia. The highest population density in Laos is in Vientiane Capital, with 149 per square kilometer. About 80% of the population are rural dwellers. Over 70% (2,220,547) are engaged in productive work, and 936,870 are unemployed, a classification which includes students (69.4%), domestic workers (12.6%), the elderly people (14.6%). There are 576,758 people working in towns, and 2,580,659 in the countryside.

32. The country has 49 ethnic groups that are officially recognized by the Government and these are grouped based on 4 ethno-linguistic families: the Tai-Kadai family (also known as the Lao ethnic group), 64.9%; the Austro-Asiatic family (also known as Mon-Khmer), 22.6%; the Hmong group (Hmong, Yao and other Hmong-Tien groups), 8.5% and, the Sino-Tibetan groups, 2.8%. Shifting agriculture systems are long established in the uplands. Traditional practice features long fallow periods between cultivations, allowing substantial forest regeneration. However, as demand for land increases and fallow periods are reduced, the effects of shifting agriculture can be harmful.

3. Socio-Economic Conditions

33. Lao PDR's HDI value and rank for 2014 is 0.575 which put the country in the medium human development category and positioned at 141 out of 188 countries and territories. Between 1980 and 2014, the country's HDI value Increased from 0.345 to 0.575, an increase of

[3] UN Capital Development Fund (Lao PDR – Fact Finding Mission Report, March 2002).

66.7% or an average annual increase of about 1.51%.

34. In 2006, the human development index was calculated by province. In the project sites, the following table presents estimates for several indicators and a provincial HDI.

Table 3.3: Human Development Index in Selected Provinces within the Project Area

Indicator/Province	Life Expectancy at Birth (Years)	Adult Literacy Rate, Age 15+ Years (%)	Combined Gross Enrolment Ratio for Primary and Secondary Education (%)	Private Consumption, Investment and Government Expenditure per Capital (PPP US$)	Human Development Index (HDI)	
					Value	Rank
Source	CPI-DGP 2002	LNLS 2001	MOE 2001-02	NSC 2003		
Northern Provinces						
Bokeo	57	59.6	48.2	1,198	0.502	12
Luang Namtha	56	48.2	44.8	1,462	0.489	14
Oudomxay	60	55.3	39.4	931	0.485	15
Houaphanh	56	57.4	46.6	1,077	0.484	16
Phongsaly	61	46.5	34.3	942	0.466	17
Source	CPI-DGP 2002	LNLS 2001	MOE 2001-02	NSC 2003		
Southern Provinces						
Champasak	59	83.0	47.1	1,469	0.575	2
Attapeu	57	73.2	40.8	1,290	0.528	8
Sekong	57	66.6	41.9	1,143	0.508	11
Saravanh	59	47.1	38.9	889	0.458	18
Central Provinces						
Bolikhamxay	55	76.3	57.9	1,356	0.546	4
Khammouane	59	66.7	50.8	1,448	0.542	5
Xieng Khouang	57	70.3	58.4	1,100	0.532	7

4. Poverty

35. In 2013, the incidence of poverty in Lao PDR was 23.2, reduced from 33.5% in 2003. Poverty was predominantly rural, with high concentration in remote, mountainous northeastern and eastern regions bordering Vietnam. However, the distribution of private household expenditures has become more unequal even as poverty incidence has been halved.[4]

36. Table 3.4 summarizes available data on poverty levels in the project provinces.

Table 3.4: Poverty in Selected Provinces of the Project Area

	Poverty Headcount Rate		
	2003	**2008**	**2013**
Lao PDR	33.5	27.6	23.2
Urban	19.7	17.4	10
Rural	37.6	31.7	28.6
Northern Provinces			
Phongsaly	50.8	46.0	12.3
Oudumxay	45.1	33.7	30.1
Bokeo	21.1	32.6	44.4
Luang Namtha	22.8	30.5	16.1
Houaphanh	51.5	50.5	39.2

[4] Warr, P. et al. (2015). Two Decades of Rising Inequality and Declining Poverty in the Lao People's Democratic Republic. ADB Economics Working Series. ADB, Manila.

	Poverty Headcount Rate		
	2003	2008	2013
Central Provinces			
Xiengkhuang	41.6	42.0	31.9
Bolikhamxay	28.7	21.5	16.4
Khammuane	33.7	31.4	26.4
Southern Provinces			
Attapeu	44.0	24.6	8.9
Sekong	41.8	51.8	42.7
Saravanh	54.3	36.3	49.8

Source: Lao Statistics Department. LSB. Poverty Profile in Lao PDR: Poverty Report for the Lao Consumption and Expenditure Survey, 2012–2013. World Bank. 2014.

5. Public Health

a. Disease Type and Incidence

37. The national health indicators of the Lao PDR have been improving steadily over the past three decades. The crude death rate declined from 15.1 to 8.0 deaths per 1,000 inhabitants between 1995 and 2010. At the same time, life expectancy at birth rose by more than 10 years, from 1995 until present. While considered a low-income country, the economy has been growing steadily with gross domestic production (GDP) growth at around 8% over the last five years. Lao is making considerable progress towards MDGs 4, 5, 6 and 7 (Health MDGs scorecard for LMICs* in the Western Pacific Region, 2012). However, malnutrition among under 5 years and persistently high maternal mortality ratio still raise serious concerns. Lao PDR is one of the crisis countries in terms of health workforce. Weakness in health systems including health financing, health information system, health infrastructure and planning and management of health services still persists.

b. Health Care Facilities and Access

38. Table 3.5 summarizes the health care facilities managed by the provincial Department of Health in the project area.

Table 3.5: Health Establishments under Department of Health in Selected Project Areas

Provinces	Total	Regional Hospital	Provincial Hospital	District Hospitals	Health Centers
Xiengkhouang	56	0	7	7	48
Luang Prabang	71	1	0	11	59
Oudomxay	47	1	0	6	40
Attapeu	29	0	1	4	24
Salavanh	51	0	1	7	43
Phongsaly	31	0	1	6	24

E. Reference Baseline Data for Health Care Waste Management in Lao PDR

39. A key component of the project is the improvement of health care waste management practices in the project area. The results of a review of existing health care waste management practices in the project area are summarized below.

1. Healthcare waste generation

40. Healthcare waste (HCW) generated from hospitals includes both non-hazardous waste and hazardous waste. No quantification of non-infectious and infectious waste components of HCW has been available in the project areas. WHO estimates that about 85% of the HCW from developing countries is non-infectious or generally risk-free healthcare waste, which is comparable to domestic waste. The remaining 15% of healthcare waste is regarded as hazardous and may create a variety of health risks. Hazardous healthcare waste can be classified into the following categories: infectious waste, highly infectious waste, sharps, pathological/anatomical waste, pharmaceutical waste, genotoxic waste, chemical waste, waste with high content of heavy metals, pressurized containers, and radioactive waste.

41. The amount of HCW generated depends on the hospital size and its scope of services. There has been no data recorded of HCW generation rates in Lao PDR. According to surveys on HCW management conducted by the MOH in Lao PDR and WHO, a provincial general hospital typically generates 0.64 kg/bed/day of general HCW and 0.14 kg/bed/day of hazardous HCW, while a district hospital typically generates 0.62 kg/bed/day of general HCW and 0.11 kg/bed/day of hazardous HCW. In terms of the relative proportion of hazardous waste generated, infectious waste and pathological waste represents about 15%, sharps represent about 1%, chemical and pharmaceutical waste represents about 3%, other waste such as waste with high content of heavy metals, and pressurized containers share represent less than 1%.

2. Healthcare waste minimization

42. Waste minimization is defined as the prevention of waste production and/or its reduction. This is not regularly practiced by healthcare establishments in the region. Minimization measures such as source reduction (modification of purchasing procedures, control of inventory, and production of less toxic materials), good management and control practices applied particularly to the purchase and use of chemicals and pharmaceuticals, and using of recyclable materials are not typically implemented.

43. Healthcare waste contains quantities of valuable and recyclable materials such as plastic, metals, paper and carton. However, waste recycling is not centrally implemented at hospital level despite the fact that it is carried out unofficially by the different offices.

3. Healthcare waste segregation

44. Lao PDR has not implemented segregation of wastes into color-coded bags or containers. Other countries like Vietnam, for example have institutionalized the segregation of three separate containers into different colors: general waste in green bags, clinical waste in yellow bags, and toxic wastes in black bags. Lao PDR should develop its own system, possibly a Manual for Health Care Waste Management under the leadership of the MOH and in coordination with the relevant regulations by the WREA as regulatory body. In other developing countries, sharps are segregated ad placed into rigid containers with certain specifications to avoid accidental punctures during handling. In Lao PDR, the provincial hospitals are generally responsible for the sharps. However, their treatment and ultimate disposal has not progressed into something environmentally acceptable. The provincial hospitals after collecting the hazardous wastes from the district hospitals, either incinerate them using low-temperature open incinerators or bury them at unsecured waste pits within their property boundaries. The successful practice of waste segregation and disposal is one of the biggest challenges in

HCW management in most developing countries such as Lao PDR. There are limitations reported, as follows:

- (i) Knowledge, attitude and practices among waste generators including hospital staff, patients and visitors are unsatisfactory
- (ii) Supply of equipment for waste segregation, especially sharp containers is insufficient in both the district hospitals and health centers
- (iii) No system has been generally introduced as a policy by the relevant authorities for enforcement

4. Healthcare waste collection

45. Of the district hospitals surveyed, there has been generally no staff assigned to be responsible for collecting healthcare waste from the generation point to interim storage points in the departments. Some weaknesses in collection have been observed in the region as follows:

- (i) Provision of equipment, waste containers in different sizes are not sufficient
- (ii) There is no budget appropriation for staff nor equipment and materials to meet these recurring needs
- (iii) Design of hazardous waste containers do not meet requirements
- (iv) Codification and labeling, waste bags and containers, especially those for clinical waste and chemical waste are not properly color-coded and labeled

5. Healthcare waste transportation

46. Some primary health care workers are made responsible for internal collection from the district hospitals. All of the district hospitals visited lack specialized devices for waste transportation. Hazardous waste is often transported by hand causing spillage and spread of disease throughout the hospital. Internal transportation plans in which the timetable and route of transportation are clearly identified are not available.

47. No private contractors or responsible government agency transports general waste out of the hospitals to a disposal facility. The district hospitals themselves manage their HCW internally, except for the UNICEF sharp safety boxes and certain anatomical wastes that the districts send to the provincial hospitals for disposal.

6. Healthcare waste storage

48. All of the visited district hospitals do not have a formally designated place to store healthcare waste except for different cans and bags of different sizes and materials. Most of the storage containers in district hospitals and health centers, do not meet design and operating regulations because of the following shortcomings:

- (i) The storage areas do not incorporate separate places for different categories of healthcare waste. As a result, general waste and clinical waste that were segregated at sources and separately collected and transported are mixed again at storage places. Chemical waste is not collected and centrally stored. Liquid wastes are disposed of in the sinks although some of the hospitals have separate septic vaults for liquid wastes for wastes are disposed
- (ii) The storages do not have roofs and locks. Unauthorized people, animals, rodents and inserts can easily access hazardous waste causing risks of spillage and

disease spread.

(iii) Storage duration often exceeds 24 hours in hot weather.

7. Healthcare waste treatment

49. No models for health care waste treatment were observed in the district hospitals visited.

50. Healthcare waste treatment technologies applied in the region are (i) medium temperature incineration; (ii) low temperature incineration; (iii) waste burial; (iv) steam autoclave; and (v) chemical disinfection.

(i) Medium temperature incineration: Pyrolytic incinerators that incinerate waste at 800–900°C are reported to be used at the provincial hospitals but these have not been confirmed by actual visits. The emissions from incinerators have not been monitored since they were installed, but polluting gas emissions and high operating costs are reported.

(ii) Low temperature incineration: Drum incinerators, brick incinerator or one-chamber, open incinerators are still common in district hospitals even though their design is out of date. Because of low effectiveness and high environmental impacts, such incinerators are no longer recommended. The gas emissions from these incinerators have reportedly been very pollutive.

(iii) Waste burial: District hospitals bury healthcare waste on their premises. Safe burial of healthcare waste is recommended by WHO. However, in comparison with requirements of sanitary landfill, the bury pits observed in hospitals often have the following shortcomings: (i) inadequate sealing of base and sides to minimize the movement of wastewater or leachate off site, (ii) no presence of site personnel capable of effective control of daily operations, (iii) no surface water collection, (iv) access to site and working areas difficult for waste delivery and site vehicles, (v) lack of surface water collection trenches around site boundaries, (vi) lack of a final cover to minimize rainwater infiltration when each phase of the landfill is completed

(iv) Wet thermal disinfection: Stream autoclaves are commonly used by hospitals to primarily treat highly infectious waste. Although wet thermal disinfection has been introduced in Lao PDR at present, application of autoclave for healthcare waste treatment is still limited to microbiological laboratories where highly infectious waste is mostly generated.

(v) Chemical disinfection: Using disinfectants to treat contaminated materials is very common in provincial and district hospitals throughout the region. However, application of chemical disinfection for healthcare waste treatment, particularly for highly infectious waste treatment is still limited to microbiological laboratories and in areas of infectious disease outbreaks.

8. Wastewater collection and treatment

51. Hospital wastewater includes rainwater, wastewater generated from healthcare activities and wastewater from toilets. Old hospitals often have a collection system for storm water, a collection system and septic tanks for wastewater from toilets but only a few of those visited have separate collection lines and separate septic tanks for wastewater generated from healthcare activities. In consequence, wastewater from healthcare activities with a high content of pathogens and certain amount of pharmaceuticals and chemicals is discharged into the storm water system line or discharged onto the land without any treatment. Beside these weaknesses

in design, there are weaknesses in operation and maintenance in terms of wastewater collection

and treatment as follows:

(i) Hospital staff often discharge chemical and pharmaceutical waste into wastewater collection systems. This practice can harm the wastewater treatment plant.
(ii) In the health centers and district hospitals areas visited, staff and patients do not know how to properly use toilet and sanitary facilities in the hospitals. This often results in blockages of the wastewater collection system. Regular and corrective maintenance of wastewater collection system is rarely carried out.

IV. SCREENING OF POTENTIAL ENVIRONMENTAL IMPACTS AND MITIGATION MEASURES

A. Rapid Environmental Assessment

52. In order to identify potential environmental impacts of the project components, the initial environmental screening was first carried out using the ADB rapid environmental assessment forms (REAs) to screen the proposed activities required for the installation of new or improved laboratory facilities/equipment such as minor repair and improvement works on the provincial and district hospitals at border provinces, districts and towns as the case may be. (Please see Appendix 2 for the form used). While the district and provincial hospitals are all existing facilities and whatever improvements are introduced bring mostly positive impacts for the environment, the REAs categorized most of the project activities as Category B because the project involves the management of infectious, hazardous, medical solid waste and wastewater and the risks inherent in the handling of laboratory wastes, and the diagnostic activities in managing highly infectious diseases at the border towns of the target border district and provincial hospitals.

53. The ADB safeguard policies require that the project's activities need to be carefully considered to avoid and/or to minimize the negative impacts on the natural environment and social environment (including environmental public health and occupational health), and provide the appropriate measures to mitigate such impacts. In accordance with the ADB guidelines, the potential impacts of medical solid and liquid wastes including laboratory wastes, being hazardous along with deficient sanitation and laundry facilities and the lack of effective wastewater equipment and treatment systems categorizes the health facilities as having significant potential negative environmental impacts that need to be mitigated.

B. Environmental Assessment Methodology

54. A survey was conducted by the Consultant and the MOH team at one border province to be representative of the other targeted provinces. The main objectives of the survey were to:

(i) Assess the current practices and environmental conditions focused on the medical waste (solid and liquid) management of the health care facilities (provincial and district hospitals and/or preventive medicine centres);
(ii) Organize meetings with the provincial agencies of MOH and DONRE to consult them about their needs and plans about the environmental management of the sub-components of the health security project to institute environmental safeguards from the impacts of laboratory waste, infectious disease bio-hazards,

(iii) hospital safety and hygiene for infection prevention and control, and medical solid

and liquid waste management; and

(iv) Collect environmental baseline data of the representative provinces included in the target border areas.

55. During the time allotted, the site surveys were carried out by a combination of methods i.e. observation, photo-documentation, data/document review and analysis, and interview or focus group discussions with key informant officials. The survey team earlier developed sets of Rapid Environmental Assessment (REA) checklists for health care facilities. The data and information on environmental issues (focused on medical solid and liquid waste management and hospital safety and hygiene for infection prevention and control) of the selected provinces under the project areas were collected from DOH, DONRE and relevant provincial agencies.

56. The Consultant and the MOH/provincial team conducted. The meetings with the provincial staff, Provincial Director and Laboratory staff were held with participation of the relevant staff to discuss the environmental situation in their respective areas focusing on the medical waste management. Similar meetings and consultations at the district hospitals or preventive medicine centres visited were also held with participation of the district hospitals staff to discuss the environmental situation of the district hospitals respectively and open discussions about their views about the project, on the medical waste management and hospital safety and hygiene for infection prevention and control, and on medical solid waste management and wastewater treatment facilities.

C. Potential Environmental Impacts and Mitigating Measures

57. For the purposes of the assessment, the following categories of impacts have been developed:

(i) **NO IMPACT:** The potential impact of the project is assessed as NO IMPACT if the project activity is physically removed in space or time from the environmental component, or if the impact is so small as to be un-measurable (i.e. negligible).

(ii) **MAJOR IMPACT – POSITIVE OR NEGATIVE:** An impact is said to be MAJOR if the project has the potential to affect an environmental component. The following criteria were used to determine whether a given impact is MAJOR:

(a) spatial scale of the impact (site, local, regional, or national/ international);
(b) time horizon of the impact (short, medium, or long term);
(c) magnitude of the change in the environmental component brought about by the project activities (small, moderate, large);
(d) importance to local human populations;
(e) compliance with international, national, provincial, or district environmental protection laws, standards, and regulations;
(f) compliance with ADB guidelines, policies, and regulations.

(iii) **MINOR IMPACT – POSITIVE OR NEGATIVE:** If an impact occurs but does not meet the criteria for a Major Impact it is assigned the category MINOR. Minor impacts occur along a spectrum ranging from those impacts that are close to being major impacts to those that are close to being negligible impacts. The judgments made in relation to the position of specific impacts along this spectrum are discussed in the text accompanying the environmental screening.

(iv) **UNKNOWN IMPACT:** The potential impact of the project will be assessed as being UNKNOWN if the magnitude of the effect cannot be predicted for any of

the following reasons:

(a) the nature and location of the project activity is uncertain;
(b) the occurrence of the environmental component within the study area is uncertain;
(c) the time scale of the effect is unknown; or
(d) the spatial scale over which the effect may occur is unknown.

58. These categories have been applied to other ADB infrastructure projects and have been adapted from ADB, *1997 Environmental Impact Assessment in Developing Countries.*

D. Screening of Environmental Impacts of Project Components

59. The purpose of this section is to undertake further screening of typical environmental impacts of the project components/sub-components. The screening addresses the potential impacts of the structural processes to be implemented and relevant activities under the loan program, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; (iii) operation of the existing solid waste management facilities and (iv) operation of existing wastewater treatment facilities. Since the project does not involve civil works construction, the environmental assessment covers the pre-procurement, procurement (including the commissioning stage), and the operation stage of the project as described fully in Section II-G. Only potential impacts that have direct and relevant significance are listed in the environmental screening (Appendix 1).

60. The following key is used in the environmental screening.

NO impact	O
MINOR NEGATIVE impact	X
MAJOR NEGATIVE impact	XX
MINOR POSITIVE impact	+
MAJOR POSITIVE impact	++
UNKNOWN impact	?

E. Findings of the Environmental Assessment

61. The TOR initially categorized this project as requiring an Initial Environmental Examination (IEE) Report and an Environmental Management Plan both of which are required for a Category B Project. It is understood that this project was tentatively classified as a Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document. This categorization was examined through the representative visits to the different project sites and the proposed project component descriptions and how the project proponent intends to mitigate the potential negative environmental impacts of the project.

62. In accordance with the ADB's *Environment Policy (2003),* Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or significance than those for Category A projects that require a full-blown Environmental Impact Statement

arising from major adverse impacts on the environment. For a Category B project, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

63. In Lao PDR, the final list of target hospitals from the border provinces and districts are still being finalized by GOL and their respective environmental assessments have not been prepared. The project is expected to have positive environmental impacts based on the level of investments in laboratory equipment to improve diagnostics of emerging diseases in support of communicable diseases control. On the other hand, this project is not supporting civil works construction for waste management. It is expected that the existing SWM equipment and wastewater treatment facilities will not be able to meet the environmental standards consistently.

64. During the project's life, the environmental assessment will continue particularly for the medical solid waste and the wastewater treatment facilities. If not upgraded or properly maintained, there will be a good chance that the assessment will also continue to have negative environmental impacts. It is very important therefore to have an environmental management plan in place. Within the plan should be a monitoring framework.

65. Separately, the projects will undergo environmental impact assessment in accordance with the relevant Lao PDR legislation on environmental pollution laws, medical solid and liquid waste management, wastewater treatment facilities, and environmental health and safety.

V. INSTITUTIONAL REQUIREMENTS AND ENVIRONMENTAL MONITORING PLAN

A. Institutional Arrangements

66. Table 5.1 summarizes the proposed environmental management responsibilities of key parties involved in the project.

Table 5.1: Environmental Management Institutional Arrangements

Agency	Environmental Management Responsibilities
ADB	Sign grant agreement with GOL including environment-related covenants Review of site specific EAs and environmental monitoring reports
MOH PCU	Responsibility for overall project implementation, including environmental management activities and implementation of EARPs Coordination of environment-related activities of PIAs including implementation of aspects of EARPs
MOH	Responsibility for project operation including operation stage environmental performance Allocation of staff with responsibility for environmental issues during operation
PIAs	Responsibility for province level project implementation Responsibility for implementing EARPs including preparation of environmental assessments - and obtaining environmental approvals for works within province Responsibility for pre-construction stage and construction stage environmental management, monitoring and reporting
WREA	Provision of advice to PIAs as required on environmental issues
WREA and ADB	Approval of EMPs for works within districts

Agency	Environmental Management Responsibilities
Suppliers/contractors	Implementation of environmental management commitments contained in site specific EMPs Monitoring and reporting of environmental performance

67. Responsible personnel assigned by the MOH would have primary responsibility for environmental issues and activities during project implementation.

B. Environmental Mitigation Plan

68. Table 5.2 contains the proposed typical environmental mitigation plan for the pre-procurement, procurement and operation stages of selected project sub-components as assessed. During project implementation, the EMPs for the site specific project sub-components will be validated as a continuing process. Reference will be made to new site information obtained to update site specific mitigation measures for inclusion in the EMP.

Table 5.2: Typical Environmental Mitigation Plan

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Procurement Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/Contracto r
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/Contracto r
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/Contracto r
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/Contracto r
Risks to public and worker health and safety	Minimize risk of accidents to public and workers	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	Supplier/Contracto r

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Operation Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Ensure compliance with relevant Lao PDR air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Lao PDR on air quality, particulates and odor	MOH
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the labs Regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	MOH
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours Notify nearby community of schedule and duration of activities	MOH
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Lao PDR and DONRE regulations.	MOH and WREA

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
		Ensure that wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal. Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Lao PDR and DONRE regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable DONRE standards for medical wastewater.	MOH
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos. Provide safety equipment to construction workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Lao PDR regulations on SWM and wastewater discharge are complied with.	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Emissions generation	Comply with relevant Lao PDR Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MONRE
Issue	**Performance Objective**	**Mitigation Measure**	**Responsibility for Implementation**
Operation Stage			
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Lao PDR standards prior to discharge Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH and WREA
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	Ensure that the applicable laws and regulations on SWM and wastewater treatment particularly on best practices and safety are complied with.	MOH and MONRE
Issue	**Performance Objective**	**Mitigation Measure**	**Responsibility for Implementation**
		Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

C. Environmental Monitoring Plan

69. Tables 5.3 and 5.4 contain the proposed environmental monitoring plan for the pre-construction, construction and operation stages of the project components. Two types of environmental monitoring are proposed to be implemented:

(i) Environmental effects monitoring is conducted to estimate the impacts of the sub-project on ambient environmental conditions.

(ii) Project environmental performance monitoring is conducted to evaluate compliance with environment-related operating procedures, national standards, and/or contractor specifications including the requirements of the EMP.

70. The following plan identifies the relevant site specific monitoring measures for inclusion in the EMP.

Table 5.3: Environmental Effects Monitoring Plan

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / MOH
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier / MOH
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier / MOH
Operation					
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH

Table 6.4: Environmental Performance Monitoring Plan*

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Covering of equipment and fixtures & use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / MOH
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier / MOH
Operation					

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Air emissions control	All criteria in Lao PDR - Air quality – odor from solid waste matter – Permitted level.	At solid waste facilities and autoclaves	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH

D. Environmental Monitoring and Reporting

71. Table 5.5 contains the proposed environmental monitoring and reporting system for the pre-construction, construction and operation stages of the project.

Table 5.5: Environmental and Monitoring Reporting Requirements

Project Phase	Type of Monitoring	Description	Responsibility	Reporting Requirements
Procurement	Supplier/Contractor's Environmental Performance Monitoring	Self-monitoring of environmental effects of minor repair and improvement works in terms of environmental performance monitoring requirements identified in EMP. Undertaken on an ongoing basis throughout the procurement process with regular monitoring frequencies.	Supplier/contractor	Commissioning reports to MOH/MONRE
	EMP Compliance Monitoring	Monitoring of Supplier/Contractor's compliance with EMP requirements. Undertaken during commissioning of equipment. Monitoring based on combination of observation and review of supplier's environmental performance monitoring results.	PIAs	Commissioning reports to MOH/ADB
Operation	Operation Environmental Monitoring	Monitoring of performance of project operation. Undertaken on a regular basis over life of project and self-reporting of compliance with EMP operation stage commitments.	MOH	1st year: 3 monthly reports to ADB and MONRE Subsequent years: 6 monthly reports to MONRE

E. Environmental Management Budget

72. Environmental management costs include costs both at the level of individual project sub-components as well as project component-wide environmental management costs. An environmental management budget to cover costs for management and monitoring both at the level of the district hospitals and the health centers will be established. A certain percentage of the total project costs can be allocated for this fund upon agreement with the MOH.

73. The EMP budget will include the following components:

(i) Marginal costs for implementation of environmental mitigation measures during pre-construction, construction and operation stages.
(ii) Marginal costs for implementation of environmental monitoring measures during pre-construction, construction and operation stages.

VI. PUBLIC CONSULTATION AND INFORMATION DISCLOSURE

A. Public Consultation Undertaken to Date

74. Consultation undertaken to date on the project has involved the following:

(i) Meetings and consultations with Provincial Health Office directors, laboratory and infection control and prevention staff representatives in the sampled project province to inform them about the need for rapid environmental assessments and obtain the current status of the district hospital facilities and health centers and the upgrades or improvements that they are proposing based on their own diagnosis.
(ii) Meetings and consultations with each District Health Office Director and/or Hospital Director together with their management and staff, laboratory and infection control and prevention staff representatives in the sampled project province to brief them about the environmental assessments that each hospital has to undertake to identify the current status of environmental conditions in the vicinity of the health facilities and identify the scope of required project interventions.

75. The initial public consultations showed a high level of acceptance of the project as the project will improve the hospitals' and health centers' current state and capability for improved laboratory services and infection prevention and control. Some suggestions were forwarded regarding the laboratory equipment needed, waste management containers, disposal technologies that are non-burn. Representatives of INGOs were concerned about the health effects of incinerators. Some of the related environmental concerns included the lack of proper management of health care waste, the lack of adequate staff for operations and maintenance of the facilities, and the basic lack of medical and non-medical equipment. Such concerns will be incorporated in the mitigation and monitoring plans during project design and implementation. Public consultation is an on-going process and the consultations will continue with the project affected communities and relevant NGOs, if any, during the detailed design and implementation phases of the project.

B. Future Public Consultation and Disclosure

76. In order to ensure that future project activities are conducted in a participatory sense and that community concerns and opinions about potential environmental impacts are taken into account during subcomponents of procurement and operation, a range of public consultation and disclosure activities will be implemented throughout activity preparation, implementation and operation. These activities, which have been developed to meet the requirements of both GOL and ADB safeguards requirements, are summarized in the following sections.

77. The following consultation activities will be implemented during the finalization of the detailed design of project activities:

(i) District level workshops in each district contained in the project area to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops will include stakeholder agencies, mass organizations (Women's Union, Youth Union and Farmers Association), other relevant district level organizations such as the District Committee for Ethnic Minorities and CPC and other relevant stakeholder representatives.

(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required particularly for the quarantine and border area outbreak response facilities.

78. The public consultation activities carried out and the subsequent outcomes will be documented in the environmental assessment documents to be prepared for each site and records of the public consultation appended to the document as outlined in the Environmental Assessment and Review Procedures for the project.

79. To ensure ongoing community involvement during project procurement and operation, the following activities will be carried out for each project activity.

(i) Community information on procurement and operational activities and details of any expected impacts and measures to control them by means of newspaper and loudspeaker announcements and direct communication by local authorities to affected households

(ii) Establishment of a grievance redress mechanism to allow community members to report concerns regarding operational activities including environmental pollution concerns.

80. The requirements for future consultation activities during procurement and operation will be documented in the site specific environmental assessments to be prepared during project implementation.

VII. ENVIRONMENTAL CRITERIA FOR PROJECT SUB-COMPONENT SELECTION

81. The following environmental criteria have been developed for the purposes of future project sub-component selection.[5] All project sub-components must:

(i) Avoid direct or indirect significant, negative impacts on protected areas defined by Decree No.333/PM on the Protection Forest (July 2010) of the Government of Lao PDR, or other known areas of ecological sensitivity including those areas identified in Section III of the IEE

(ii) Avoid loss of significant areas of vegetation or permanent, negative impacts on a known rare or endangered flora or fauna species

(iii) Avoid pollution of waterways, surface waterbodies or groundwater resources with ecological values or which are used for domestic or agricultural water supply

(iv) Avoid direct or indirect significant, negative impacts on important items of cultural heritage, including those sites identified in Section III of the IEE

[5] Environmental criteria apply only to the following structural project sub-components: Minor repair and improvement works; laboratory equipment installations; solid waste management facilities and wastewater treatment facilities.

(v) Not cause any other environmental impacts that would trigger categorization as a 'Category A' project in accordance with the ADB's *Environmental Policy, OM.20 Environmental considerations in ADB operations* and *Environmental Assessment Guidelines* (2003)

82. Once project components have been selected using the defined criteria, they will be subject to further environmental analysis through implementation of the environmental assessment and review procedures (EARPs) presented in Section VIII.

VIII. ENVIRONMENTAL ASSESSMENT AND REVIEW PROCEDURES

A. Introduction

83. The following Environmental Assessment and Review Procedures (EARPs) document the procedures for the environmental assessment of the project sub-components that will be implemented under Components 2 and 3 of the project. The EARPs have been harmonized with the GOV's environmental assessment requirements as far as possible to ensure a streamlined environmental assessment process for project loan activities. The EARPs have been developed to comply with the ADB's *Environmental Assessment Guidelines* (2003).

B. Overview of Types of Project Sub-Components to be Assessed

84. The project targets border districts of 12 provinces along Lao PDR's borders with Myanmar, PR China, Viet Nam, Thailand, Cambodia and Lao PDR, and some districts along the economic corridors. The selection of the final provinces and districts would be based on:

(i) economic status of the province
(ii) health and health service statistics
(iii) regional risks and priority clusters
(iv) existing support from other partners

85. All project sub-components at one location will be grouped together to form a 'project activity for the purposes of the application of the EARPs.

C. Lao PDR's Environmental Assessment and Review Procedures

86. Environmental legislation and associated regulatory instruments in Lao PDR that are relevant to the selection of future project/sub-project components are given below. The GOL's environmental safeguards procedures are set out in the following instruments:

(i) Directive No. 8056/MONRE dated December 17, 2013 on the adoption and promulgation of the list of investment projects and activities subjected to IEE and EIA.
(ii) Guideline No. 8030/MONRE on the Process of Assessment of Social and Natural Environmental Impact from Investment Projects and Activities Assessment (December 17, 2013) sets the guideline for the implementation of the process of EIA for development projects and activities.
(iii) Decision No. 0555/MOIC on Management of wastes from Industrial and Handicraft Processing Factory (March 20, 2012) sets out the principle and measures for management of wastes including hazardous wastes from industrial processing factory.

(iv) Law on Environment Protection (Amended) No. 29/NA (2012) sets out the principles, rules and measures on management, monitoring of protection, control, rehabilitation of environment and demand for EIA for development project

(v) Law on Water and Water Resources No. 02-96 (1996) sets out the principles, regulations, measures relating to the administration, exploitation, use and development of water and water resources to preserve sustainability and sufficient quality and quantity of water

(vi) Decision No. 2734/PMO.WREA on National Environment Quality Standard (2009) define the standard values indicating ambient noise, air, water and soil quality and standard maximum value for pollution discharge from industries, development projects and activities.

(vii) Decision No. 2062/MOIC on Standard for Air Emission from Industrial Processing Factory (October 14, 2009) defines the standard and maximum value of, and principle and obligations for management and monitoring of air pollution/emission discharge from industrial processing factory.

87. GOL legislation does not require sector level environmental assessments to be carried out for projects such as this project. Thus, unlike the ADB process, there will not be one overarching environmental document for the project prepared under the GOL environmental assessment framework. Investments financed by the loan will be evaluated by the GOL on a site by site basis. All sub-components at one site will be grouped together to form a 'project activity' for and for each project activity, an environmental assessment report will be required to be prepared. The type of environmental assessment report required will depend on the nature, scale and location of the investment.

D. Specific Procedures to be used for Project Sub-components under the Sector-type Loan

1. Responsibilities and Authorities

88. Table 8.1 sets out the responsibilities and authorities of key organizations involved in the implementation of the EARPs.

Table 8.1: Responsibilities for EARP Implementation

Organization	EARP Implementation Responsibilities
CPMU	Check environmental selection criteria have been applied in selection of project sub-components Provide advice to PPMU on environmental assessment (EA) preparation Review and provide "no-objection" on EAs submitted by PPMUs Submit EA to ADB for review and approval
PPMU	Overall responsibility for EA preparation and submission for approval including engagement of consultants if required to prepare EIAR Apply environmental selection criteria to identify future project sub-components
PPC	Ensure that the PPMU is adequately resourced to properly manage project sub-components including safeguards issues Appraise and approve EIARs
MONRE	Provide advice and guidance on environmental issues during project sub-component preparation

Organization	EARP Implementation Responsibilities
District PCs	Approval of project sub-component CEP/EMPs
ADB	Receipt and review of EA for each project sub-component

89. Institutional strengthening for organizations involved in EARP implementation would be carried out as follows:

(i) **Environment Support Consultants:** A national consultant would be engaged to work with the CPMU and PPMU Environment Officers and MOH staff to establish systems and tools to implement their project responsibilities and to provide technical on-the-job training and support. Such systems and tools would include example EA documents and templates for use throughout project implementation and organisation of forums to share lessons learnt between PPMUs. These positions would be implemented intermittently throughout project implementation.

(ii) **CPMU Environment Officer:** The CPMU Environment Officer would be the main point of contact for environmental safeguards issues at the central level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iii) **PPMU Environment Officer:** The PPMU Environment Officer would be the primary point of contact for environmental safeguards issues at the province level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iv) **MOH Environment Officer:** An existing staff member within the MOH would be allocated to have responsibility for environmental issues during project operation. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

2. Environmental Criteria for Future Project Sub-component Selection

90. The environmental criteria for future project sub-component selection are documented below:

(i) Avoid direct or indirect significant, negative impacts on protected areas defined by Decree No. 333/PM on the Protection Forest (July 2010) of the Government of Lao PDR, or other known areas of ecological sensitivity including those areas identified in Section III of the IEE

(ii) Avoid loss of significant areas of vegetation or permanent, negative impacts on a known rare or endangered flora or fauna species

(iii) Avoid pollution of waterways, surface waterbodies or groundwater resources with ecological values or which are used for domestic or agricultural water supply

(iv) Avoid direct or indirect significant, negative impacts on important items of cultural heritage, including those sites identified in Section III of the IEE

(v) Not cause any other environmental impacts that would trigger categorization as a 'Category A' project in accordance with the ADB's *Environmental Policy, OM.20 Environmental considerations in ADB operations* and *Environmental Assessment Guidelines* (2003)

3. Procedures for Environmental Assessment of Project Sub-components

a. Environmental Categorization

91. The first step in the EARPs will be the determination of the environmental categorization for each subproject in terms of both ADB and GOVL requirements.

92. In terms of ADB environmental categorization, the environmental selection criteria that have been developed for subprojects will ensure that all subprojects will be classified either as:

(i) Category B in accordance with the ADB's *Environmental Assessment Guidelines* and thus subject to preparation of an IEE; or
(ii) Category C in accordance with the ADB's *Environmental Assessment Guidelines* and thus not subject to formal environmental assessment.

93. The determination of whether a subproject is Category B or Category C will be made by the PPMU (with advice from the CPMU as necessary) using guidance from the ADB's *Environmental Assessment Guidelines.*

94. In terms of GOL environmental categorization, reference to Lao EIA procedural manual indicates that some subprojects may require one of the following levels of environmental assessment:

(i) **Preparation of EIAR:** A small number of project activities may trigger categorization of environmental impact that may require detailed EIAR. Types of activities that may be subject to EIARs include hospitals with more than 50 beds; incinerators or WWTPS with capacity greater than $1000m^3$/day.
(ii) **Preparation of CEP**: Project activities that do not trigger an EIAR will require a less detailed environmental assessment in the form of a CEP.
(iii) **No environmental assessment:** Some subprojects involving very minor upgrading or improvement works may not require any assessment under GOV safeguards requirements; however, there is no clear guidance provided in the GOV legislation as to when no assessment is required and this determination will be made on a case by case basis by DONRE and/or DPC in consultation with the PPMU during the environmental categorization process.

95. The determination of the appropriate environmental categorization of each subproject in accordance with GOL safeguards requirements will be made by the PPMU, based on advice from CPMU and the relevant DONRE and District PC, at the outset of the environmental assessment process with reference to Lao PDR's environmental categorization procedure.

b. Preparation of Environmental Assessment Documents

96. For all project activities[6] an environmental assessment document will be required to be prepared that will incorporate the following elements:

(i) Required contents of EIAR or CEP document as established by the EIA preparation guidelines

[6] For the purposes of the EARPs a 'project activity' is defined as all project sub-components being carried out at a particular location.

(ii) Appendix containing a site specific Environmental Management Plan (EMP) prepared following the format and structure contained in the guidelines
(iii) Appendix containing the results of public consultation and information disclosure activities

97. The information required to be included in the appendices of the EA document are consistent with, but represents a strengthening of, GOL requirements for addressing environmental management issues and public consultation activities in environmental assessment documentation.

c. Requirements for Environmental Management Plans

98. The EA will be required to include an Environmental Management Plan (EMP) for each project sub-component. The EMP will address environmental mitigation and monitoring activities, institutional arrangements and strengthening requirements, public consultation activities during project implementation and operation and environmental monitoring and reporting requirements.

99. Table 8.2 summarizes the potential impacts and proposed mitigation measures for the project activities that will form the basis of the EMP for each project sub-component.

Table 8.2: Project Environmental Impacts and Mitigation Measures

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Procurement Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/Contractor
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/Contractor
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weather proof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/Contractor
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/Contractor
Risks to public and worker health and safety	Minimize risk of accidents to public and workers	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	PPMU

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	PPMU
Operation Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Ensure compliance with relevant Lao PDR air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Lao PDR on air quality, particulates and odor	PPMU
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the labs Regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	PPMU
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours Notify nearby community of schedule and duration of activities	PPMU
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Lao PDR and DONRE regulations.	PPMU
		Ensure that wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal. Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Lao PDR and DONRE regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable DONRE standards for medical wastewater.	PPMU

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos. Provide safety equipment to construction workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Lao PDR regulations on SWM and wastewater discharge are complied with.	MOH
Emissions generation	Comply with relevant Lao PDR Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MONRE
Operation Stage			
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Lao PDR standards prior to Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1. Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1. Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	Ensure that the applicable Lao PDR regulations on SWM and wastewater treatment particularly on best practices and safety are complied with.	PPMU

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
		Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

100. Tables 8.3 and 8.4 summarize the proposed monitoring measures for the project activities that will form the basis of the EMP for each project sub-component.

Table 8.3: Environmental Effects Monitoring Plan[7]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility for Implementation
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / PPMU
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier / PPMU
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier/PPMU
Operation					
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH

[7] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table.

Table 8.4: Environmental Performance Monitoring Plan[8]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility for Implementation
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Covering of equipment and fixtures & use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/PPMU
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier/PPMU
Operation					
Air emissions control	All criteria in Lao PDR - Air quality – odor from solid waste matter - Permitted level.	At solid waste facilities and autoclaves	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified in Lao PDR standards	Weekly for first 6 months and then monthly thereafter	MOH

d. Requirements for Public Consultation and Disclosure

101. There is a requirement that public consultation and information disclosure takes place for each project activity during preparation of the EA. The following minimum requirements for public consultation and disclosure must be met for each project activity.

102. At the outset of the preparation of the EA, local authorities and community representatives in the vicinity of, or who are likely to be affected by, the project should be informed of the project activity and given an opportunity to provide feedback on potential environmental issues or required management measures. The following activities will be carried out for each project activity:

(i) District level workshops in each district contained in the project area to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops with include stakeholder agencies, mass organizations (Women's' Union, Youth Union and Farmers Association), other relevant district level organizations such as the District Committee for Ethnic Minorities and CPC and commune representatives.

(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required.

[8] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table.

103. In addition, information on the project activity and consultation activities will be provided to the local community through newspaper notices and/or public announcements.

104. Following approval of the environmental assessment document, a copy of the approval and a summary of the environmental assessment document will be sent to all relevant DPCs and CPCs. Information regarding the approved project and the proposed environmental management measures will be posted at suitable locations on the project site.

105. The public consultation activities carried out and the subsequent outcomes must be documented in the EA and the records of the public consultation appended to the document.

e. Review of Environmental Assessment Documents by GOL and ADB

106. At the same time that the EA is submitted to the relevant GOL authorities (in Lao language), it will be submitted by the CPMU (in English language) to the ADB. The ADB will review the document for compliance with its environmental safeguards requirements.

107. All environmental assessment documents prepared using these EARPs will be reviewed and approved by the GOL. The approval process that will be implemented by the GOL as set out in the relevant decree.

108. For sub-projects with a value of more than $1million, approval of environmental assessment documents will be required from the ADB prior to the commencement of construction works

f. Monitoring and Reporting of EARP Implementation

109. Monitoring and reporting of EARP implementation will be undertaken to ensure that the procedures are being adequately implemented and to identify any modifications or corrective action that may be required to improve the efficiency of the EARPs throughout the project implementation process. The monitoring of EARP implementation will be incorporated into the overall project monitoring and evaluation and reporting system. EARP implementation will be monitored at the province and central levels.

110. Reporting of EARP implementation will take place on a 6 monthly basis. Each PPMU will report to the CPMU on the monitoring parameters contained in Table 8.2, and the CPMU will consolidate these reports, together with the results of the central level monitoring for submission to the ADB.

111. Table 8.5 summarizes the monitoring processes that will be carried out for EARP implementation.

Table 8.5: Monitoring of EARP Implementation

Monitoring Parameter	Monitoring Method	Frequency of Monitoring	Responsibility for Monitoring
Verification of EA preparation and approval before commencement of project component construction	Verification of: (i) EA document produced, (ii) GOV certificate issued, (iii) ADB no-objection issued	Each project sub-component before commencement of construction	PPMU
		Random checks of at least 15% of project sub-components	CPMU

Monitoring Parameter	Monitoring Method	Frequency of Monitoring	Responsibility for Monitoring
		Random check of small number of project sub-components	CPMU
Adequacy of public consultation / disclosure activities to meet EARP requirements	Number and type of public consultation and disclosure events and key issues raised	For all project sub-components	PPMU

E. Confirmation that the Environmental Assessment and Review Procedures conform to ADB's Requirements

112. The EARPs presented in this section have been developed to take account of the ADB's environmental safeguards requirements. Specifically, the EARPS require development of environmental mitigation and monitoring plans and institutional arrangements, and implementation of public consultation activities to meet the ADB's requirements.

113. The review of the environmental assessment documents for each project activity that will be carried out by the ADB will ensure compliance of the products of these EARPs with ADB safeguards requirements.

F. Staffing Requirements and Budget for EARP Implementation

114. Table 8.6 summarizes the estimated staffing requirements and budget for EARP implementation for each project activity.

Table 8.6: Staffing Requirements and Budget for EARP Implementation

Organization	Responsible Personnel	Human/Financial Resources for EARP Implementation assuming EIAR Level Assessment	Human/Financial Resources for EARP Implementation assuming CEP Level Assessment
CPMU	CPMU Environment Officer	3 person weeks	1-person week
PPMU	PPMU Environment Officer	4 person weeks $20,000	3 person weeks $5,000

IX. FINDINGS AND RECOMMENDATIONS

A. Findings

115. The terms of reference initially categorized this project as requiring an Initial Environmental Examination (IEE) report and an Environmental Management Plan (EMP) both of which are required for Category A and B projects. It is understood that this project was tentatively classified as Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document. This categorization was examined through the respective visits to the different project sites and the proposed project component descriptions and how the project component intends to mitigate the potential negative environmental impacts of the project.

116. In accordance with the ADB's *Safeguard Policies Statement (2009)*, Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or

significance than those for Category A projects that require a full Environmental Impact Assessment (EIA) arising from major adverse impacts on the environment. For Category B projects, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

117. The final list of the project's subcomponents and the project descriptions for their implementation have indicated that the project will be a Category B. The negative impacts expected to occur during operation stages of the project. Namely:

(i) **During the procurement stage**: Probably some structures of the laboratories and/or other structures of the hospitals need to be repaired and upgraded before assembly of the equipment. However, the negative impacts during this phase will be negligible due to the scale of the activities are limited and these negative impacts will be localized and temporary. Such impacts include generation of noise and dust, deterioration of water quality through sediment laden runoff and will be readily managed to acceptable levels through implementation of standard environmental management practices.

(ii) **During operation stage**: Liquid and solid waste generated by the operation of the laboratories as well as the hospitals as a whole are likely to be the sources of negative impacts on the environment if they are not managed properly. Such pollution sources will include infectious specimens, chemicals for testing, wastewater and emission of the laboratories. These pollution sources are long-term and consecutive, and therefore, mitigation measures should be considered adequately through both structural measures (the technical systems for collection and treatment the wastewater, hazardous waste, infectious waste and emission generate from the laboratory should be equipped synchronously) and management measures (application procedure of separation of wastes at source, procedure of management, collection and treatment of hazardous/infectious wastes, etc.). During the Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices particularly in relation to solid waste and wastewater treatment facilities.

B. Recommendations

118. It is recommended that the Project should ensure that for the selected health facilities the laboratories should be well-managed with trained staff. Based on the field assessment and the project proposals, most of laboratories have standardized biosafety level 3 for the provincial health facilities (hospitals and preventive medicine centres) and standardized biosafety level 2 for the district (health facilities (hospitals and preventive medicine centres). However, most of laboratories in the provinces visited are not equipped with the collection and treatment systems for the waste emissions generated and the wastewater from the laboratories are not treated according to the environmental standards. Therefore, the implementing agencies need to consider the appropriate equipment and structures for further investments to ensure that the operation of the health facilities are sound and will not cause significant impacts to the environment. The mitigation measures will also be managed by the provinces and made part of their operational plans for the health facilities invested.

119. Separately, the project will undergo environmental impact assessment in accordance with the following Lao PDR legislation: Directive No.8056/MONRE dated December 17, 2013 on the adoption and promulgation of the list of investment projects and activities subjected to IEE and EIA; Guidelines no. 8030/MONRE on Process of Assessment of Social and Natural Environmental Impact from Investment Projects and Activities Assessment (December 17, 2013). The Environmental Impact Assessment is required for all newly improved hospital projects. For the repair, renovation and upgrade of the hospitals, depending on the scale of the construction activities, an EIA or Environmental Protection Scheme have to be prepared in the next phase of the project in accordance with Lao PDR regulations.

X. CONCLUSIONS

120. The project activities are expected to have a range of benefits on the natural and social environment, and only minor or negligible negative environmental impacts. The majority of minor negative impacts are expected to occur during the procurement and operation phase. These will be localized, minor and temporary and will be readily managed to acceptable levels through the implementation of the appropriate solid waste, wastewater, and environmental management practices. Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices.

121. This IEE Report includes an Environmental Management Plan (EMP) defining the types of environmental mitigation and monitoring measures required to offset potential negative environmental impacts. The development of the EMP takes into account the likely level of technical, financial and human resources available for each of the subproject components. The EMPs will be updated as project implementation progresses beginning with the detailed design. Site-specific conditions may change the nature of the assumptions on the EMPs as the details of the upgrades and improvement projects of the hospitals and health centers become more precise and sensitive to the prevailing environmental conditions of the different project locations.

122. Based on the findings of the Environmental Assessment, it is concluded that the project will not have a significant effect on the environment. The investments in the health security project, overall, will bring forth more positive than negative environmental impacts and greater health security particularly in the border provinces. In view of this, an EIA is not required to be prepared for this project. Individual project activities will be assessed following the Environmental Assessment Review Procedure as prescribed by ADB for the other sub-project component activities while site-specific environmental mitigation and monitoring measures will be developed and implemented accordingly as set out in the EMPs.

XI. REFERENCES

ADB. 2009. Safeguard Policy Statement
ADB. 2002. Environmental Policy and Operations Manual 20
ADB. 2003. Environmental Assessment Guidelines, Manila
ADB. 1997. Environmental Impact Assessment in Developing Countries

Appendix 1: Environmental Screening of Project Sub-Components

POTENTIAL IMPACT	PRE - PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Impacts on the Natural Environment				
Dust generation and air emissions	O	X	O	**Minor Repair and Improvement Works** During minor repair and improvement work, localized, temporary negative impacts may result from dust generation from removal and installation of existing equipment, frames, cabinets, and supports to clear the way for new laboratory improvements and equipment. Mitigation measures will include use of wet rags and vacuum cleaners for dust suppression, containment and minimization of work areas, and utilizing temporary protective curtains on existing facilities and equipment. No impacts are expected during the operation stage.
	O	X	++	**Laboratory Equipment Commissioning including IPC Services** Negative Impact as above for dust emissions. As a mitigating and control measure, emissions from the labs will be collected and treated to ensure the compliance with relevant the environmental standards of Lao PDR as current regulations on air (poison gases and odor) IPC "standard precautions" to be implemented to enhance positive impact during operations. Standard precautions include: use of PPE and environmental cleaning.
	O	O	X	**Solid Waste Management Facilities** Negative impact as above for dust emissions. For IPC, autoclaves will be designed and controlled to ensure compliance with relevant Vietnam air quality emissions standards namely criteria contained in MONRE/DONRE regulations on: air (odor and particulates) and water quality – for steam condensate of medical liquid waste from autoclaves permitted level. Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Lao PDR on air quality, particulates and odor.
	O	O	O	**Wastewater Treatment Facilities** No impact
Odor generation	O	O	O	**Minor Repair and Improvement Works** No impact
	O	O	X	**Laboratory Equipment Commissioning including IPC Services** During operation improper use or maintenance of lab facilities and equipment may result in minor, localized impacts from odor generation. Mitigation measures will include development and implementation of guidance and action for operation of the labs and training of personnel in proper operation of the labs.
	O	O	X	**Solid Waste Management Facilities** During operation improper use or maintenance of waste storage areas may result in minor, localized impacts from odor generation. Mitigation measures will include development of operational procedures for temporary and permanent waste storage areas, regular removal of waste from temporary storage areas and training of personnel in proper waste management practices.

POTENTIAL IMPACT	PRE - PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** During operation improper use or maintenance of wastewater treatment facilities may result in minor, localized impacts from odor generation. Mitigation measures will include development of appropriate operational procedures and training for personnel.
Noise generation	O	X	O	**Minor Repair and Improvements Works** During minor repair and improvement work, minor, localized, temporary impacts may result from noise generation from use of tools and installation equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of tools and equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected rooms of the duration and extent of installation works. No impacts are expected during the operation phase of the works.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** Minor negative impacts and mitigating measures as above.
	O	O	X	**Solid Waste Management Facilities** During collection, transport and disposal operations, minor, localized, temporary impacts may result from noise generation from use of containers, vehicles and equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected areas of the duration medical waste management activities.
	O	O	X	**Wastewater Treatment Facilities** Minor negative impacts and mitigating measures during operations as above
	O	X	O	**Minor Repair and Improvement Works** Minor negative impacts on surface water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from the drainage ways.
Surface water quality deterioration	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, surface water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.
	O	O	X	**Solid Waste Management Facilities** During operation stage, surface water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect waterways. Discharge from solid waste facilities will comply with criteria contained in the applicable Lao PDR and DONRE regulations.

POTENTIAL IMPACT	PRE - PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
Ground water quality deterioration	O	X	O	**Minor Repair and Improvement Works** Minor negative impacts on ground water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation that will seep through ground water sources or wells. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from ground water sources.
	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, ground water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include protecting groundwater sources permanently and the development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to the environment.
	O	O	X	**Solid Waste Management Facilities** During operation stage, ground water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect ground water sources. Discharge from solid waste facilities will comply with criteria contained in the applicable Lao PDR and DONRE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect ground water quality. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
Soil Contamination	O	X	O	**Minor Repair and Improvement Works** During operation, minor impacts of cleaning activities resulting in contamination of soils with cleaning chemicals and agents from repair and improvement activities. Mitigation measures will include ensuring that a barrier between the working surfaces and the soil are used to avoid contamination during the works.
	O	O	O	**Laboratory Equipment Commissioning including IPC Services** No impacts.
	O	O	X	**Solid Waste Management Facilities** During operation stage, soil could be adversely affected by improper disposal of solid waste particularly for hospitals that bury medical wastes into their own grounds. Mitigation measures will include ensuring sealing and containment of burial pits or dumping grounds prior to external municipal disposal Discharge from solid waste facilities will comply with criteria contained in the applicable Lao PDR and DONRE regulations.

POTENTIAL IMPACT	PRE - PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect surrounding soils. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
Impacts on the socio-economic environment				
Amenity of surrounding land use	O	X	O	**Minor repair and improvement works** During procurement very minor, localized and temporary impacts to amenity of surrounding land use may occur in the form of dust and noise generation. Such impacts will be readily mitigated through the range of measures previously described on dust, odor and noise.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** Same as above during procurement**,** the laboratories may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Solid Waste Management Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Wastewater Treatment Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.
Impacts on Public Health and Safety				
Risks to public health and safety	O	X	O	**Minor Repair and Improvement Works** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks in public safety for nearby receivers if not properly managed. Mitigating measures include adopting and ensuring that the suppliers comply with safety guidelines established by the provincial and district hospitals.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.
	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Lao PDR regulations on SWM are complied with.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Lao PDR regulations on wastewater discharge are complied with.

Impact				Description
Risks to health and safety of workers	O	X	O	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals. Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.
	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to the hospital workers. Mitigating measures include ensuring that the applicable Lao PDR regulations on SWM are complied with.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff. Mitigating measures include ensuring that the applicable Lao PDR regulations on wastewater discharge are complied with.
Increase in illness due to environmental pollution such as: dust, air, water supply contaminants, solid and hazardous wastes, untreated sewage surface water runoff, and wastewater	O	X	O	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.
	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Viet Nam regulations on SWM are complied with. Also sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions. Implement solid and hazardous waste management plans. Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff and the public. Mitigating measures include ensuring that the applicable Lao PDR regulations on wastewater discharge are complied with.
Accidents and injury	O	X	O	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for accidents and injury Mitigating measures include adopting and ensuring that the hospital's safety guidelines are established and practiced by the provincial and district hospitals. Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.

	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks of accident and injury. Mitigating measures include ensuring that the applicable Lao PDR regulations on SWM particularly on best practices and safety are complied with.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks the risks of accident and injury. Mitigating measures include ensuring that the applicable Lao PDR regulations on wastewater discharge are complied with and safety practices are always observed

Appendix 2: RAPID ENVIRONMENTAL ASSESSMENT FORM (MODIFIED)

Instructions:

- This checklist focuses on environmental issues and concerns. To ensure that social dimensions are adequately considered, refer also to ADB checklists and handbooks on (i) involuntary resettlement, (ii) indigenous peoples planning, (iii) poverty reduction, (iv) participation, and (v) gender and development.
- Answer the questions assuming the "without mitigation" case. The purpose is to identify potential impacts. Use the "remarks" section to discuss any anticipated mitigation measures.

Project Title: Greater Mekong Subregion Health Security Project
Location: Lao PDR
Proposed Environmental Category: B

SCREENING QUESTIONS	Yes	No	REMARKS
A. PROJECT SITING **IS THE PROJECT AREA:**			
DENSELY POPULATED?		X	
HEAVY WITH DEVELOPMENT ACTIVITIES?		X	
ADJACENT TO OR WITHIN ANY ENVIRONMENTALLY SENSITIVE AREAS?		X	
CULTURAL HERITAGE SITE		X	
PROTECTED AREA		X	
WETLAND		X	
MANGROVE		X	
ESTUARINE		X	
BUFFER ZONE OF PROTECTED AREA		X	
SPECIAL AREA FOR PROTECTING BIODIVERSITY		X	
BAY		X	
B. POTENTIAL ENVIRONMENTAL IMPACTS **WILL THE PROJECT CAUS**E			
impacts on the sustainability of associated sanitation and solid waste disposal systems and their interactions with other urban services?	X		
deterioration of surrounding environmental conditions due to rapid urban population growth, commercial and industrial activity, and increased waste generation to the point that both manmade and natural systems are overloaded and the capacities to manage these systems are overwhelmed?		X	

SCREENING QUESTIONS	Yes	No	REMARKS
degradation of land and ecosystems (e.g. loss of wetlands and wild lands, coastal zones, watersheds and forests)?		X	
increase in soil erosion and siltation?		x	
increase in peak and flood flows?		x	
loss of downstream beneficial uses (water supply or fisheries)?	x		Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to stream sources of water. Target district hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with GOL/WREA emission standards
unnecessary loss of ecological value and decreased biodiversity by replacement of natural forest with plantation with limited number of species?		x	
dislocation or involuntary resettlement of people?		X	
displacement of people or reduce their access to forest resources?		X	
degradation of cultural property, and loss of cultural heritage and tourism revenues?		X	
encroachment into precious ecosystem (e.g. sensitive habitats like protected forest areas or terrestrial wildlife habitats?		x	
occupation of low-lying lands, floodplains and steep hillsides by informal settlers and low-income groups, and their exposure to increased health hazards and risks due to pollutive industry?		X	
water resource problems (e.g. depletion/degradation of available water supply, deterioration for surface and ground water quality, and pollution of receiving waters?	X		Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to boreholes/wells used as groundwater source. Target district hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with GOL/WREA emission standards
air pollution from fuel gas discharged into the atmosphere?		X	
social conflicts between construction workers from other areas and local workers?		X	

SCREENING QUESTIONS	Yes	No	REMARKS
road blocking and temporary flooding due to land excavation during rainy season?	☐	X	
noise and dust from construction activities?	X	☐	Potential impacts from minor repair and improvement works in laboratories
traffic disturbances due to construction material transport and wastes?	☐	X	Only minor repair and improvement works for laboratories are anticipated
increased road traffic due to interference of construction activities?	☐	x	
hazardous driving conditions where construction interferes with pre-existing roads?	☐	x	
short-term soil erosion and silt runoff due to construction?	☐	X	
hazards to public health due to ambient, household and occupational pollution, thermal inversion, and smog formation?	☐	X	
short-term construction impacts (e.g. soil erosion and silt runoff, deterioration of water and air quality, noise, dust and vibration from construction equipment?	X	☐	Potential minor impacts from repair and improvement works of laboratories within existing hospital building facilities
overdrawing of ground water, leading to land subsidence, lowered ground water table, and salinization?	☐	X	
contamination of surface and ground waters due to improper waste disposal?	X	☐	Potential impact for hospitals with deficient and substandard medical solid waste management systems especially if the hospital grounds are used as temporary waste transfer stations. Target district hospitals should mitigate by ensuring that an operational medical waste management system is in place including treatment facilities that comply with GOL/WREA emission standards.
contamination of soil and groundwater from solid wastes from water treatment sludges, cafeteria or lunchroom wastes, ashes and incineration residues, etc.?	x	☐	Same as above

SCREENING QUESTIONS	Yes	No	REMARKS
contamination of air quality from incineration (if incinerator is present at the facility)?	x	☐	Potential impact for hospitals with deficient and substandard incinerators that produce emissions that are not compliant with air emission standards. Target district hospitals should mitigate by ensuring that an operational medical waste disposal system is in place that complies with GOV/MONRE air emission standards.
health and safety hazards to workers from toxic gases and hazardous materials present in the facility?	x	☐	Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management
water pollution from discharge of liquid effluents?	x	☐	Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management
pollution of receiving waters resulting in amenity losses, fisheries and marine resource depletion, and health problems?	☐	**x**	
public health and safety hazards due to solid waste disposal in sanitary landfills?	x	☐	Potential impact by hospitals operating without medical solid waste treatment facilities. Mitigate by ensuring that a compliant disposal system is in place or is worked out with the municipality and no open dumping is allowed at the hospital grounds.
poor sanitation and solid waste disposal in construction camps and work sites, and possible transmission of communicable diseases from workers to local populations?	☐	x	Work is within existing premises
increased noise and air pollution resulting from traffic volume?	☐	x	
creation of temporary breeding habitats for mosquito vectors of disease?	x	☐	Potential impact from hospitals that have deficient and substandard drainage facilities. Mitigating measure is to upgrade, maintain and ensure that no ponding from drainage systems occurs.

Initial Environmental Examination

May 2016

Myanmar: Greater Mekong Subregion Health Security Project

Prepared by Conseil Santé for the Ministry of Health and the Asian Development Bank.

CURRENCY EQUIVALENTS
(as of March 2016)

Currency Unit	–	Myanmar Kyat (MMK)
$1.00	=	1,190 MMK

WEIGHTS AND MEASURES

Ha	–	Hectare
Kg	–	Kilogram
Km	–	Kilometer
L / l	–	Liter
m	–	Meter
mg	–	Milligram
µg	–	Microgram

NOTE

In this report, "$" refers to US dollars.

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ABBREVIATIONS

ADB	–	Asian Development Bank
AIDS	–	Acquired Immune Deficiency Syndrome
APSED	–	Asia Pacific Strategy for Emerging Diseases
BOD	–	Biological oxygen demand
CDC	–	Communicable Diseases Control
CEP	–	Commitment on Environmental Protection
CLMV	–	Cambodia, Lao PDR, Myanmar and Viet Nam
COD	–	Chemical oxygen demand
DHC	–	District Health Committee
DHD	–	District Health Department
DHIS	–	District Health Information system
DMS	–	Department of Medical Services
DOH	–	Department of Health
DPH	–	Department of Public Health
DPHIS	–	Department of Planning and Health Information Systems
EA	–	Environmental assessment / Executing Agency
EARF	–	Environmental Assessment and Review Framework
EARP	–	Environmental Assessment and Review Procedures
ECD	–	Environmental Conservation Department
EHF	–	Ebola Hemorrhagic Fever
EIA	–	Environmental Impact Assessment
EIAR	–	Environmental Impact Assessment Report
EID	–	Emerging Infectious Diseases
EMP	–	Environmental Management Plan
EU	–	European Union
GMS	–	Greater Mekong Subregion
GOM	–	Government of the Republic of the Union of Myanmar
HAI	–	Hospital acquired Infection
HCWM	–	Health Care Waste Management
HMIS	–	Health Management Information System
HIV	–	Human Immunodeficiency Virus
IA	–	Implementing Agency
IEC	–	Information, Education and Communication
IEE	–	Initial Environmental Examination
IHR	–	International Health Regulations
INGO	–	International non-government organization
IOM	–	International Organization for Migration
IP	–	Indigenous peoples
IPC	–	Infection Prevention and Control
ISWM	–	Integrated Solid Waste Management
JICA	–	Japan International Cooperation Agency
MERS	–	Middle East Respiratory Syndrome
MEVs	–	Migrants and mobile populations, ethnic minorities, and other vulnerable groups
MMP	–	Mobile and migrant population
MEF	–	Ministry of Economics and Finance
MOH	–	Ministry of Health
MOECAF	–	Ministry of Environmental Conservation and Forestry
NGO	–	Non-government organization

NHL	–	National Health Laboratory
PAH	–	Project affected household
PAM	–	Project Administration Manual
PCU	–	Project Coordination Unit
PM	–	Particulate matter
PMU	–	Project Management Unit
PPE	–	Personal Protective Equipment
PPTA	–	Project Preparatory Technical Assistance
Project	–	The Greater Mekong Subregion Health Security Project
REA	–	Rapid Environmental Assessment
RHD	–	Regional Health Department
RCU	–	Regional Coordination Unit
SHD	–	State Health Department
SWM	–	Solid Waste Management
TB	–	Tuberculosis
WB	–	World Bank
WHO	–	World Health Organization
WHS	–	World Heritage Site
WWTP	–	Wastewater treatment plant

I. INTRODUCTION

A. Background of the Project

1. The Greater Mekong Subregion (GMS) comprises Cambodia, China (Yunnan and Guangxi), Laos, Myanmar, Thailand, and Viet Nam, with a population of about 326 million people. The region has gone through rapid economic development, with overall GDP growth of 5-10% per year during the past decade. The major demographic, economic and technological differences among the GMS countries, combined with improved connectivity and trade facilitation, bring about substantial business dynamics. Regional investments have increased rapidly, stimulated by regional security, low cost labor, and improved connectivity. Better roads, ports and trade agreements facilitate participation in the global market. Regional tourism has also increased dramatically. GMS Countries are industrializing rapidly, resulting in a rapid increase in migrant workers, mostly internally, but also externally. Urbanization is increasing rapidly, and creating new challenges that require major investments. This has also increased the risk of the spread of communicable diseases associated with increased connectivity, employment, and social and physical living environment.

2. Under the GMS economic development program, the Governments of Cambodia, Lao People's Democratic Republic (Lao PDR), Viet Nam and Myanmar, and the Asian Development Bank (ADB) aim to achieve core capacities for the control of emerging infectious diseases (EIDs) and other major public health threats based on international standards of the World Health Organization (WHO). A GMS Health Security Project (the Project) of $132 million has been proposed for 2016 including a contribution of $125 from ADB's Special Funds resources, and government counterpart funds of $7.0 million. The Project follows other health projects for communicable diseases control (CDC), HIV, Malaria, and related regional technical assistance.[1]

B. Purpose and Structure of the Report

3. The project is categorized as a Category B project in accordance with ADB's *Environment Policy*. The Initial Environmental Examination (IEE) presented in this report is to comply with the requirements of ADB in relation to environmental assessment of ADB-financed projects. In particular, the IEE has been prepared to fulfill the requirements of the ADB's *Environmental Policy* and *Operations Manual (OM) 20: Environmental Considerations in ADB Operations*. The IEE has been based on the guidance contained in the ADB's *Environmental Assessment Guidelines* (2003).[2]

4. The following methodology has been implemented in the preparation of the IEE:

- (i) Review of project-related documents and literature relevant to the project areas initially surveyed
- (ii) Site visits to view the environmental conditions in representative project areas and the general location of the projects
- (iii) Consultation with local and national authorities to source information on project area characteristics and potential project impacts
- (iv) Identification of existing environmental and socio-economic characteristics to

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[1] Including Community Action for HIV Prevention in 2001; GMS Regional Communicable Diseases Control Project in 2004; Second GMS Communicable Diseases Control Project in 2010; GMS Capacity Building for HIV/AIDS Prevention Project in 2012; Japan Fund for Poverty Reduction projects such as for Model Healthy Village; and technical assistance for malaria and dengue control, health education, e-Health, and related areas.

[2] ADB. 2003. *Environmental Assessment Guidelines.* Manila.

develop project baseline data

(v) Analysis of typical environmental impacts of project components and identification of suitable typical mitigation measures to ameliorate potential impacts

(vi) Development of institutional arrangements for implementation of environmental management and monitoring

(vii) Development of a set of environmental criteria for future project activity selection

(viii) Development of environmental assessment and review procedures (EARPs) for future project sub-components.

II. DESCRIPTION OF THE PROJECT

A. Project Rationale

5. The Republic of the Union of Myanmar, aiming to comply with WHO standards to achieve GMS health security, has requested renewed ADB assistance by way of project support to address critical gaps in core capacities. MOH and WHO have conducted evaluation of Asia Pacific Strategy for Emerging Diseases (APSED) implementation in 2014. Myanmar has not yet achieved International Health Regulations (IHR) and APSED targets. Core functions owned by MOH are well in place, but other functions depending more on collaboration with other countries, sectors, partners, community, and the private sector are less advanced. The recent MERS and Ebola outbreaks, and the Zika virus scare have put re-emerging infection diseases (EIDs) back in the limelight. While progress in other regional priorities is mixed, there is major progress in the control of malaria and dengue, and less progress in the control of HIV/AIDS and tuberculosis and the major emerging concerns of HAI or nosocomial infections and multiple drug resistance.

B. Project Design

6. The project goal is to strengthen the GMS health security, with the following indicators: (i) zero major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased treatment of vulnerable groups for communicable diseases. The proposed project outcomes are: (i) improved coverage of GMS public health security system and compliance with IHR/APSED; and (ii) CDC coverage increased in vulnerable groups in CLMV border areas, in particular for migrants, ethnic minorities, and other vulnerable groups (MEVs) as prioritized by the Governments. The proposed project outputs are: (i) increased GMS collaboration and MEV access to CDC in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases.

7. The Project is being financed through a project loan between the ADB and the Government of the Republic of the Union of Myanmar. In Myanmar, the proposed project of $12.6 million is to be financed by an ADB Special Funds loan of $12 million and $0.6 million in Government counterpart funds. The Department of Public Health and the Department of Medical Services will represent MOH as the Executing Agency. In summary, the Government will use the loan primarily to finance hardware (laboratory and IPC equipment, supplies and devices) and use government resources to finance software (training and workshops) and project management.

a. Regional Cooperation and CDC for Vulnerable Groups in Border Areas

8. Regional cooperation is mainly in the form of information exchange and joint outbreak responses. While national level information exchange is affected by lack of leadership, cross-

border cooperation is gaining momentum.

9. Sub-groups of MEVs in border areas have unique risk of exposure to particular diseases. The risks may vary by occupation and location. However, there are particular concerns for cross-border migrant workers returning home with HIV or TB, who may not have access to care on their return. HIV-infected youths and pregnant mothers also may have limited access to services and care.

b. Surveillance and Response

10. The project will explore new strategies for reaching MEVs and for timely reporting of patients with certain symptoms from remote communities using syndromic surveillance. Several disease reporting systems are in place which are not linked, do not reach communities, and do not provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, thereby also limiting the efforts to improve disease control and community prevention and preparedness. In addition, through workshops and other knowledge management activities, specific strategies for disease control and system strengthening will be developed. Workshops will be comprised of carefully prepared participatory learning and strategic planning events with monitoring of follow up actions by the regional coordination unit. Through bilateral agreements with the neighboring border countries, the Project will explore strategies to reach various MEVs who are more likely to be exposed to different types of diseases.

c. Laboratory services and Hospital Infection Prevention and Control

11. In Myanmar as in the other GMS countries, much of the efforts in improving laboratory services have gone into strategic planning, provision of equipment and setting up laboratory services in the larger regional hubs often using mentoring, quality control at central level, and, more recently, also multiple initiatives to improve biosafety. However, as laboratory services are complex requiring some 20 subsystems to be in place, the support for the subsystems have received much less attention such as support for: undergraduate education; laboratory management, facilities, registration and inspection/audit; medical-laboratory linkages; and transport and maintenance systems. It is necessary to address these gaps that will ensure better use of past investments in staff and equipment.

12. Township Hospitals, rural health centers and health sub-centers are the most likely points of contact for newly emerging diseases, and also pose a major concern in terms of spreading these diseases. In addition, the general hospitals and bigger health facilities are also a source of HAI or nosocomial infections and drug resistance. Current equipment and practices in these health facilities for infection prevention and control, and waste disposal are sub-standard and unsafe, and would not meet IHR or APSED obligations. Myanmar needs to launch a new IPC plan and, based on the WHO guidelines, roll out a comprehensive IPC program that requires strong MOH commitment and more investments in IPC scholarships, infection control management, and hospital equipment and hygiene supplies.

C. Project Location

13. As planned, the scope of the GMS Health Security Project in Myanmar will cover the border towns accessible from the respective capitals of 5 border States and 1 Region (Division)

along its borders with PR China in the north, Lao PDR and Thailand in the center, and Thailand in the south. In view of the focus on regional concerns, the country's current economic direction and health sector setting, and this project being the first major re-engagement of ADB in the public health sector, it has been proposed to target the major hubs along economic corridors with Thailand. For purposes of this IEE, the general hospitals surveyed, area observations and interviews with key informants will be indicative and representative of the scope of environmental impact assessment and review that shall be performed for the other remaining states/division in accordance with ADB guidelines as the project progresses (See Figure 2).

Figure 2: GMS Health Security Project – Myanmar Border States and Division

1	Shan North- Capital: Lashio, Border towns: Namkhan/Muse (PR China)
2	Shan East- Capital: Keng Tung, Border town: Tachileik (Lao PDR and Thailand)
3	Kayah State- Capital: Loakaw, Border town: Mese (Thailand)
4	Kayin State- Capital: Hpa-An, Border town: Myawaddy (Thailand)
5	Mon State- Capital: MawlaMyine, Border town: Ye (Thailand)
6	Tanintharyi Division: Capital: Dawei, Border town: Kawthaung (Thailand)

D. Project Outputs of Environmental Concern

14. The requirement for an environmental impact assessment is linked to the following Project Subcomponents: (1) Sub-component 2-5, Component 2, **Output 2** and (2) Sub-component 3-4, Component 3, **Output 3** of the above project summary, namely:

(i) **Sub-Component 2-5:** **improve capacity of outbreak response teams including transport**

(ii) **Sub-Component 3-4**: **provide laboratory equipment and training for infection prevention and control, including laundry services and waste disposal**

15. The above sub-components will require screening of potential environmental impacts and a discussion of mitigating or enhancement measures as a result of the impacts because the activities involve public health risks and potential accidents, minor repair and improvement works, the installation and commissioning of laboratory equipment and related devices, and the operation of the target state/region hospitals' existing medical waste management and waste water treatment facilities – all of which impact the project's environmental setting and require environmental safeguards.

16. The screening addresses the potential impacts of the relevant project activities under the loan program, which are re-defined for purposes of the IEE, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; (iii) operation of the existing solid waste management facilities; and (iv) operation of the existing wastewater treatment facilities described as follows:

(i) **Project Activity 1 – Minor repair and improvement works.** This activity includes the minor repair and improvement works of the hospital facilities specifically affected by the provision of access, accommodation, modification and

installation of new or upgraded laboratory equipment and auxiliary devices, IPC equipment and devices including laundry equipment, computer systems, etc.

(ii) **Project Activity 2 – Laboratory equipment commissioning including IPC services.** This activity includes the mobilization, equipment installation, commissioning, demobilization, recurrent maintenance checks by the suppliers/contractors, and the operation from installation and during the life of the equipment. The equipment means the totality of the laboratory equipment, auxiliary equipment, laundry and washing/drying equipment, and relevant IPC devices and supplies, laundry equipment including the transport vehicles for the transport of laboratory specimen procured under the Project.

(iii) **Project Activity 3 – Solid Waste Management facilities.** The collective activity assumes existing activities that include: (1) the storage and segregation (as applicable) of medical infectious/hazardous and non-infectious/non-hazardous wastes; (2) collection and transfer for disposal or recycling (as applicable); (3) internal and external transportation of medical waste; recycling or composting of non-hazardous wastes; and (4) disposal at: (i) an approved and dedicated disposal facility such as a provincial hospital; (ii) permanent burial in specially designed, secure landfills which will incorporate lining and leachate management systems; (iii) sterilization using either chemicals or steam; and (iv) incineration using an approved incinerator designed to mitigate hazardous emissions. The operational activities will vary according to the type of facility but will include receipt of waste, burial of waste, burning of waste, general site maintenance, and odor and vermin control.

(iv) **Project Activity 4 – Wastewater treatment facilities.** The collective activity assumes the existing operations of wastewater treatment facilities that are installed at the target hospital facilities to treat effluent to meet relevant environmental standards prior to discharge to waterways or municipal wastewater systems. The scale of operation activities will vary according to the type of facility but includes wastewater treatment process control, site maintenance, and odor control.

17. Since the project does not involve civil works construction, the stages of the project cycle during which screening is to be conducted and into which the temporal boundaries of the activities have been divided are: the **pre-procurement stage**, the **procurement (including the commissioning) stage**, and the **operation stage** from the viewpoint of the hospital facilities.

18. The Project will finance the procurement of laboratory equipment and supplies, transport vehicles, laundry and other infection prevention and control equipment, computer systems and devices for the newly-improved hospitals and other institutions identified by state authorities serving as the target populations. A total of 6 target states/region will comprise the beneficiaries of the project. Equipment purchases will be in accordance with established MOH standards and will replace old and non-functioning equipment, upgrade technology for existing procedures, or provide new services. The Project will also support the purchase of an initial inventory of reagents and other supplies needed to properly utilize the new equipment. Procurement and supply of equipment will be closely coordinated with the other components of the project implementation.

19. Once completed, the newly improved and renovated laboratory facilities and supplies, IPC equipment and related devices, computers and related systems, and transport vehicles that are part of the Project need to be properly maintained to realize benefits and justify investments. The Project will ensure that hospital personnel are properly trained to use the equipment and

operating manuals are supplied in the Myanmar language. The GOM shall support the preparation of guidelines for preventive maintenance and training of hospital personnel in preventive maintenance procedures.

20. The GOM has also assured that the supplies needed to operate the equipment, as well as the costs of maintenance will be provided during and beyond the project period through recurrent costs and adequate increases in operation and maintenance budgets.

21. Moreover, while this project does not include civil works and medical waste management and waste water treatment equipment, the investments will be made with the assurance from the GOM that all facilities included in this Project have adequate safe water, sanitation, and medical waste management systems, including waste water systems, proper containers to segregate contaminated and hazardous waste, proper collection and storage facilities, and access to modern medical waste incineration and/or non-burn treatment and disposal facilities in compliance with the country's environmental laws and the safeguards policy of the ADB. It is incumbent upon the GOM that hospital personnel in all facilities covered by the project will be trained in the theory, methodologies, and supervision of modern medical waste and waste water management practices. In addition, the Project will support consulting assistance to work with authorities in each target province to develop a province-wide plan for the management of medical waste.

E. Project Category

22. The project is initially categorized as B for environment based on ADB's *Safeguard Policy Statement* (2009) as the project involves components dealing with laboratory bio-hazards and hospital solid and liquid waste management. An IEE has been prepared based on field surveys of 3 general hospitals (Hpa-an, Mawlamyine and Keng Tung) of the capitals of 3 out of 6 target border states/region (Kayin, Mon and Shan (East) States), and data obtained from interviews with key officials of the Department of Public Health and the Department of Medical Services of the MOH, and WHO in dealing with environmental impact assessment, the regulation of hazardous substances, air and water pollution control, and health care waste management. MOH (2014) and WHO data were also obtained and analyzed regarding the status of health care waste management in Myanmar. The findings on the practices in hospital safety and sanitation, medical solid and liquid waste management, infection prevention and control, and risk of accidents and spills during storage, transfer, transport and containment of bio-hazards, and a rapid environmental assessment (REA) confirmed the project to be Category B. Each of the 5 participating States and 1 Region (Division) will prepare EMPs covering all project activities during implementation and in accordance with the environmental laws and health regulations of GOM.

III. DESCRIPTION OF THE ENVIRONMENT

A. Physical Resources

1. Topography

23. Myanmar may be divided roughly into five major topographic and climatic zones: the mountainous region, the Shan Plateau, the central dry zone, the delta region, and the coastal region. It is a land of hills and valleys and is rimmed in the north, east and west by mountain ranges forming a giant horseshoe. Enclosed within the mountain barriers are the flat lands of Ayeyarwady, Chindwin and Sittaung River valleys where most of the country's agricultural land

and population are concentrated. This central core of the country, which falls within the rain shadow area, is relatively flat and constitutes the Central Dry Zone.

2. Climate

24. There are three seasons: wet (mid-May to mid-October, cold (November to February), and dry (March to mid-May). There is significant spatial variability in annual rainfall, with levels as high as 5,000 mm in the mountainous coastal and Delta regions, but only about 600mm in the central lowlands (Dry Zone). Temperature also varies across the country, with highs above 43 degrees Celsius (C) in Central Myanmar, around 36°C in Northern Myanmar and only 29°C at the eastern plateau.

3. Water Resources

25. Myanmar has abundant water resources with five major rivers basins. Rainfall amounts vary from one region to another—from highs of 4,000–6,000 mm annually along the coastal reaches and in the mountains of Rakhine and Tanintharyi, to as low as 500–1,000 mm in the dry Central region. Excessive rainfall in other regions of Myanmar, notably in the Delta region, often results in flooding, the loss of standing crops and the displacement of significant portions of the population.

B. Ecological Resources

26. Myanmar is located between three biogeographic regions: in the north – Indochina, Indian sub-continent, and Eurasia; in the south – taninthayi forests which cover the northern section between Indochina and Sundaic ecological Zones. Forests are the dominant ecosystem in Myanmar, with 45 % of the country ecologically classified as forest (FAO 2015). Myanmar's forest area was noted to have declined from 39.7 million hectares in 1989 to 30.5 million hectares in 2010, with an average annual loss of 438,000 hectares of forest per year. This is an annual decline of 1.1%, which accelerated to 1.9% between 2006 and 2010. This is the fastest rate among major countries in South and Southeast Asia. The rate of forest degradation has been even faster, as the closed forest area fell 2.5% during 1989 to 2010. This too has worsened, as the rate grew to 3.1% between 2006 and 2010. Not only are Myanmar's forests being rapidly lost, but this loss has been concentrated in the densest and biologically important forest areas.

C. Economic Development

1. Economic Structure

27. Despite economic sanctions since the late 1980s, Myanmar's economy has maintained relatively steady growth—by an estimated 5.5% in fiscal year 2011 (ended 31 March 2012) and by an average of 4.9% over the previous 3 years. Prior to the devastation wrought by Cyclone Nargis in 2008, the economy had reportedly been growing at more than 10% annually. The economy is predominantly agricultural, with rice being the main crop and staple food. In 2010, the agriculture sector accounted for about 36% of GDP, down from 57% in 2001. In contrast, the share of GDP accounted for by the industry sector more than doubled, to 26%. Liberalization of the economy and opening up to foreign direct investment (FDI) has prompted rapid growth of the industry sector, notably exports of natural gas. Although employment data are unavailable, it appears that the agriculture sector still accounts for about 70% of total

employment.[3]

2. Land Use

28. Myanmar remains well endowed with forests and vegetation cover. About half of the total land area (676,777 square kilometers) is covered with forests. These are public forests and are classified either as Reserved Forests or Unclassed Forests.

D. Social and Cultural Resources

1. Administrative Areas

29. The country is divided administratively into seven states and seven divisions. These are subdivided into 64 districts, which are further divided into 324 townships. The townships are subdivided into 13,759 village tracts, which form the basic administrative unit in Myanmar. See Table below for administrative profile of project States.

Table 3.1: Administrative Units, Population and Land Area of Project States

States	State Structure		Population (2014 Census)	Land Area (Km2)	Population Density (2014 Census)
	Districts	Townships			
Shan	12	40	5,815,384	155,801	38
Kayah	2	7	143,461	11,733	24
Kayin	3	7	1,572,657	30,381	52
Mon	2	10	2,050,282	12,297	167
Tanintharyi	3	10	1,406,434	33,748	32

2. Population and Community Structure

30. Myanmar's population is 51.419 million of which 24.8 million are male and 26.5 million are female. Two-thirds of the population lives in rural areas, and are largely dependent on subsistence farming. Some 25% of the population lives below the poverty line. Poverty is heavily concentrated in rural areas (85%), and disparities are pronounced across states.

31. The Union of Myanmar is made up of 135 national races, of which the main national races are Kachin, Kayah, Kayin, Chin, Bamar, Mon, Rakhine and Shan. The Bamar form the largest national race constituting 70% of the whole population. In the religious sector, 89.2% of the population is Buddhist, while Christianity, Islam, Hinduism, Judaism and Animism are also practiced.

3. Socio-Economic Conditions

32. Myanmar's HDI value for 2014 is 0.536—which is in the low human development category—positioning the country at 148 out of 188 countries and territories. Between 1980 and 2014, Myanmar's HDI value increased from 0.334 to 0.536, an increase of 60.3% or an average annual increase of about 1.40%.

4. Poverty

33. The poverty incidence in Myanmar is at 25% based on the results of the IHLCA-II survey

[3] Asian Development Bank (2013). Myanmar: Agriculture, Natural Resources, and Environment Initial Sector Assessment, Strategy, and Road Map, ADB, Manila.

of 2009-2010. Poverty incidence is twice as high in rural than urban areas at 29% and 15% respectively. Most of the poor live in rural areas (85%). The highest incidence of poverty is in the Chin region at 73%. The four major contributing states/regions to national poverty incidence are Ayeyarwady (19%), Mandalay (15%), Rakhine (12%) and Shan State (11%).[4]

Table 3.2: Incidence of Poverty in Project States, 2010

State	Poverty Incidence	National Poverty Share
Kayah	11.4	1
Kayin	17.4	1.9
Mon	16.3	16.3
Shan North	37.4	5.1
Shan East	46.4	1.9
Tanintharyi	32.6	3.5
Union	25.6	100

Source: IHLCA Survey 2009-2010.

5. Public Health

a. Disease Type and Incidence

34. Life expectancy at birth increased for both males and females between 1980 and 2011. The top five causes of disability adjusted life years (DALYs) in 2010 were lower respiratory tract infections, tuberculosis, diarrhoeal diseases, Human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) and stroke. New among the top 10 causes of DALYs in 2010 were HIV/AIDS, ischemic heart disease, road injury and cirrhosis of the liver – these require effective prevention policy. The top five risk factors are diet, tobacco smoking, household air pollution from solid fuels, high blood pressure, and high blood sugar.[5]

35. Non-communicable diseases (NCDs) contribute to approximately 40% of deaths in Myanmar. NCDs and injuries generally rose between 1990 and 2010, while communicable, maternal, neonatal and nutritional causes of DALYs generally declined. Improvements in access to safe water and adequate sanitation have been reported. However, diarrhea remains among the top five causes of death. There has been an increase in the child immunization coverage, a decline in infant mortality rate (IMR), under-five mortality rate (U5MR) and maternal mortality ratio (MMR). Nearly seven decades of internal conflict in Myanmar have harmfully affected the lives of hundreds of thousands of civilians. Myanmar is also prone to natural disasters: coastal regions exposed to cyclones and tropical storms, and the whole country at risk from earthquakes. Cyclone Nargis was the largest natural disaster in Myanmar's recent history.

b. Health Care Facilities and Access

36. The Ministry of Health is the main service provider and also handles the regulatory functions in protecting the health of the people. The network of hospitals and health centers, expands down to village level, provide curative services ranging from primary to tertiary health care. Township health departments, managing the township health system, are the backbone of PHC and provide comprehensive health services at the local level. At the regional administrative

[4] IHLCA Project Technical Unit with the Ministry of National Planning & Economic Development (2011). Integrated Household Living Conditions Survey in Myanmar (2009-2010). Retrieved from http://www.mm.undp.org/content/myanmar/en/home/library/poverty/publication_1.html.

[5] World Health Organization (2014). The Republic of the Union of Myanmar Health System Review Health Systems in Transition. Vol. 4 No. 3 2014.

level, Regional and State Health Departments provide supervisory and technical support, while at the same time managing the provision of tertiary care and referral services.

37. The private health sector has also been a major source of service provision since inception of the health system in the country. Services provided are mostly confined to urban settings and were initially limited to primary and ambulatory care. More intensive and institutional care is now available in big cities. Most people are inclined to seek private health care on becoming aware of their illness. But severe cases requiring specialized care mainly rely on the public facilities.

38. There has been an increase in the number of public hospitals since the early 2000s, in total an additional 140 were added. Ayeyawady Region has received the most, followed by Sagaing Region; however, there was no change in the number of hospitals in Chin State. Co-investment by the local community in building rural health centres and sub-rural health centres is widely practiced. The number of private hospitals increased within this decade, but at a lower rate than public hospitals.

39. Hospital equipment is usually provided by the government budget and MOH's share of government expenditure was increased four-fold in 2012. In terms of human resources for health, recruitment of doctors, nurses and midwives have been increasing since the early 2000s, but have not yet reached the global standard of 2.28 doctor, nurse and midwife positions per 1,000 populations. There is also underproduction of dental surgeons, pharmacists and technicians as compared to doctors and nurses.

40. See Table below for Health establishments in the project areas.

Table 3.3: Health Facilities in Project States

By Region and State	Specialist Hospital		General Hospital With Specialist		Other		Station		Total	
	No.	Beds	No.	Beds	No.	Beds	No.	Beds	No.	Beds
Kayah State	-	-	1	200	7	200	9	144	17	544
Kayin State	-	-	1	200	8	400	21	336	30	986
Tanintharyi Region	-	-	2	400	10	391	21	336	33	1127
Mon State	-	-	1	300	11	441	21	336	33	1077
Shan State	1	200	4	800	61	2430	84	1344	151	4774

E. Reference Baseline Data for Health Care Waste Management in Myanmar

41. A key component of the project is the improvement of health care waste management practices in the project areas. In Myanmar, the coordination and supervision of health care wastes at all levels in the country is not clearly developed and needs further strengthening while a National Action Plan should be implemented to manage practices at all levels in an integrated health system.[6] The results of a review of existing health care waste management practices in the 3 general hospitals: Hpa-An, Mawlamyine, and Keng Tung (Kyaing Tong) in 3 border states surveyed under the GMS Health Security Project are summarized below.

[6] World Bank. 2014. *Myanmar - Essential Health Services Access Project: environmental management plan*. Myanmar: s.n.

(i) Healthcare waste generation

42. Healthcare waste (HCW) generated from hospitals includes both non-hazardous waste and hazardous waste. No quantification of non-infectious and infectious waste components of HCW has been available in the project areas surveyed. WHO estimates that about 85% of the HCW from developing countries is non-infectious or generally risk-free healthcare waste, which is comparable to domestic waste. The remaining 15% of healthcare waste is regarded as hazardous and may create a variety of health risks. Hazardous healthcare waste can be classified into the following categories: infectious waste, highly infectious waste, sharps, pathological/anatomical waste, pharmaceutical waste, genotoxic waste, chemical waste, waste with high content of heavy metals, pressurized containers, and radioactive waste.

43. The amount of HCW generated depends on the hospital size and its scope of services. To date there has been no research data recorded of HCW generation rates in Myanmar. According to surveys on HCW management conducted by the MOH in Vietnam and WHO, a provincial general hospital typically generates 0.64 kg/bed/day of general HCW and 0.14 kg/bed/day of hazardous HCW, while a district hospital typically generates 0.62 kg/bed/day of general HCW and 0.11 kg/bed/day of hazardous HCW. In terms of the relative proportion of hazardous waste generated, infectious waste and pathological waste represents about 15%, sharps represent about 1%, chemical and pharmaceutical waste represents about 3%, other waste such as waste with high content of heavy metals, and pressurized containers share represent less than 1%.

(ii) Healthcare waste minimization

44. Waste minimization is defined as the prevention of waste production and/or its reduction. This is not regularly practiced by healthcare establishments in the region such as in Myanmar. Minimization measures such as source reduction (modification of purchasing procedures, control of inventory, and production of less toxic materials), good management and control practices applied particularly to the purchase and use of chemicals and pharmaceuticals, and using of recyclable materials are not typically implemented.

45. Healthcare waste contains quantities of valuable and recyclable materials such as plastic, metals, paper and carton. However, waste recycling is not centrally implemented at hospital level despite the fact that it is carried out unofficially by the different offices.

(iii) Healthcare waste segregation

46. Myanmar has not formally implemented segregation of wastes into color-coded bags or containers. Within the hospitals that received support, basic segregation has been introduced but without standard operating procedures or regular training provided. Other countries like Viet Nam, for example have institutionalized the segregation of three separate containers into different colors: general waste in green bags, clinical waste in yellow bags, and toxic wastes in black bags. In other developing countries, sharps are segregated and placed into rigid containers with certain specifications to avoid accidental punctures or spillage during handling. In Myanmar, the general hospitals that were visited have been owning to being generally responsible for the sharps wastes from collection to disposal. However, their treatment and ultimate disposal has not progressed into something environmentally acceptable. The general hospitals that were surveyed collect the hazardous wastes including the sharps wastes, then either incinerate them using low-temperature open incinerators or bury them at unsecured waste pits within their property boundaries. The successful practice of waste segregation and disposal

is one of the biggest challenges in HCW management in most developing countries such as Myanmar. There are limitations reported, as follows:

- (i) Knowledge, attitude and practices among waste generators including hospital staff, patients and visitors are unsatisfactory
- (ii) Supply of equipment for waste segregation, especially sharp containers is insufficient in both the district hospitals and health centers as a consequence of inadequate funding
- (iii) No system has been generally introduced as a policy by the relevant authorities for enforcement

(iv) Healthcare waste collection

47. Of the general hospitals surveyed, the staff assigned to be responsible for collecting healthcare waste from the generation point to interim storage points in the departments have been generally on an ad-hoc basis. No institutionalized committees have been formed to take on the function. Some weaknesses in collection have been observed as follows:

- (i) Provision of equipment, waste containers in different sizes are not sufficient
- (ii) There is no budget appropriation for staff nor equipment and materials to meet these recurring needs
- (iii) Design of hazardous waste containers do not meet requirements
- (iv) Codification and labeling, waste bags and containers, especially those for clinical waste and chemical waste are not properly color-coded and labeled

(v) Healthcare waste transportation

48. Some primary health care workers are made responsible for internal collection from the hospitals. All of the hospitals visited lack specialized devices for waste transportation. Hazardous waste is often transported by hand causing spillage and spread of disease throughout the hospital. Internal transportation plans in which the timetable and route of transportation are clearly identified are not available.

49. No private contractors or responsible government agency transports general waste out of the hospitals to a disposal facility. The hospitals themselves manage their HCW internally, except for donor-provided sharps safety boxes and certain anatomical wastes that the districts send to the provincial hospitals for disposal.

(vi) Healthcare waste storage

50. All of the visited hospitals do not have a formally designated place to store healthcare waste except for different cans and bags of different sizes and materials. Most of the storage containers in hospitals, do not meet design and operating regulations because of the following shortcomings:

- (i) The storage areas do not incorporate separate places for different categories of healthcare waste. As a result, general waste and clinical waste that were segregated at sources and separately collected and transported are mixed again at storage places. Chemical waste is not collected and centrally stored. Liquid wastes are disposed of in the sinks although some of the hospitals have separate septic vaults for liquid wastes for wastes are disposed

(ii) The storages do not have roofs and locks. Unauthorized people, animals, rodents and insects can easily access hazardous waste causing risks of spillage and disease spread.

(iii) Storage duration often exceeds 24 hours in hot weather.

(vii) Healthcare waste treatment

51. No models for health care waste treatment were observed in the hospitals visited.

52. Healthcare waste treatment technologies applied in the region typically are (i) medium temperature incineration, (ii) low temperature incineration, (iii) waste burial, (iv) steam autoclave, (v) chemical disinfection;

(i) Medium temperature incineration: Pyrolytic incinerators that incinerate waste at 800 – 900°C are reported to be used at the provincial hospitals but these have not been confirmed by actual visits. The emissions from incinerators have not been monitored since they were installed, but polluting gas emissions and high operating costs are reported.

(ii) Low temperature incineration: Drum incinerators, brick incinerator or one-chamber, open incinerators are still common in district hospitals even though their design is out of date. Because of low effectiveness and high environmental impacts, such incinerators are no longer recommended. The gas emissions from these incinerators have reportedly been very pollutive.

(iii) Waste burial: District hospitals bury healthcare waste on their premises. Safe burial of healthcare waste is recommended by WHO. However, in comparison with requirements of sanitary landfill, the bury pits observed in hospitals often have the following shortcomings: (i) inadequate sealing of base and sides to minimize the movement of wastewater or leachate off site, (ii) no presence of site personnel capable of effective control of daily operations, (iii) no surface water collection, (iv) access to site and working areas difficult for waste delivery and site vehicles, (v) lack of surface water collection trenches around site boundaries, (vi) lack of a final cover to minimize rainwater infiltration when each phase of the landfill is completed

(iv) Wet thermal disinfection: Stream autoclaves are commonly used by hospitals to primarily treat highly infectious waste. Although wet thermal disinfection has been introduced in Myanmar at present, application of autoclave for healthcare waste treatment is still limited to microbiological laboratories where highly infectious waste is mostly generated.

(v) Chemical disinfection: Using disinfectants to treat contaminated materials is very common in provincial and district hospitals. However, application of chemical disinfection for healthcare waste treatment, particularly for highly infectious waste treatment is still limited to microbiological laboratories and in areas of infectious disease outbreaks.

(viii) Wastewater collection and treatment

53. Hospital wastewater includes rainwater, wastewater generated from healthcare activities and wastewater from toilets. The hospitals visited have open collection systems for storm water, a collection system and septic tanks for wastewater from toilets but only a few of those visited have separate collection lines and separate septic tanks for wastewater generated from healthcare activities. In consequence, wastewater from healthcare activities with a high content

of pathogens and certain amount of pharmaceuticals and chemicals is discharged into the storm water system line or discharged onto the land without any treatment. Beside these weaknesses in design, there are weaknesses in operation and maintenance in terms of wastewater collection and treatment as follows:

(i) Hospital staff often discharge chemical and pharmaceutical waste into wastewater collection systems. This practice can harm the wastewater treatment plant, if any.
(ii) In the hospitals areas visited, staff and patients do not know how to properly maintain toilet and sanitary facilities in the hospitals. This often results in blockages of the wastewater collection system. Regular and corrective maintenance of wastewater collection system is rarely carried out.

IV. SCREENING OF POTENTIAL ENVIRONMENTAL IMPACTS AND MITIGATION MEASURES

A. Rapid Environmental Assessment

54. In order to identify potential environmental impacts of the project components, the initial environmental screening was first carried out using the ADB rapid environmental assessment forms (REAs) to screen the proposed activities required for the installation of new or improved laboratory facilities/equipment such as minor repair and improvement works on the general hospitals at the border states as the case may be. (Please see Appendix 2 for the form used). While the hospitals are all existing facilities and whatever improvements are introduced bring mostly positive impacts for the environment, the REAs categorized most of the project activities as Category B because the project involves the management of infectious, hazardous, medical solid waste and wastewater and the risks inherent in the handling of laboratory wastes, and the diagnostic activities in managing highly infectious diseases at the border towns of the target border state and regional hospitals.

55. The ADB safeguard policies require that the project's activities need to be carefully considered to avoid and/or to minimize the negative impacts on the natural environment and social environment (including environmental public health and occupational health), and provide the appropriate measures to mitigate such impacts. In accordance with the ADB guidelines, the potential impacts of medical solid and liquid wastes including laboratory wastes, being hazardous along with deficient sanitation and laundry facilities and the lack of effective wastewater equipment and treatment systems categorizes the health facilities as having significant potential negative environmental impacts that need to be mitigated.

B. Environmental Assessment Methodology

56. Surveys were conducted by the Consultant and the MOH team in 3 general hospitals: Hpa-An, Mawlamyine and Keng Tung (Kyaing Tong) General Hospitals, and held discussions with the officials of the laboratories, infection control sections and the hospital directors. The general hospitals visited were representative of the other targeted hospitals in the border states. The main objectives of the survey were to:

(i) Assess the current practices and environmental conditions focused on the medical waste (solid and liquid) management of the health care facilities;
(ii) Organize meetings with the state agencies of MOH, the State Health Departments, and hospital heads to consult them about their needs and plans

about the environmental management of the sub-components of the health security project to institute environmental safeguards from the impacts of laboratory waste, infectious disease bio-hazards, hospital safety and hygiene for infection prevention and control, and medical solid and liquid waste management; and

(iii) Collect environmental baseline data of the representative states included in the target border areas.

57. During the time allotted, the site surveys were carried out by a combination of methods i.e. observation, photo-documentation, data/document review and analysis, and interview or focus group discussions with key informant officials. The survey team earlier developed sets of Rapid Environmental Assessment (REA) checklists for health care facilities. The data and information on environmental issues (focused on medical solid and liquid waste management and hospital safety and hygiene for infection prevention and control) of the selected provinces under the project areas were collected from the general hospitals, MOH, MOECAF and relevant provincial agencies.

58. The Consultant and the hospital and laboratory officials and staff held discussions relevant to the environmental situation in their respective areas focusing on the medical solid and liquid wastes, and laboratory waste management. Similar meetings and consultations at the hospital visited were also held with participation of the hospitals staff to discuss the environmental situation of the hospitals respectively and their views about the project, on the medical waste management and hospital safety and hygiene for infection prevention and control, and on medical solid waste management and wastewater treatment facilities.

C. Potential Environmental Impacts and Mitigating Measures

59. For the purposes of the assessment, the following categories of impacts have been developed:

(i) **NO IMPACT:** The potential impact of the project is assessed as NO IMPACT if the project activity is physically removed in space or time from the environmental component, or if the impact is so small as to be un-measurable (i.e. negligible).

(ii) **MAJOR IMPACT – POSITIVE OR NEGATIVE:** An impact is said to be MAJOR if the project has the potential to affect an environmental component. The following criteria were used to determine whether a given impact is MAJOR:

a. spatial scale of the impact (site, local, regional, or national/ international);
b. time horizon of the impact (short, medium, or long term);
c. magnitude of the change in the environmental component brought about by the project activities (small, moderate, large);
d. importance to local human populations;
e. compliance with international, national, provincial, or district environmental protection laws, standards, and regulations;
f. compliance with ADB guidelines, policies, and regulations.

(iii) **MINOR IMPACT – POSITIVE OR NEGATIVE:** If an impact occurs but does not meet the criteria for a Major Impact it is assigned the category MINOR. Minor impacts occur along a spectrum ranging from those impacts that are close to being major impacts to those that are close to being negligible impacts. The

judgments made in relation to the position of specific impacts along this spectrum are discussed in the text accompanying the environmental screening.

(iv) **UNKNOWN IMPACT:** The potential impact of the project will be assessed as being UNKNOWN if the magnitude of the effect cannot be predicted for any of the following reasons:

a. the nature and location of the project activity is uncertain;
b. the occurrence of the environmental component within the study area is uncertain;
c. the time scale of the effect is unknown; or
d. the spatial scale over which the effect may occur is unknown.

60. These categories have been applied to other ADB infrastructure projects and have been adapted from ADB, *1997 Environmental Impact Assessment in Developing Countries.*

D. Screening of Environmental Impacts of Project Components

61. The purpose of this section is to undertake further screening of typical environmental impacts of the project components/sub-components. The screening addresses the potential impacts of the structural processes to be implemented and relevant activities under the loan program, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; iii) operation of the existing solid waste management facilities and (iv) operation of existing wastewater treatment facilities. Since the project does not involve civil works construction, the environmental assessment covers the pre-procurement, procurement (including the commissioning stage), and the operation stage of the project as described fully in Section II-G. Only potential impacts that have direct and relevant significance are listed in the environmental screening in Appendix 1).

62. The following key is used in the environmental screening.

NO impact	O
MINOR NEGATIVE impact	X
MAJOR NEGATIVE impact	XX
MINOR POSITIVE impact	+
MAJOR POSITIVE impact	++
UNKNOWN impact	?

E. Findings of the Environmental Assessment

63. The TOR initially categorized this project as requiring an Initial Environmental Examination (IEE) Report and an Environmental Management Plan both of which are required for a Category B Project. It is understood that this project was tentatively classified as a Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document. This categorization was examined through the representative visits to the different project sites and the proposed project component descriptions and how the project proponent intends to mitigate the potential negative

environmental impacts of the project.

64. In accordance with the ADB's *Environment Policy (2003),* Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or significance than those for Category A projects that require a full-blown Environmental Impact Statement arising from major adverse impacts on the environment. For a Category B project, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

65. In Myanmar, the final list of target hospitals from the border states and region are still being finalized by GOM through the MOH, and their respective environmental assessments have not been prepared. The project is expected to have positive environmental impacts based on the level of investments in laboratory equipment to improve diagnostics of emerging diseases in support of communicable diseases control. On the other hand, this project is not supporting civil works construction for waste management. It is expected that the existing SWM equipment and wastewater treatment facilities will not be able to meet the environmental standards consistently.

66. During the project's life, the environmental assessment will continue particularly for the medical solid waste and the wastewater treatment facilities. If not upgraded or properly maintained, there will be a good chance that the assessment will also continue to have negative environmental impacts. It is very important therefore to have an environmental management plan in place. Within the plan should be a monitoring framework.

67. Separately, the projects will undergo environmental impact assessment in accordance with the relevant Myanmar legislation on environmental pollution laws, medical solid and liquid waste management, wastewater treatment facilities, and environmental health and safety.

V. INSTITUTIONAL REQUIREMENTS AND ENVIRONMENTAL MONITORING PLAN

A. Institutional Arrangements

68. Table 5.1 summarizes the proposed environmental management responsibilities of key parties involved in the project.

Table 5.1: Environmental Management Institutional Arrangements

Agency	Environmental Management Responsibilities
ADB	Sign grant agreement with Government of the Republic of the Union of Myanmar including environment-related covenants Review of site specific EAs and environmental monitoring reports
MOH	Responsibility for overall project implementation, including environmental management activities and implementation of EARPs Coordination of environment-related activities of PIAs including implementation of aspects of EARPs
MOH	Responsibility for project operation including operation stage environmental performance Allocation of staff with responsibility for environmental issues during

Agency	Environmental Management Responsibilities
	operation
SHD/RHD	Responsibility for state/division level project implementation Responsibility for implementing EARPs including preparation of environmental assessments – and obtaining environmental approvals for works within province Responsibility for pre-construction stage and construction stage environmental management, monitoring and reporting
MOECAF	Provision of advice to PIAs as required on environmental issues
MOECAF and ADB	Approval of EMPs for works within states
Suppliers/contractors	Implementation of environmental management commitments contained in site specific EMPs Monitoring and reporting of environmental performance

69. Responsible personnel assigned by the MOH would have primary responsibility for environmental issues and activities during project implementation.

B. Environmental Mitigation Plan

70. Table 5.2 contains the proposed typical environmental mitigation plan for the pre-procurement, procurement and operation stages of selected project sub-components as assessed. During project implementation, the EMPs for the site specific project sub-components will be validated as a continuing process. Reference will be made to new site information obtained to update site specific mitigation measures for inclusion in the EMP.

Table 5.2: Typical Environmental Mitigation Plan

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
		Procurement Stage	
Dust and emissions generation	Minimize emissions of dust and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/Contractor
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/Contractor

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/Contractor
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/Contractor
Risks to public and worker health and safety	Minimize risk of accidents to public and workers	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	Supplier/Contractor
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Operation Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Ensure compliance with relevant Myanmar air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Myanmar on air quality, particulates and odor	MOH and MOECAF
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the labs Regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	MOH
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours Notify nearby community of schedule and duration of activities	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Myanmar and MOECAF regulations. Ensure that wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	MOH and MOECAF
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal. Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Myanmar and MOECAF regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable MOECAF standards for medical wastewater.	MOECAF
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos, if any Provide safety equipment to repair workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Viet Nam regulations on SWM and wastewater discharge are complied with.	MOH and MOECAF
Emissions generation	Comply with relevant MOECAF Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MOECAF
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Myanmar standards prior to discharge Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH and MOECAF
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	Ensure that the applicable laws and regulations on SWM and wastewater treatment particularly on best practices and safety are complied with. Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH and MOECAF MOH

C. Environmental Monitoring Plan

71. Tables 5.3 and 5.4 contain the proposed environmental monitoring plan for the pre-construction, construction and operation stages of the project components. Two types of environmental monitoring are proposed to be implemented:

(i) Environmental effects monitoring is conducted to estimate the impacts of the sub-project on ambient environmental conditions.
(ii) Project environmental performance monitoring is conducted to evaluate compliance with environment-related operating procedures, national standards, and/or contractor specifications including the requirements of the EMP.

72. The following plan identifies the relevant site specific monitoring measures for inclusion in the EMP.

Table 5.3: Environmental Effects Monitoring Plan

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/MOH
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier/MOH
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier/MOECAF
Operation					
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified in Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOECAF
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOECAF

Table 5.4: Environmental Performance Monitoring Plan*

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Covering of equipment and fixtures & use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/MOECAF
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier/MOECAF
Operation					
Air emissions control	All criteria in Myanmar - Air quality – odor from solid waste matter - Permitted level.	At solid waste facilities and autoclaves	As specified in Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOECAF
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOECAF

D. Environmental Monitoring and Reporting

73. Table 5.5 contains the proposed environmental monitoring and reporting system for the pre-construction, construction and operation stages of the project.

Table 5.5: Environmental and Monitoring Reporting Requirements

Project Phase	Type of Monitoring	Description	Responsibility	Reporting Requirements
Procurement	Supplier/ Contractor's Environmental Performance Monitoring	Self-monitoring of environmental effects of minor repair and improvement works in terms of environmental performance monitoring requirements identified in EMP. Undertaken on an ongoing basis throughout the procurement process with regular monitoring frequencies.	Supplier/ contractor	Commissioning reports to MOH/MOECAF
	EMP Compliance Monitoring	Monitoring of Supplier/Contractor's compliance with EMP requirements. Undertaken during commissioning of equipment. Monitoring based on combination of observation and review of supplier's environmental performance monitoring results.	SHD/RHD	Commissioning reports to MOH/ ADB
Operation	Operation Environmental Monitoring	Monitoring of performance of project operation. Undertaken on a regular basis over life of project and self-reporting of compliance with EMP operation stage commitments.	MOH	1st year: 3 monthly reports to ADB and MOECAF Subsequent years: 6 monthly reports to MOE

E. Environmental Management Budget

74. Environmental management costs include costs both at the level of individual project sub-components as well as project component-wide environmental management costs. An environmental management budget to cover costs for management and monitoring both at the level of the district hospitals and the health centers will be established. A certain percentage of the total project costs can be allocated for this fund upon agreement with the MOH.

75. The EMP budget will include the following components:

(i) Marginal costs for implementation of environmental mitigation measures during pre-procurement, procurement and operation stages
(ii) Marginal costs for implementation of environmental monitoring measures during pre-procurement, procurement and operation stages

VI. PUBLIC CONSULTATION AND INFORMATION DISCLOSURE

A. Public Consultation Undertaken to Date

76. Consultation undertaken to date on the project has involved the following:

(i) Meetings and consultations with State Health Department directors, laboratory and infection control and prevention staff representatives in the sampled project province to inform them about the need for rapid environmental assessments and obtain the current status of the district hospital facilities and health centers and the upgrades or improvements that they are proposing based on their own diagnosis.
(ii) Meetings and consultations with the Hospital Office Director and/or Hospital Director together with their management and staff, laboratory and infection control and prevention staff representatives in the sampled project province to brief them about the environmental assessments that each hospital has to undertake to identify the current status of environmental conditions in the vicinity of the health facilities and identify the scope of required project interventions.
(iii) Meetings and consultations with the INGOs, if any, operating in the border towns.

77. The initial public consultations showed a high level of acceptance of the project as the project will improve the hospitals' and health centers' current state and capability for improved laboratory services and infection prevention and control. Some suggestions were forwarded regarding the laboratory equipment needed, waste management containers, disposal technologies that are non-burn. Representatives of INGOs were concerned about the health effects of medical and liquid waste management as well as laboratory wastes handling which are not clearly addressed by government. Some of the related environmental concerns included the lack of proper management of health care waste, the lack of adequate staff for operations and maintenance of the facilities, and the basic lack of medical and non-medical equipment. Such concerns will be incorporated in the mitigation and monitoring plans during project design and implementation. Public consultation is an on-going process and the consultations will continue with the project affected communities and relevant NGOs, if any, during the detailed design and implementation phases of the project.

B. Future Public Consultation and Disclosure

78. In order to ensure that future project activities are conducted in a participatory sense and that community concerns and opinions about potential environmental impacts are taken into account during subcomponents of procurement and operation, a range of public consultation and disclosure activities will be implemented throughout activity preparation, implementation and operation. These activities, which have been developed to meet the requirements of both GOM and ADB safeguards requirements, are summarized in the following sections.

79. The following consultation activities will be implemented during the finalization of the detailed design of project activities:

(i) State/division level workshops in each capital or township involved in the project border state or division to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops will include stakeholder agencies, mass organizations (Women's' Union, Youth Union and Farmers Association), other relevant district level organizations such as the District Committee for Ethnic Minorities and CPC and other relevant stakeholder representatives.

(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required particularly for the quarantine and border area outbreak response facilities.

80. The public consultation activities carried out and the subsequent outcomes will be documented in the environmental assessment documents to be prepared for each site and records of the public consultation appended to the document as outlined in the Environmental Assessment and Review Procedures for the project.

81. To ensure ongoing community involvement during project procurement and operation, the following activities will be carried out for each project activity.

(i) Community information on procurement and operational activities and details of any expected impacts and measures to control them by means of newspaper and loudspeaker announcements and direct communication by local authorities to affected households

(ii) Establishment of a grievance redress mechanism to allow community members to report concerns regarding operational activities including environmental pollution concerns.

82. The requirements for future consultation activities during procurement and operation will be documented in the site specific environmental assessments to be prepared during project implementation.

VII. ENVIRONMENTAL CRITERIA FOR PROJECT SUB-COMPONENT SELECTION

83. The following environmental criteria have been developed for the purposes of future project sub-component selection.[7].All project sub-components must:

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[7] Environmental criteria apply only to the following structural project sub-components: Minor repair and improvement works; laboratory equipment installations; solid waste management facilities and wastewater treatment facilities.

(i) Avoid direct or indirect significant, negative impacts on protected areas defined by the Forestry Law (1992), Protection of Wildlife and Wild Plants and Conservation of Natural Areas Law (1994) or other known areas of ecological sensitivity including those areas identified in Section III of the IEE
(ii) Avoid loss of significant areas of vegetation or permanent, negative impacts on a known rare or endangered flora or fauna species
(iii) Avoid pollution of waterways, surface waterbodies or groundwater resources with ecological values or which are used for domestic or agricultural water supply
(iv) Avoid direct or indirect significant, negative impacts on important items of cultural heritage, including those sites identified in Section III of the IEE
(v) Not cause any other environmental impacts that would trigger categorization as a 'Category A' project in accordance with the ADB's *Environmental Policy, OM.20 Environmental considerations in ADB operations* and *Environmental Assessment Guidelines* (2003)

84. Once project components have been selected using the defined criteria, they will be subject to further environmental analysis through implementation of the environmental assessment and review procedures (EARPs) presented in Section VIII.

VIII. ENVIRONMENTAL ASSESSMENT AND REVIEW PROCEDURES

A. Introduction

85. The following Environmental Assessment and Review Procedures (EARPs) document the procedures for the environmental assessment of the project sub-components that will be implemented under Components 2 and 3 of the project. The EARPs have been harmonized with the GOM's environmental assessment requirements as far as possible to ensure a streamlined environmental assessment process for project loan activities. The EARPs have been developed to comply with the ADB's *Environmental Assessment Guidelines* (2003).

B. Overview of Types of Project Sub-Components to be Assessed

86. The project targets border districts of 5 states and 1 division along Myanmar's borders with PR China, Lao PDR, and Thailand, and some townships along the economic corridors. The selection of the final border towns, as selected by MOH, were based on:

(i) security
(ii) health sector need
(iii) regional relevance in terms of economic corridors with major border crossings
(iv) feasibility
(v) potential for demonstrating good practices and training others
(vi) limitation of the sites

87. All project sub-components at one location will be grouped together to form a 'project activity for the purposes of the application of the EARPs.

C. Myanmar's Environmental Assessment and Review Procedures

88. Environmental legislation and associated regulatory instruments in Myanmar that are relevant to the selection of future project/sub-project components are given below. The GOM's

environmental safeguards procedures are set out in the following, but not limited to the following instruments:

(i) Constitution of the Republic of the Union of Myanmar (2008): Articles 45 and 390
(ii) National Environmental Policy
(iii) The Environmental Conservation Law (30 March 2012)
(iv) The Environmental Conservation Rules (05 June 2014)
(v) EIA Procedures (Final Draft as of 2015)
(vi) Convention on Biological Diversity and its Cartagena and Nagoya Protocols
(vii) United Nations Framework Convention on Climate Change and its Kyoto Protocol
(viii) Basel Convention on the control of Transboundary Movements of Hazardous Wastes and their Disposal

89. The GOM legislation does not require sector level environmental assessments to be carried out for projects such as this project. Thus, unlike the ADB process, there will not be one overarching environmental document for the project prepared under the Government of Myanmar's environmental assessment framework. Investments financed by the loan will be evaluated by the Government on a site by site basis. All sub-components at one site will be grouped together to form a 'project activity' for and for each project activity, an environmental assessment report will be required to be prepared. The type of environmental assessment report required will depend on the nature, scale and location of the investment.

D. Specific Procedures to be used for Project Sub-components under the Sector-type Loan

1. Responsibilities and Authorities

90. Table 8.1 sets out the responsibilities and authorities of key organizations involved in the implementation of the EARPs.

Table 8.1: Responsibilities for EARP Implementation

Organization	EARP Implementation Responsibilities
PMU	Check environmental selection criteria have been applied in selection of project sub-components Provide advice to PIA on environmental assessment (EA) preparation Review and provide "no-objection" on EAs submitted by PMUs Submit EA to ADB for review and approval
PMU	Overall responsibility for EA preparation and submission for approval including engagement of consultants if required to prepare EIAR Apply environmental selection criteria to identify future project sub-components
MOH	Ensure that the PMU is adequately resourced to properly manage project sub-components including safeguards issues Appraise and approve EIARs
MOE	Provide advice and guidance on environmental issues during project sub-component preparation
MOH	Approval of project sub-component CEP/EMPs
ADB	Receipt and review of EA for each project sub-component

91. Institutional strengthening for organizations involved in EARP implementation would be carried out as follows:

(i) **Environment Support Consultants:** A national consultant would be engaged to work with the PMU and MOECAF Environment Officers and MOH staff to establish systems and tools to implement their project responsibilities and to provide technical on-the-job training and support. Such systems and tools would include example EA documents and templates for use throughout project implementation and organisation of forums to share lessons learnt between PMUs. These positions would be implemented intermittently throughout project implementation.

(ii) **PMU Environment Officer:** The PMU Environment Officer would be the main point of contact for environmental safeguards issues at the central level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iii) **SHD Environment Officer:** The SHD Environment Officer would be the primary point of contact for environmental safeguards issues at the province level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iv) **MOH Environment Officer:** An existing staff member within the MOH would be allocated to have responsibility for environmental issues during project operation. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

2. Environmental Criteria for Future Project Sub-component Selection

92. The environmental criteria for future project sub-component selection are documented below:

(i) Constitution of the Republic of the Union of Myanmar (2008): Articles 45 and 390
(ii) National Environmental Policy
(iii) The Environmental Conservation Law (30 March 2012)
(iv) The Environmental Conservation Rules (05 June 2014)
(v) EIA Procedures (Final Draft as of 2015)
(vi) Convention on Biological Diversity and its Cartagena and Nagoya Protocols
(vii) United Nations Framework Convention on Climate Change and its Kyoto Protocol
(viii) Basel Convention on the control of Transboundary Movements of Hazardous Wastes and their Disposal

3. Procedures for Environmental Assessment of Project Sub-components

a. Environmental Categorization

93. The first step in the EARPs will be the determination of the environmental categorization for each subproject in terms of both ADB and GOM requirements.

94. In terms of ADB environmental categorization, the environmental selection criteria that have been developed for subprojects will ensure that all subprojects will be classified either as:

(i) Category B in accordance with the ADB's *Environmental Assessment Guidelines* and thus subject to preparation of an IEE; or
(ii) Category C in accordance with the ADB's *Environmental Assessment Guidelines* and thus not subject to formal environmental assessment.

95. The determination of whether a subproject is Category B or Category C will be made by the PMU (with advice from the MOH as necessary) using guidance from the ADB's *Environmental Assessment Guidelines.*

96. In terms of the GOM's environmental categorization, reference to environmental impact screening indicates that some subprojects may require one of the following levels of environmental assessment:

(i) **Preparation of EIAR:** A small number of project activities may trigger consideration of the EIA decree for a detailed EIAR. Types of activities that may be subject to EIARs include hospitals with more than 50 beds; incinerators or WWTP with capacity greater than 1000m^3/day.

(ii) **Preparation of CEP**: Project activities that do not trigger an EIAR will require a less detailed environmental assessment in the form of a CEP.

(iii) **No environmental assessment:** Some subprojects involving very minor upgrading or improvement works may not require any assessment under the GOM's safeguards requirements; however, there is no clear guidance provided in the Government legislation as to when no assessment is required and this determination will be made on a case by case basis by MOECAF and/or SHD in consultation with the PMU during the environmental categorization process.

97. The determination of the appropriate environmental categorization of each subproject in accordance with Government of Myanmar's safeguards requirements will be made by the PHD, based on advice from PMU and the relevant MOECAF at the outset of the environmental assessment process with reference to the EIA decree pertaining to environmental categorization by screening.

b. Preparation of Environmental Assessment Documents

98. For all project activities[8] an environmental assessment document will be required to be prepared that will incorporate the following elements:

(i) Required contents of EIAR or CEP document as established in the GOM's EIA regulations

(ii) Appendix containing a site specific Environmental Management Plan (EMP) prepared following the format and structure contained in Section V

(iii) Appendix containing the results of public consultation and information disclosure activities

99. The information required to be included in the appendices of the EA document are consistent with, but represents a strengthening of the GOMs requirements for addressing environmental management issues and public consultation activities in environmental assessment documentation.

c. Requirements for Environmental Management Plans

100. The EA will be required to include an Environmental Management Plan (EMP) for each project sub-component. The EMP will address environmental mitigation and monitoring activities, institutional arrangements and strengthening requirements, public consultation

[8] For the purposes of the EARPs a 'project activity' is defined as all project sub-components being carried out at a particular location.

activities during project implementation and operation and environmental monitoring and reporting requirements.

101. Table 8.2 summarizes the potential impacts and proposed mitigation measures for the project activities that will form the basis of the EMP for each project sub-component.

Table 8.2: Project Environmental Impacts and Mitigation Measures

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Procurement Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/Contractor
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/Contractor
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/Contractor
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/Contractor
Risks to public and worker health and safety	Minimize risk of accidents to public and workers	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	MOH
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	SHD
Operation Stage			

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Dust and emissions generation	Minimize emissions of dust and other pollutants	Ensure compliance with relevant Myanmar's air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Myanmar on air quality, particulates and odor	SHD
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the laboratory. Regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	SHD
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours Notify nearby community of schedule and duration of activities	SHD
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Myanmar and MOECAF regulations. Ensure that wastewater from the laboratories will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	SHD
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal.	SHD

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
		Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Myanmar and MOECAF regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable MOECAF standards for medical wastewater.	
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos. Provide safety equipment to construction workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Myanmar regulations on SWM and wastewater discharge are complied with.	MOH
Emissions generation	Comply with relevant Myanmar Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MOECAF
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Myanmar standards prior to discharge Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	Ensure that the applicable regulations on SWM and wastewater treatment particularly on best practices and safety are complied with.	SHD
		Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

102. Tables 8.3 and 8.4 summarize the proposed monitoring measures for the project activities that will form the basis of the EMP for each project sub-component.

Table 8.3: Environmental Effects Monitoring Plan[9]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/PPMU
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier/PPMU
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier/PPMU
Operation					
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOH

[9] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table.

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOH

Table 8.4: Environmental Performance Monitoring Plan[10]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Covering of equipment and fixtures & use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier / SHD
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier / PHD
Operation					
Air emissions control	All criteria in Myanmar – Air quality – odor from solid waste matter – Permitted level.	At solid waste facilities and autoclaves	As specified in Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified in Myanmar standards	Weekly for first 6 months and then monthly thereafter	MOH

d. Requirements for Public Consultation and Disclosure

103. There is a requirement that public consultation and information disclosure takes place for each project activity during preparation of the EA. The following minimum requirements for public consultation and disclosure must be met for each project activity.

104. At the outset of the preparation of the EA, local authorities and community representatives in the vicinity of, or who are likely to be affected by, the project should be informed of the project activity and given an opportunity to provide feedback on potential environmental issues or required management measures. The following activities will be carried out for each project activity:

(i) State level workshops in each border town included in the project area to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops with include

[10] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table

stakeholder agencies, mass organizations (Womens' Union, Youth Union and Farmers Association), other relevant district level organizations such as the township committees for Ethnic Minorities, commune committees and representatives.

(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required.

105. In addition, information on the project activity and consultation activities will be provided to the local community through newspaper notices and/or public announcements.

106. Following approval of the environmental assessment document, a copy of the approval and a summary of the environmental assessment document will be sent to all relevant township committees. Information regarding the approved project and the proposed environmental management measures will be posted at suitable locations on the project site.

107. The public consultation activities carried out and the subsequent outcomes must be documented in the EA and the records of the public consultation appended to the document.

e. Review of Environmental Assessment Documents by GOM and ADB

108. At the same time that the EA is submitted to the relevant GOM authorities (in Myanmar language), it will be submitted by the PMU (in English language) to the ADB. The ADB will review the document for compliance with its environmental safeguards requirements.

109. All environmental assessment documents prepared using these EARPs will be reviewed and approved by the GOM. The approval process that will be implemented by the GOM as set out in the relevant decree.

110. For sub-projects with a value of more than $1million, approval of environmental assessment documents will be required from the ADB prior to the commencement of procurement works.

f. Monitoring and Reporting of EARP Implementation

111. Monitoring and reporting of EARP implementation will be undertaken to ensure that the procedures are being adequately implemented and to identify any modifications or corrective action that may be required to improve the efficiency of the EARPs throughout the project implementation process. The monitoring of EARP implementation will be incorporated into the overall project monitoring and evaluation and reporting system. EARP implementation will be monitored at the province and central levels.

112. Reporting of EARP implementation will take place on a 6 monthly basis. Each PPMU will report to the CPMU on the monitoring parameters contained in Table 8.2, and the CPMU will consolidate these reports, together with the results of the central level monitoring for submission to the ADB.

113. Table 8.5 summarizes the monitoring processes that will be carried out for EARP implementation.

Table 8.5: Monitoring of EARP Implementation

Monitoring Parameter	Monitoring Method	Frequency of Monitoring	Responsibility for Monitoring
Verification of EA preparation and approval before commencement of project component construction	Verification of: (i) EA document produced, (ii) GOM certificate issued, (iii) ADB no-objection issued	Each project sub-component before commencement of construction	SHD
		Random checks of at least 15% of project sub-components	PMU
		Random check of small number of project sub-components	PMU
Adequacy of public consultation / disclosure activities to meet EARP requirements	Number and type of public consultation and disclosure events and key issues raised	For all project sub-components	SHD

E. Confirmation that the Environmental Assessment and Review Procedures conform to ADB's Requirements

114. The EARPs presented in this section have been developed to take account of the ADB's environmental safeguards requirements. Specifically, the EARPs require development of environmental mitigation and monitoring plans and institutional arrangements, and implementation of public consultation activities to meet the ADB's requirements.

115. The review of the environmental assessment documents for each project activity that will be carried out by the ADB will ensure compliance of the products of these EARPs with ADB safeguards requirements.

F. Staffing Requirements and Budget for EARP Implementation

116. Table 8.6 summarizes the estimated staffing requirements and budget for EARP implementation for each project activity.

Table 8.6: Staffing Requirements and Budget for EARP Implementation

Organization	Responsible Personnel	Human/Financial Resources for EARP Implementation assuming EIAR Level Assessment	Human/Financial Resources for EARP Implementation assuming CEP Level Assessment
PMU	PMU Environment Officer	3 person weeks	1-person week
SHD	SHD Environment Officer	4 person weeks $20,000	3 person weeks $5,000

IX. FINDINGS AND RECOMMENDATIONS

A. Findings

117. The terms of reference initially categorized this project as requiring an Initial Environmental Examination (IEE) report and an Environmental Management Plan (EMP) both of which are required for Category A and B projects. It is understood that this project was tentatively classified as Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document.

This categorization was examined through the respective visits to the different project sites and the proposed project component descriptions and how the project component intends to mitigate the potential negative environmental impacts of the project.

118. In accordance with the ADB's *Safeguard Policies Statement (2009)*, Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or significance than those for Category A projects that require a full Environmental Impact Assessment (EIA) arising from major adverse impacts on the environment. For Category B projects, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

119. The final list of the project's subcomponents and the project descriptions for their implementation have indicated that the project will be a Category B. The negative impacts expected to occur during operation stages of the project. Namely:

(i) **During the procurement stage**: Probably some structures of the laboratories and/or other structures of the hospitals need to be repaired and upgraded before assembly of the equipment. However, the negative impacts during this phase will be negligible due to the scale of the activities are limited and these negative impacts will be localized and temporary. Such impacts include generation of noise and dust, deterioration of water quality through sediment laden runoff and will be readily managed to acceptable levels through implementation of standard environmental management practices.

(ii) **During operation stage**: Liquid and solid waste generated by the operation of the laboratories as well as the hospitals as a whole are likely to be the sources of negative impacts on the environment if they are not managed properly. Such pollution sources will include infectious specimens, chemicals for testing, wastewater and emission of the laboratories. These pollution sources are long-term and consecutive, and therefore, mitigation measures should be considered adequately through both structural measures (the technical systems for collection and treatment the wastewater, hazardous waste, infectious waste and emission generate from the laboratory should be equipped synchronously) and management measures (application procedure of separation of wastes at source, procedure of management, collection and treatment of hazardous/infectious wastes, etc.). During the Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices particularly in relation to solid waste and wastewater treatment facilities.

B. Recommendations

120. It is recommended that the Project should ensure that for the selected health facilities the laboratories should be well-managed with trained staff. Based on the field assessment and the project proposals, most of laboratories have standardized biosafety level 3 for the specialist hospitals, and standardized biosafety level 2 for the general hospitals. However, most of laboratories in the provinces visited are not equipped with the collection and treatment systems for the waste emissions generated and the wastewater from the laboratories are not treated according to the environmental standards. Therefore, the implementing agencies need to consider the appropriate equipment and structures for further investments to ensure that the

operation of the health facilities are sound and will not cause significant impacts to the environment. The mitigation measures will also be managed by the provinces and made part of their operational plans for the health facilities invested.

121. Separately, the project will undergo environmental impact assessment in accordance with Myanmar's laws on environmental impact assessment. The Environmental Impact Assessment is required for all newly improved hospital projects. For the repair, renovation and upgrade of the hospitals, depending on the scale of the improvement activities, an EIA or Environmental Protection Scheme have to be prepared in the next phase of the project in accordance with Government of Myanmar's regulations.

X. CONCLUSIONS

122. The project activities are expected to have a range of benefits on the natural and social environment, and only minor or negligible negative environmental impacts. The majority of minor negative impacts are expected to occur during the procurement phase and operation phase. These will be localized, minor and temporary and will be readily managed to acceptable levels through the implementation of the appropriate solid waste, wastewater, and environmental management practices. Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices.

123. This IEE Report includes an Environmental Management Plan (EMP) defining the types of environmental mitigation and monitoring measures required to offset potential negative environmental impacts. The development of the EMP takes into account the likely level of technical, financial and human resources available for each of the subproject components. The EMPs will be updated as project implementation progresses beginning with the detailed design. Site-specific conditions may change the nature of the assumptions on the EMPs as the details of the upgrades and improvement projects of the hospitals and health centers become more precise and sensitive to the prevailing environmental conditions of the different project locations.

124. Based on the findings of the environmental assessment, it is concluded that that the project will not have a significant effect on the environment. The investments in the health security project, overall, will bring forth more positive than negative environmental impacts and greater health security particularly in the border provinces. In view of this, an EIA is not required to be prepared for this project. Individual project activities will be assessed following the Environmental Assessment Review Procedure as prescribed by ADB for the other sub-project component activities while site-specific environmental mitigation and monitoring measures will be developed and implemented accordingly as set out in the EMPs.

XI. REFERENCES

ADB. 2009. Safeguard Policy Statement
ADB. 2002. Environmental Policy and Operations Manual 20
ADB. 2003. Environmental Assessment Guidelines, Manila
ADB. 1997. Environmental Impact Assessment in Developing Countries

Appendix 1: Environmental Screening of Project Sub-Components

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Impacts on the Natural Environment				
Dust generation and air emissions	O	X	O	**Minor Repair and Improvement Works** During minor repair and improvement work, localized, temporary negative impacts may result from dust generation from removal and installation of existing equipment, frames, cabinets, and supports to clear the way for new laboratory improvements and equipment. Mitigation measures will include use of wet rags and vacuum cleaners for dust suppression, containment and minimization of work areas, and utilizing temporary protective curtains on existing facilities and equipment. No impacts are expected during the operation stage.
	O	X	++	**Laboratory Equipment Commissioning including IPC Services** Negative Impact as above for dust emissions**.** As a mitigating and control measure, emissions from the labs will be collected and treated to ensure the compliance with relevant the environmental standards of Myanmar as current regulations on air (poison gases and odor) IPC "standard precautions" to be implemented to enhance positive impact during operations. Standard precautions include: use of PPE and environmental cleaning.
	O	O	X	**Solid Waste Management Facilities** Negative impact as above for dust emissions. For IPC, autoclaves will be designed and controlled to ensure compliance with relevant Myamar air quality emissions standards namely criteria contained in MONRE/DONRE regulations on: air (odor and particulates) and water quality – for steam condensate of medical liquid waste from autoclaves permitted level. Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Myanmar on air quality, particulates and
	O	O	O	**Wastewater Treatment Facilities** No impact
Odor generation	O	O	O	**Minor Repair and Improvement Works** No impact
	O	O	X	**Laboratory Equipment Commissioning including IPC Services** During operation improper use or maintenance of lab facilities and equipment may result in minor, localized impacts from odor generation. Mitigation measures will include development and implementation of guidance and action for operation of the labs and training of personnel in proper operation of the labs.
	O	O	X	**Solid Waste Management Facilities** During operation improper use or maintenance of waste storage areas may result in minor, localized impacts from odor generation. Mitigation measures will include development of operational procedures for temporary and permanent waste storage areas, regular removal of waste from temporary storage areas and training of personnel in proper waste management practices.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** During operation improper use or maintenance of wastewater treatment facilities may result in minor, localized impacts from odor generation. Mitigation measures will include development of appropriate operational procedures and training for personnel.
Noise generation	O	X	O	**Minor Repair and Improvements Works** During minor repair and improvement work, minor, localized, temporary impacts may result from noise generation from use of tools and installation equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of tools and equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected rooms of the duration and extent of installation works. No impacts are expected during the operation phase of the works.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** Minor negative impacts and mitigating measures as above.
	O	O	X	**Solid Waste Management Facilities** During collection, transport and disposal operations, minor, localized, temporary impacts may result from noise generation from use of containers, vehicles and equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected areas of the duration medical waste management activities.
	O	O	X	**Wastewater Treatment Facilities** Minor negative impacts and mitigating measures during operations as above
Surface water quality deterioration	O	X	O	**Minor Repair and Improvement Works** Minor negative impacts on surface water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from the drainage ways.
	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, surface water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Solid Waste Management Facilities** During operation stage, surface water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect waterways. Discharge from solid waste facilities will comply with criteria contained in the applicable Myanmar and DONRE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
Ground water quality deterioration	O	X	O	**Minor Repair and Improvement Works** Minor negative impacts on ground water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation that will seep through ground water sources or wells. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from ground water sources.
	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, ground water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include protecting groundwater sources permanently and the development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to the environment.
	O	O	X	**Solid Waste Management Facilities** During operation stage, ground water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect ground water sources. Discharge from solid waste facilities will comply with criteria contained in the applicable Myanmar and DONRE regulations.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect ground water quality. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
Soil Contamination	O	X	O	**Minor Repair and Improvement Works** During operation, minor impacts of cleaning activities resulting in contamination of soils with cleaning chemicals and agents from repair and improvement activities. Mitigation measures will include ensuring that a barrier between the working surfaces and the soil are used to avoid contamination during the works.
	O	O	O	**Laboratory Equipment Commissioning including IPC Services** No impacts.
	O	O	X	**Solid Waste Management Facilities** During operation stage, soil could be adversely affected by improper disposal of solid waste particularly for hospitals that bury medical wastes into their own grounds. Mitigation measures will include ensuring sealing and containment of burial pits or dumping grounds prior to external municipal disposal Discharge from solid waste facilities will comply with criteria contained in the applicable Myanmar and DONRE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect surrounding soils. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
Impacts on the socio-economic environment				
Amenity of surrounding land use	O	X	O	**Minor repair and improvement works** During procurement very minor, localized and temporary impacts to amenity of surrounding land use may occur in the form of dust and noise generation. Such impacts will be readily mitigated through the range of measures previously described on dust, odor and noise.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** Same as above during procurement**,** the laboratories may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Solid Waste Management Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Wastewater Treatment Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Impacts on Public Health and Safety				
Risks to public health and safety	O	X	O	**Minor Repair and Improvement Works** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks in public safety for nearby receivers if not properly managed. Mitigating measures include adopting and ensuring that the suppliers comply with safety guidelines established by the provincial and district hospitals.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.
	O	O	X	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Viet Nam regulations on SWM are complied with.
	O	O	X	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Viet Nam regulations on wastewater discharge are complied with.
Risks to health and safety of workers				**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals. Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.
				Laboratory Equipment Commissioning including IPC Services Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.
				Solid Waste Management Facilities Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to the hospital workers. Mitigating measures include ensuring that the applicable Myanmar regulations on SWM are complied with.
				Wastewater Treatment Facilities Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff. Mitigating measures include ensuring that the applicable Myanmar regulations on wastewater discharge are complied with.

<table>
<tr><th>POTENTIAL IMPACT</th><th>PRE-PROCUREMENT STAGE</th><th>PROCUREMENT STAGE</th><th>OPERATION STAGE</th><th>DISCUSSION OF IMPACT AND MITIGATION MEASURES</th></tr>
<tr><td rowspan="4">Increase in illness due to environmental pollution such as: dust, air, water supply contaminants, solid and hazardous wastes, untreated sewage surface water runoff, and wastewater</td><td>O</td><td>X</td><td>O</td><td>Minor Repair and Maintenance Work
Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise

Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals.</td></tr>
<tr><td>O</td><td>O</td><td>++</td><td>Laboratory Equipment Commissioning including IPC Services
Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.</td></tr>
<tr><td>O</td><td>O</td><td>X</td><td>Solid Waste Management Facilities
Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety.

Mitigating measures include ensuring that the applicable Viet Nam regulations on SWM are complied with. Also sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions. Implement solid and hazardous waste management plans. Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.</td></tr>
<tr><td>O</td><td>O</td><td>X</td><td>Wastewater Treatment Facilities
Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff and the public.

Mitigating measures include ensuring that the applicable Viet Nam regulations on wastewater discharge are complied with.</td></tr>
<tr><td rowspan="3">Accidents and injury</td><td>O</td><td>X</td><td>O</td><td>Minor Repair and Maintenance Work
Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for accidents and injury

Mitigating measures include adopting and ensuring that the hospital's safety guidelines are established and practiced by the provincial and district hospitals.

Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.</td></tr>
<tr><td>O</td><td>O</td><td>++</td><td>Laboratory Equipment Commissioning including IPC Services
Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.</td></tr>
<tr><td>O</td><td>O</td><td>X</td><td>Solid Waste Management Facilities
Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks of accident and injury.

Mitigating measures include ensuring that the applicable Myanmar regulations on SWM particularly on best practices and safety are complied with.</td></tr>
</table>

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks the risks of accident and injury. Mitigating measures include ensuring that the applicable Myanmar regulations on wastewater discharge are complied with and safety practices are always observe.

Appendix 2: RAPID ENVIRONMENTAL ASSESSMENT FORM (MODIFIED)

Instructions:

- This checklist focuses on environmental issues and concerns. To ensure that social dimensions are adequately considered, refer also to ADB checklists and handbooks on (i) involuntary resettlement, (ii) indigenous peoples planning, (iii) poverty reduction, (iv) participation, and (v) gender and development.
- Answer the questions assuming the "without mitigation" case. The purpose is to identify potential impacts. Use the "remarks" section to discuss any anticipated mitigation measures.

Project Title: Greater Mekong Subregion Health Security Project
Location: Myanmar
Proposed Environmental Category: B

SCREENING QUESTIONS	Yes	No	REMARKS
A. PROJECT SITING IS THE PROJECT AREA:			
DENSELY POPULATED?		X	
HEAVY WITH DEVELOPMENT ACTIVITIES?		X	
ADJACENT TO OR WITHIN ANY ENVIRONMENTALLY SENSITIVE AREAS?		X	
CULTURAL HERITAGE SITE		X	
PROTECTED AREA		X	
WETLAND		X	
MANGROVE		X	
ESTUARINE		X	
BUFFER ZONE OF PROTECTED AREA		X	
SPECIAL AREA FOR PROTECTING BIODIVERSITY		X	
BAY		X	
B. POTENTIAL ENVIRONMENTAL IMPACTS WILL THE PROJECT CAUSE…			
impacts on the sustainability of associated sanitation and solid waste disposal systems and their interactions with other urban services?	X		
deterioration of surrounding environmental conditions due to rapid urban population growth, commercial and industrial activity, and increased waste generation to the point that both manmade and natural systems are overloaded and the capacities to manage these systems are overwhelming		X	

SCREENING QUESTIONS	Yes	No	REMARKS
degradation of land and ecosystems (e.g. loss of wetlands and wild lands, coastal zones, watersheds and forests)?		X	
increase in soil erosion and siltation?		x	
increase in peak and flood flows?		x	
loss of downstream beneficial uses (water supply or fisheries)?	x		Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to stream sources of water. Target hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with MOECAF emission standards
unnecessary loss of ecological value and decreased biodiversity by replacement of natural forest with plantation with limited number of species?		x	
dislocation or involuntary resettlement of people?		X	
displacement of people or reduce their access to forest resources?		X	
degradation of cultural property, and loss of cultural heritage and tourism revenues?		X	
encroachment into precious ecosystem (e.g. sensitive habitats like protected forest areas or terrestrial wildlife habitats?		x	
occupation of low-lying lands, floodplains and steep hillsides by informal settlers and low-income groups, and their exposure to increased health hazards and risks due to pollutive industry?		X	
water resource problems (e.g. depletion/degradation of available water supply, deterioration for surface and ground water quality, and pollution of receiving waters?	X		Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to boreholes/wells used as groundwater source. Target hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with MOECAF emission standards
air pollution from fuel gas discharged into the atmosphere?		X	
social conflicts between construction workers from other areas and local workers?		X	
road blocking and temporary flooding due to land excavation during rainy season?		X	
noise and dust from construction activities?	X		Potential impacts from minor repair and improvement works in laboratories

SCREENING QUESTIONS	Yes	No	REMARKS
traffic disturbances due to construction material transport and wastes?		X	Only minor repair and improvement works for laboratories are anticipated
increased road traffic due to interference of construction activities?		x	
hazardous driving conditions where construction interferes with pre-existing roads?		x	
short-term soil erosion and silt runoff due to construction?		X	
hazards to public health due to ambient, household and occupational pollution, thermal inversion, and smog formation?		X	
short-term construction impacts (e.g. soil erosion and silt runoff, deterioration of water and air quality, noise, dust and vibration from construction equipment?	X		Potential minor impacts from repair and improvement works of laboratories within existing hospital building facilities
overdrawing of ground water, leading to land subsidence, lowered ground water table, and salinization?		X	
contamination of surface and ground waters due to improper waste disposal?	X		Potential impact for hospitals with deficient and substandard medical solid waste management systems especially if the hospital grounds are used as temporary waste transfer stations. Target hospitals should mitigate by ensuring that an operational medical waste management system is in place including treatment facilities that comply with MOECAF emission standards.
contamination of soil and groundwater from solid wastes from water treatment sludges, cafeteria or lunchroom wastes, ashes and incineration residues, etc.?	x		Same as above
contamination of air quality from incineration (if incinerator is present at the facility)?	x		Potential impact for hospitals with deficient and substandard incinerators that produce emissions that are not compliant with air emission standards. Target hospitals should mitigate by ensuring that an operational medical waste disposal system is in place that complies with MOECAF air emission standards.
health and safety hazards to workers from toxic gases and hazardous materials present in the facility?	x		Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management
water pollution from discharge of liquid effluents?	x		Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management

SCREENING QUESTIONS	Yes	No	REMARKS
pollution of receiving waters resulting in amenity losses, fisheries and marine resource depletion, and health problems	☐	x	
public health and safety hazards due to solid waste disposal in sanitary landfills?	x	☐	Potential impact by hospitals operating without medical solid waste treatment facilities. Mitigate by ensuring that a compliant disposal system is in place or is worked out with the municipality and no open dumping is allowed at the hospital grounds.
poor sanitation and solid waste disposal in construction camps and work sites, and possible transmission of communicable diseases from workers to local populations?	☐	x	Work is within existing premises
increased noise and air pollution resulting from traffic volume?	☐	x	
creation of temporary breeding habitats for mosquito vectors of disease?	x	☐	Potential impact from hospitals that have deficient and substandard drainage facilities. Mitigating measure is to upgrade, maintain and ensure that no ponding from drainage systems occurs.

Initial Environmental Examination

May 2016

VIE: Greater Mekong Subregion Health Security Project

Prepared by Conseil Santé for the Ministry of Health and the Asian Development Bank.

CURRENCY EQUIVALENTS
(as of March 2016)

Currency Unit	–	Vietnamese dong (VND)
$1.00	=	22,330 VND

NOTE

In this report, "$" refers to US dollars.

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ABBREVIATIONS

ADB	–	Asian Development Bank
AIDS	–	Acquired Immune Deficiency Syndrome
APSED	–	Asia Pacific Strategy for Emerging Diseases
BOD	–	Biological oxygen demand
CDC	–	Communicable Diseases Control
CHS	–	Commune Health Station
CLMV	–	Cambodia, Lao PDR, Myanmar and Viet Nam
COD	–	Chemical oxygen demand
CPC	–	Commune Peoples Committee
CPMU	–	Central Project Management Unit
DHIS	–	District Health Information system
DOH	–	Department of Health
DONRE	–	Department of Natural Resources and Environment
DPC	–	District Peoples Committee
EA	–	Environmental assessment
EARF	–	Environmental Assessment and Review Framework
EARP	–	Environmental Assessment and Review Procedures
EHF	–	Ebola Hemorrhagic Fever
EIA	–	Environmental Impact Assessment
EIAR	–	Environmental Impact Assessment Report
EID	–	Emerging Infectious Diseases
EMP	–	Environmental Management Plan
GDPM	–	General Department of Preventive Medicine (MOH Viet Nam)
GOV	–	Government of Viet Nam
GMS	–	Greater Mekong Subregion
HAI	–	Hospital acquired Infection
HCWM	–	Health Care Waste Management
HMIS	–	Health Management Information System
HIV	–	Human Immunodeficiency Virus
IA	–	Implementing Agency
ICP	–	Intercommunal Polyclinic
IEE	–	Initial Environmental Examination
IHR	–	International Health Regulations
INGO	–	International non-government organization
IOM	–	International Organization for Migration
IP	–	Indigenous peoples
IPC	–	Infection Prevention and Control
ISWM	–	Integrated Solid Waste Management
MERS	–	Middle East Respiratory Syndrome
MEVs	–	Migrants and mobile populations, ethnic minorities, and other vulnerable group
MMPs	–	Migrant and mobile populations
MOH	–	Ministry of Health
MONRE	–	Ministry of Natural Resources and Environment
MPI	–	Ministry of Planning and Investment
NGO	–	Non-government organization
PAH	–	Project affected household
PAM	–	Project Administration Manual
PM	–	Particulate matter

PMU	–	Project Management Unit (Central)
PPC	–	Province Peoples Committee
PPE	–	Personal Protective Equipment
PPMC	–	Provincial Preventive Medicine Center
PPMU	–	Provincial Project Management Unit
PPTA	–	Project Preparatory Technical Assistance
Project	–	The Greater Mekong Subregion Health Security Project
REA	–	Rapid Environmental Assessment
SWM	–	Solid Waste Management
TCVN	–	Vietnamese environmental quality standards
VHW	–	Village Health Worker
WB	–	World Bank
WHO	–	World Health Organization
WHS	–	World Heritage Site
WWTP	–	Wastewater treatment plant

I. INTRODUCTION

A. Project Rationale

1. The Greater Mekong Subregion (GMS) comprises Cambodia, China (Yunnan and Guangxi), Laos, Myanmar, Thailand, and Viet Nam, with a population of about 326 million people. The region has gone through rapid economic development, with overall GDP growth of 5-10% per year during the past decade. The major demographic, economic and technological differences among the GMS countries, combined with improved connectivity and trade facilitation, bring about substantial business dynamics. Regional investments have increased rapidly, stimulated by regional security, low cost labor, and improved connectivity. Better roads, ports and trade agreements facilitate participation in the global market. Regional tourism has also increased dramatically. GMS Countries are industrializing rapidly, resulting in a rapid increase in migrant workers, mostly internally, but also externally. Urbanization is increasing rapidly, and creating new challenges that require major investments. This has also increased the risk of the spread of communicable diseases associated with increased connectivity, employment, and social and physical living environment.

2. Under the GMS economic development program, the Governments of Viet Nam (GOV), Cambodia, Lao PDR and Myanmar, and the Asian Development Bank (ADB) are working together to improve prevention and control of emerging infectious diseases and other diseases of regional importance in the GMS. A GMS Health Security Project (the Project) of $135 million has been proposed for 2016, with two thirds of the funding to be provided from the ADB regional fund. The Project follows other health projects for communicable diseases control (CDC), HIV, Malaria, and related regional technical assistance such as for e-Health.[1]

B. Purpose and Structure of the Report

3. The project is categorized as a Category B project in accordance with ADB's *Environment Policy*. The Initial Environmental Examination (IEE) presented in this report is to comply with the requirements of ADB in relation to environmental assessment of ADB financed projects. In particular, the IEE has been prepared to fulfill the requirements of the ADB's *Environmental Policy* and *Operations Manual (OM) 20: Environmental Considerations in ADB Operations*. The IEE is based on a selection of representative provinces based on ADB's *Environmental Assessment Guidelines* (2003).[2]

4. The following methodology has been implemented in the preparation of the IEE:

(i) Review of project-related documents and literature relevant to the project areas initially surveyed
(ii) Site visits to view the environmental conditions in representative project areas and the general location of the projects
(iii) Consultation with local and national authorities to source information on project area characteristics and potential project impacts
(iv) Identification of existing environmental and socio-economic characteristics to develop project baseline data

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[1] Including Community Action for HIV Prevention in 2001; GMS Regional Communicable Diseases Control Project in 2004; Second GMS Communicable Diseases Control Project in 2010; GMS Capacity Building for HIV/AIDS Prevention Project in 2012; Japan Fund for Poverty Reduction projects such as for Model Healthy Village; and technical assistance for malaria and dengue control, health education, e-Health, and related areas.

[2] ADB. 2003. *Environmental Assessment Guidelines.* Manila.

(v) Analysis of typical environmental impacts of project components and identification of suitable typical mitigation measures to ameliorate potential impacts
(vi) Development of institutional arrangements for implementation of environmental management and monitoring
(vii) Development of a set of environmental criteria for future project activity selection
(viii) Development of environmental assessment and review procedures (EARPs) for future project sub-components.

II. DESCRIPTION OF THE PROJECT

A. Project Rationale

5. The Government of Viet Nam aims to achieve core capacities for the control of emerging infectious diseases (EIDs) and other major public health threats based on international standards of the World Health Organization (WHO) especially at the border areas. Cambodia, aiming to comply with WHO standards to achieve GMS health security, has requested ADB project support to address critical gaps in core capacities. MOH and WHO have conducted evaluation of Asia Pacific Strategy for Emerging Diseases (APSED) implementation in 2014. Viet Nam has not yet achieved International Health Regulations (IHR) and APSED targets. Core functions owned by MOH are well in place, but other functions depending more on collaboration with other countries, sectors, partners, community, and the private sector are less advanced. The recent MERS and Ebola outbreaks, and the Zika virus scare have put re-emerging infection diseases (EIDs) back in the limelight. While progress in other regional priorities is mixed, there is major progress in the control of malaria and dengue, and less progress in the control of HIV/AIDS and tuberculosis and the major emerging concerns of nosocomial infections and multiple drug resistance.

B. Project Design

6. The project goal is to strengthen the GMS health security, with the following indicators: (i) zero major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased treatment of vulnerable groups for communicable diseases. The proposed project outcomes are: (i) improved coverage of GMS public health security system and compliance with IHR/APSED; and (ii) CDC coverage increased in vulnerable groups in CLMV border areas, in particular for migrants, ethnic minorities, and other vulnerable groups (MEVs) as prioritized by the Governments. The proposed project outputs are: (i) increased GMS collaboration and MEV access to CDC in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases.

7. In Viet Nam, the proposed project amount is $84 million to be financed by an Asian Development Fund (ADF) loan of $80 million and $4 million (5%) in Government counterpart funds. The General Department of Preventive Medicine (GDPM) represents MOH as the Executing Agency in collaboration with the Ministry of Planning and Investment (MPI), Ministry of Finance (MOF) and the State Bank of Viet Nam (SBV). In summary, the GOV will use the loan to finance hardware (laboratory equipment, computers, transport and other auxiliary devices, and use government resources to finance software (training and workshops).

1. Regional Cooperation and CDC in border areas

8. Regional cooperation is mainly in the form of information exchange and joint outbreak responses. While national level information exchange is affected by lack of leadership, cross-border cooperation is gaining momentum.

9. Sub-groups of MEVs in border areas have unique risk of exposure to particular diseases. The risks may vary by occupation and location. However, there are particular concerns for cross-border migrant workers returning home with HIV or TB, who may not have access to care on their return. HIV-infected youths and pregnant mothers also may have limited access to services and care. The project will explore new strategies for reaching MEVs and for timely reporting of patients with certain symptoms from remote communities using syndromic surveillance.

2. Surveillance and Response

10. Several disease reporting systems are in place which are not linked, do not reach communities, and do not provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, thereby also limiting the efforts to improve disease control and community prevention and preparedness. In addition, through workshops and other knowledge management activities, specific strategies for disease control and system strengthening will be developed. Workshops will be comprised of carefully prepared participatory learning and strategic planning events with monitoring of follow up actions by the regional coordination unit. Through bilateral agreements with the neighboring border countries, the Project will explore strategies to reach various MEVs who are more likely to be exposed to different types of diseases.

3. Laboratory services and Hospital Infection Prevention and Control

11. The Joint Annual Health Reviews have found that “The network of preventive medicine facilities at Provincial and District levels is fragmented and lacks linkages for management and provision of services.” Many laboratories were built before Viet Nam had engaged in a systematic manner with international standards of biosafety and quality and so require a significant investment in order to meet IHR and APSED requirements. The tests performed at each laboratory are determined, largely, by the ability of patients to pay for a diagnostic test, not by personal need or public health relevance. Diagnostic testing is not guided by systematic Quality processes. Two additional biosafety issues that require attention are laboratory laundry services and waste disposal. The undergraduate training of medical laboratory staff is not well aligned with the tasks they are required to perform in the workplace. In-service training in the workplace is ad hoc. There is no formal process for internal and external quality assurance and for auditing of diagnostic laboratories for compliance with quality and safety guidelines. CDC II provided key equipment to a number of Provincial laboratories to enable them to undertake communicable disease diagnostic activities safely and reliably. It is important to provide the consumable items that will enable fuller use of these earlier investments in equipment.

12. Hospital and health centers are the most likely point of contact for any emerging disease, and also pose a major concern in terms of spreading these diseases. In addition, health facilities are a source of nosocomial infections and drug resistance. Current equipment and practices in health facilities for infection prevention and control are unsafe and waste

disposal would not meet IHR or APSED obligations. Viet Nam MOH, with support of WHO, is rolling out an IPC program and the World Bank provides support for waste management infrastructure.

C. Project Location

13. As planned, the scope of the GMS Health Security Project will cover 250 districts (including the border districts along Vietnam's border with China, Lao PDR and Cambodia and some districts along the economic corridors) of 36 targeted provinces.[3] Vietnam is composed of 63 administrative units at provincial level (provinces and cities under the central government). The areas covered by the proposed project account for more than a half of the provincial administrative units (more than 60%) and are located in the major geographic regions of the country. For purposes of this IEE and because of the time constraints, three (3) typical provinces representing the northern, central and southern provinces within the scope of the project have been surveyed as indicative and representative of the extent of environmental impact assessment and review that shall have to be performed for the other remaining provinces and districts in accordance with ADB guidelines as the project progresses.

D. Project Outputs

Output 1: Strengthening regional, cross-border, and inter-sectoral CDC

14. MOH has made progress with regional information sharing and cross-border cooperation for CDC. However, this is still in a nascent stage. In addition, some groups of MEVs that are more likely to get and spread infectious diseases are not using regular health services. Under this component, it is proposed that the Project: (i) supports regional, cross-border, and inter-sectoral information sharing and coordination of outbreak control among GMS countries; (ii) develops better disease control strategies, (iii) develops regional capacity for evidence-based CDC; and (iv) improves CDC for MEVs along borders and economic corridors in targeted border provinces. Support is needed for information exchange, use of best practices, joint outbreak control, and engaging MEVs to contain the spread of diseases.

Output 2: Strengthening national disease surveillance and outbreak response

15. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, Malaria and Tuberculosis is strong. However, the system needs to be more computerized and extended to reach all health centers and communities by employing syndromic reporting. Linkages or integration among surveillance systems with HMIS/DHIS should also be considered. MOH also needs to improve capacity for disease outbreak responses at central, provincial, and district levels. Under this component, it is proposed that the Project supports (i) syndromic reporting at community level; (ii) web-based reporting including information technology support; (iii) integration of surveillance, HMIS and registration systems, including linking clinical and laboratory surveillance; (iv) risk analysis, communication, and community preparedness; (v) improving capacity of outbreak response teams including transport; and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

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[3] Source: Project Detailed outline for the GMS Health Security Project in Viet Nam – MOH, Oct. 2015 (with figures updated during PPTA).

Output 3: Improving laboratory services and hospital infection prevention and control

16. District facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial or hospital-acquired infections (HAIs) are becoming a major public health problem. Under this component, it is proposed that the Project supports: (i) pre-and in-service training; (ii) district laboratory services; (ii) internal and external quality assurance and assessment for compliance with national safety and quality guidelines; and (iv) provide laboratory equipment and training for infection prevention and control, including laundry services and waste disposal, and case management of dangerous diseases.

E. Project Outputs of Environmental Concern

17. The requirement for an environmental impact assessment is linked to the following Project Subcomponents: (1) Sub-component 2-5, Component 2, **Output 2** and (2) Sub-component 3-4, Component 3, **Output 3** of the above project summary, namely:

Sub-Component 2-5:	**improve capacity of outbreak response teams including transport**
Sub-Component 3-4	**provide laboratory equipment and training for infection prevention and control, including laundry services and waste disposal**

18. The above sub-components will require screening of potential environmental impacts and a discussion of mitigating or enhancement measures as a result of the impacts because the activities involve public health risks and potential accidents, minor repair and improvement works, the installation and commissioning of laboratory equipment and related devices, and the operation of the target provincial/district hospitals' existing medical waste management and waste water treatment facilities – all of which impact the project's environmental setting and require environmental safeguards.

19. The screening addresses the potential impacts of the relevant project activities under the loan program, which are re-defined for purposes of the IEE, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; (iii) operation of the existing solid waste management facilities and (iv) operation of the existing wastewater treatment facilities described as follows:

Project Activity 1 – Minor repair and improvement works. This activity includes the minor repair and improvement works of the hospital facilities specifically affected by the provision of access, accommodation, modification and installation of new or upgraded laboratory equipment and auxiliary devices, IPC equipment and devices including laundry equipment, computer systems, etc.

Project Activity 2 – Laboratory equipment commissioning including IPC services. This activity includes the mobilization, equipment installation, commissioning, demobilization, recurrent maintenance checks by the suppliers/contractors, and the operation from installation and during the life of the equipment. The equipment means

the totality of the laboratory equipment, auxiliary equipment, laundry and washing/drying equipment, and relevant IPC devices and supplies, laundry equipment including the transport vehicles for the transport of laboratory specimen procured under the Project.

Project Activity 3 - Solid Waste Management facilities. The collective activity assumes existing activities that include: (1) the storage and segregation (as applicable) of medical infectious/hazardous and non-infectious/non-hazardous wastes; (2) collection and transfer for disposal or recycling (as applicable); (3) internal and external transportation of medical waste; recycling or composting of non-hazardous wastes; and (4) disposal at: (i) an approved and dedicated disposal facility such as a provincial hospital; (ii) permanent burial in specially designed, secure landfills which will incorporate lining and leachate management systems; (iii) sterilization using either chemicals or steam; and (iv) incineration using an approved incinerator designed to mitigate hazardous emissions. The operational activities will vary according to the type of facility but will include receipt of waste, burial of waste, burning of waste, general site maintenance, and odor and vermin control.

Project Activity 4 - Wastewater treatment facilities. The collective activity assumes the existing operations of wastewater treatment facilities that are installed at the target hospital facilities to treat effluent to meet relevant TCVN standards prior to discharge to waterways or municipal wastewater systems. The scale of operation activities will vary according to the type of facility but includes wastewater treatment process control, site maintenance, and odor control.

20. Since the project does not involve civil works construction, the stages of the project cycle during which screening is to be conducted and into which the temporal boundaries of the activities have been divided are: the **pre-procurement stage**, the **procurement (including the commissioning) stage**, and the **operation stage** from the viewpoint of the hospital facilities.

21. The Project will finance the procurement of laboratory equipment and supplies, transport vehicles, laundry and other infection prevention and control equipment, computer systems and devices for the newly-improved hospitals and other institutions identified by provincial authorities serving as the target populations. A total of 32 target provinces will comprise the beneficiaries of the project. Equipment purchases will be in accordance with established MOH standards and will replace old and non-functioning equipment, upgrade technology for existing procedures, or provide new services. The Project will also support the purchase of an initial inventory of reagents and other supplies needed to properly utilize the new equipment. Procurement and supply of equipment will be closely coordinated with the other components of the project implementation.

22. Once completed, the newly improved and renovated laboratory facilities and supplies, IPC equipment and related devices, computers and related systems, and transport vehicles that are part of the Project need to be properly maintained to realize benefits and justify investments. The Project will ensure that hospital personnel are properly trained to use the equipment and operating manuals are supplied in Vietnamese. The GOV shall support the preparation of guidelines for preventive maintenance and training of hospital personnel in preventive maintenance procedures.

23. The Government has also assured that the supplies needed to operate the equipment, as well as the costs of maintenance will be provided during and beyond the project period through recurrent costs and adequate increases in operation and maintenance budgets.

24. Moreover, while this project does not include civil works and medical waste management and waste water treatment equipment, the investments will be made with the assurance from GOV that all facilities included in this Project have adequate safe water, sanitation, and medical waste management systems, including waste water systems, proper containers to segregate contaminated and hazardous waste, proper collection and storage facilities, and access to modern medical waste incineration and/or disposal facilities in compliance with the safeguards policy of the ADB. It is incumbent upon the GOV that hospital personnel in all facilities covered by the project will be trained in the theory, methodologies, and supervision of modern medical waste and waste water management practices. In addition, the Project will support consulting assistance to work with authorities in each target province to develop a province-wide plan for the management of medical waste.

F. Project Category

25. The project is initially categorized as B for environment based on ADB's *Safeguard Policy Statement* (2009) as it involves laboratory bio-hazards and hospital solid and liquid waste management. An IEE based on a detailed survey of 7 district hospitals purposively sampled in 3 northern, central and southern border provinces, and earlier surveys of 2 other provincial/district hospitals is being prepared to be representative for the project. The surveys examined the current design standards in hospital safety and sanitation, laboratory biohazard management, infection prevention and control, and medical and liquid waste management in the region, and established current state of compliance by the hospitals to verify Category B. Each of the participating provinces will prepare EMPs covering all project activities during implementation and in accordance with the environmental laws of Viet Nam.

III. DESCRIPTION OF THE ENVIRONMENT

A. Physical Resources

26. Viet Nam is composed of 63 administrative units at provincial level (provinces and cities under the central government). The areas covered by the proposed project account for more than a half of the provincial administrative units (more than 60%) and are located in the major geographic regions of the country. The descriptions of the physical resources below illustrate how the remaining participating provinces would be described in terms of the existing environmental conditions that will be impacted within the scope of the project.

1. Topography and Soils

27. **Dien Bien province**. Dien Bien province has 10 district administrative units (including 1 city, 1 town and 8 districts) and shares a border with both China (38.5 km) and Lao DPR (360 km). Topographic features are complex with deep ravines and large ridge slopes of 30-35 degrees accounting for about 70% of the natural area. There are 4 main types of terrain in Dien Bien: high and moderate mountains, low mountains, plateau mountains; and plains among mountains.

28. **Nghe An province**. Nghe An province has 10 district administrative units (including 1 city, 3 towns and 17 districts) and shares a border with Lao DPR with a total length of 419 km. In general, the terrain is tilted from the Northwest – Southeast with three terrain morphologies: the mountains, midlands and coastal plains, of which mountainous area accounts for about 83% of natural area with terrain slope of more than 8 degrees.

29. **Tay Ninh province**. Tay Ninh province has 9 district administrative units and shares a border with Cambodia with a total length of 220 km. Tay Ninh province is located in the transition zone between the hills of South Central Highlands and the Mekong Delta region, therefore the terrain has both the characteristics of plain terrain and mountainous terrain.

2. Climate and Air Quality

30. Dien Bien and Nghe An provinces have tropical monsoon climates with a cold winter. The climate is divided into two seasons: hot summer and cold winter. Tay Ninh province has tropical monsoon climate but without a cold winter. The year is divided into two seasons: the dry season from November to April and rainy season from May to October. In the sampled provinces, surface waters in rivers and springs is plentiful during the rainy season while during the dry season, the flow is significantly reduced.

3. Drainage Network and Surface Water and Groundwater Quality

31. Monitoring of surface water quality has been carried out in extensive ways in the sampled provinces with 35 regular monitoring points (Dien Bien: 13, Nghe An: 7, and Tay Ninh: 15) on the main river systems. Monitoring results during the period from 2010 to 2014 in the sampled provinces indicated that the surface water quality of rivers is generally good, especially in the upstream reaches.

4. Water Resources

32. At all the sampled provinces groundwater is plentiful. Monitoring of ground water quality has been carried out in extensive ways in the sampled provinces with 37 regular monitoring points (Dien Bien: 9, Nghe An: 13 and Tay Ninh: 15). Monitoring results during the period from 2010 to 2013 in the sampled provinces indicated that the ground water quality is generally good, except Coliform indicators in Tay Ninh (1 point) and Nghe An (1 point) exceeding the standards (compared to QCVN 09: 2018/BTNMT - National Technical Regulation on ground water quality).

B. Ecological Resources

33. Forest cover in the sampled provinces of the project area ranges from 36.6% of total land area in Dien Bien province to 58.44% in Nghe An province. There are three main ecoregions present in the project area.[4]

C. Economic Development

1. Economic Structure

34. During the period from 2010 to 2015, the provincial economy had a growth rate from 5.82% to 10.5% per year, of which the annual average is: Dien Bien province - 6.25%; Nghe An province – 5.82%, and Tay Ninh province - 10.5%. At present, the regional economy is still based on agriculture, forestry and fisheries with these sectors accounting for approximately 70% of gross domestic product (GDP). However, the economic structure is gradually changing with an increase in the economic contribution of the service and industry/construction sectors.

[4] As defined by Wikramanayake *et al*, 2002 in World Bank. 2005. *Vietnam Environment Monitor 2005 – Biodiversity.* Hanoi.

D. Social and Cultural Resources

1. Administrative Areas

35. Administrative areas in the selected project area are identified in Table 3.8.

Table 3.8: Administrative Units in Project Provinces

	Cities under provinces	Urban districts	Towns	Rural districts	Precincts	Town under districts	Communes
Dien Bien	1	–	1	8	9	5	116
Nghe An	1	–	3	17	32	17	341
Tay Ninh	1	–	–	8	7	8	80

Source: Provincial Statistical Yearbooks, 2014.

2. Population and Community Structure

36. In 2014, the total population of the sampled provinces is approximately 4.7 million (Dien Bien province: 534,772; Nghe An province: 3,037,440; and Tay Ninh province: 1,095,583), representing about 5.2% of the national population. The average population density is about 156 people/km^2 (Dien Bien: 55.9 people/km^2; Nghe An: 184.2 people/km^2; and Tay Ninh: 271.5 people/km^2). More than 4 million people, representing 85.2% of total population, live in rural areas.

37. There are 42 ethnic groups living in the sampled provinces, of which the Kinh ethnic group represents 79.8% of the total population.

Table 3.9: Population Structure in Project Area

Provinces	Population	% Ethnic Minorities	% Rural Population
Dien Bien	534,772	82.3	97
Nghe An	3,037,400	15.2	17.5
Tay Ninh	1,095,583	1.69	2.04

Source: Provincial Statistical Yearbooks, 2014.

3. Socio-Economic Conditions

38. The UNDP has identified a Human Development Index (HDI) for the provinces in Viet Nam.[5] The HDI is representative of a number of socio-economic development characteristics and factors such as illiteracy, poverty, access to infrastructure and services, child mortality, and life expectancy. A score of 1 for each factor is the best performance and the closer a score is to 0, the poorer the performance has been for that factor. The scores are then combined to reach an overall HDI score.

39. Provinces in Viet Nam have been ranked, based on their composite HDI score, from 1 (the province that performs best over the range of factors) to 61 (the province that performs worst over the range of factors).[6]

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[5] UNDP. 2003. *Vietnam National Development Report*. Hanoi.

[6] The report and HDI ranking was published prior to the creation of three new provinces.

Table 3.10: Human Development Index in Selected Provinces within the Project Area

Province	HDI Score	HDI Ranking in Viet Nam[7]	Adult illiteracy (%)	Pop without access to safe water (%)	Pop without access to sanitation (%)
Dien Bien	0.600	61	n/a	29.7	68.6
Nghe An	0.700	39	7.1	25.2	46.2
Tay Ninh	0.721	21	11.1	14.2	41.5

Sources: UNDP, Vietnam Human Development Report, 2011 and Provincial socio-economic reports, 2014.

4. Poverty

40. Table 3.11 summarizes available data on poverty levels in the selected provinces.

Table 3.11: Poverty in Selected Provinces of the Project Area

Province	Total poverty rate (%)	Urban poverty rate (%)	Rural poverty rate (%)
Dien Bien	28.2	89.9	10.1
Nghe An	10.28	82.6	17.4
Tay Ninh	1.98	91.3	8.7

Source: ADB, 2006.

41. The following comments on poverty in the project provinces can be made:

(i) Poverty is largely a rural phenomenon. Throughout the area, rural poverty rates are higher than urban poverty rates. Poverty tends to be higher in remote rural areas without access to transport infrastructure and other services. Landless and land-poor households also tend to suffer greater poverty incidence.

(ii) In many of the project provinces there are numerous households living just above the poverty line. These households do not exhibit characteristics in their daily living that are significantly different from poor households and they have a greater risk of falling back below the poverty line.

5. Public Health

Disease Type and Incidence

42. Table 3.12 summarizes incidence of infant mortality and indicator diseases in the project area.

Table 3.12: Health Indicators in Selected Provinces

	Infant Mortality Rate (%)	Malaria Cases (per 100,000 people)	Tuberculosis Cases (per 100,000 people)	HIV Cases (per 100,000 people)
Dien Bien	n.d.	45	183	26
Nghe An	n.d.	94.8	113	2
Tay Ninh	n.d.	454	97	1

Source: UNDP, 2006.

[7] Presents a ranking from a total of 63 cities/provinces.

7. Health Care Facilities and Access

43. Table 3.13 summarizes the health care facilities managed by the provincial Department of Health in the project area.

Table 3.13: Health Establishments under Department of Health in Selected Provinces

	Total	Hospital	Regional polyclinic	Sanatorium and rehabilitation hospital	Medical service unit
Dien Bien	169	21	17	1	130
Nghe An	553	72	---	1	480
Tay Ninh	107	13	---	1	93

Source: Provincial DOH's reports, 2015.

E. Reference Baseline Data for Health Care Waste Management in Viet Nam[8]

44. A key component of the project is the improvement of health care waste management practices in the targeted provincial and district hospitals in project areas within the scope of the GMS Health Security Project. The results of a review of existing health care waste management practices in other projects funded by ADB in Viet Nam are summarized below. These practices – described below – were observed in the southern central coastal region of Viet Nam but can serve as reference data for the environmental assessment of other applicable Project Sub-components in the GMS Health Security Project particularly in the southern provinces of Viet Nam. Specific baseline data of environmental conditions of the sampled provinces is described in Section IV. Some of the practices are described where applicable in the provinces surveyed for the Project.

1. Healthcare waste generation

45. Healthcare waste (HCW) generated from hospitals includes both non-hazardous waste and hazardous waste. About 75% of the waste produced by health-care providers is non-risk or general healthcare waste, which is comparable to domestic waste. The remaining 25% of healthcare waste is regarded as hazardous and may create a variety of health risks. Hazardous healthcare waste can be classified into the following categories: infectious waste, highly infectious waste, sharps, pathological/anatomical waste, pharmaceutical waste, genotoxic waste, chemical waste, waste with high content of heavy metals, pressurized containers, and radioactive waste.

46. The amount of HCW generated depends on the hospital size and its scope of services. According to surveys on HCW management conducted by MOH and WHO, a provincial general hospital typically generates 0.64 kg/bed/day of general HCW and 0.14 kg/bed/day of hazardous HCW, while a district hospital typically generates 0.62 kg/bed/day of general HCW and 0.11 kg/bed/day of hazardous HCW. In terms of the relative proportion of hazardous waste generated, infectious waste and pathological waste represent about 15%, sharps represent about 1%, chemical and pharmaceutical waste represent about 3%, other waste such as waste with high content of heavy metals, and pressurized containers represent about 1%. Several provincial general hospitals in the southern central coastal region of Vietnam that provide cancer diagnosis treatment also generate significant amounts of genotoxic waste and radioactive waste.

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[8] Source: ADB IEE Report for Health Care in the South Central Coast Region of Viet Nam, 2008.

2. Healthcare waste minimization

47. Waste minimization is defined as the prevention of waste production and/or its reduction is not regular practiced by healthcare establishments in the region. Minimization measures such as source reduction (modification of purchasing procedures, control of inventory, and production of less toxic materials), good management and control practices applied particularly to the purchase and use of chemicals and pharmaceuticals, and using of recyclable materials are not typically implemented.

48. Healthcare waste contains quantities of valuable and recyclable materials such as plastic, metals, paper and carton. However, waste recycling is not centrally implemented at hospital level despite the fact that it is carried out unofficially at the departmental level.

3. Healthcare waste segregation

49. According to Vietnamese regulations, all HCW generators are responsible for segregating waste into three separate bags: general waste in green bag, clinical waste in yellow bag, and toxic waste in black bag. Sharps are segregated into rigid containers with certain specifications. Almost all the hospitals in the region have introduced this segregation system for many years. Hazardous waste is therefore basically separated from non-hazardous waste at the source. However, there are still some limitations reported, as follows:

(i) Knowledge, attitude and practices among waste generators including hospital staff, patients and visitors are unsatisfactory
(ii) Supply of equipment for waste segregation, especially sharp containers is insufficient in rural areas

4. Healthcare waste collection

50. Orderlies or cleaners are responsible for collecting healthcare waste from the generation point to interim storage points in the departments. Some weaknesses in collection have been observed in the region as follows:

(i) Provision of equipment, waste containers in different sizes are not sufficient
(ii) Design of hazardous waste containers do not meet requirements
(iii) Codification and labeling, waste bags and containers, especially those for clinical waste and chemical waste are not properly color-coded and labeled

5. Healthcare waste transportation

51. Orderlies or environmental workers who are working in the infection control department or administrative departments are responsible for internal transportation. Except for some provincial general hospitals which have better resource, most of the hospitals visited lack specialized devices for waste transportation. Hazardous waste is often transported by hand causing spillage and spread of disease throughout the hospital. Internal transportation plans in which the timetable and route of transportation are clearly identified are not available.

52. Almost all hospitals sign contracts with local environmental companies (URENCOs) to transport general waste out of the hospitals to the landfills. For the hospitals without onsite waste treatment facility, clinical waste is transported out of the hospital too. Specialized transportation

vehicles are available. However, control systems with consignment note to accompany the waste from its place of production to the site of final disposal is not established.

6. Healthcare waste storage

53. All of the visited hospitals have a designated place to store healthcare waste. However, most storage, especially storage of hospitals at district level and in rural areas, do not meet design and operating regulations because of the following shortcomings:

(i) Storage do not incorporate separate places for different categories of healthcare waste. As a result, general waste and clinical waste that were segregated at sources and separately collected and transported are mixed again at storage places. Chemical waste is not collected and centrally stored.
(ii) Storage do not have roofs and locks. Unauthorized people, animals, rodents and inserts can easily access hazardous waste causing risks of spillage and disease spread.
(iii) Storage do not have electricity and/or water supply meaning that the operation, cleaning and maintenance of storage and transportation equipment are more difficult. It is reported that people living or working nearby have often complained about odors and emission from the poorly maintained storages.
(iv) Storage duration often exceeds 24 hours in hot weather.

7. Healthcare waste treatment

54. There are two models of healthcare waste treatment in the region, the centralized model and decentralized model:

(i) Centralized model: treatment facilities are often located in big hospitals and serve several hospitals in the vicinity. This model has been established in the urban areas of Nghe An and Tay Ninh provinces.
(ii) Decentralized model: the treatment facility is located in hospital and serves only one hospital. This model is popular in Dien Bien province.

55. Healthcare waste treatment technologies applied in the region are (i) medium temperature incineration, (ii) low temperature incineration, (iii) waste burial, (iv) stream autoclave, (v) chemical disinfection, describes as follows:

(i) Medium temperature incineration: Pyrolytic incinerators that incinerate waste at 800 – 900°C appear in provincial level hospitals in urban areas and often serve several hospitals. The provinces surveyed have one or two pyrolytic incinerators located in the center of the province. They are all old incinerators and have been poorly maintained. The emissions from incinerators have been monitored but not regularly as required. Polluting gas emissions and high operating costs have been reported.
(ii) Low temperature incineration: Drum incinerators, brick incinerator or one-chamber incinerators are still common in district hospitals in Dien Bien even though their design is out of date. Because of low effectiveness and high environmental impacts, such incinerators are no longer recommended.
(iii) Waste burial: District hospitals and health centers in rural areas often bury healthcare waste on their premises. Safe burial of healthcare waste is recommended by WHO. However, in comparison with requirements of a sanitary

landfill, the bury pits observed in hospitals often have the following shortcomings: (i) inadequate sealing of base and sides to minimize the movement of wastewater or leachate off site, (ii) no presence of site personnel capable of effective control of daily operations, (iii) no surface water collection, (iv) access to site and working areas difficult for waste delivery and site vehicles, (v) lack of surface water collection trenches around site boundaries, (vi) lack of a final cover to minimize rainwater infiltration when each phase of the landfill is completed.

(iv) Wet thermal disinfection: Stream autoclaves are commonly used by hospitals to primarily treat highly infectious waste. Although wet thermal disinfection has been introduced in Vietnam at present application of autoclave for healthcare waste treatment is still limited to microbiological laboratories where highly infectious waste is mostly generated. This type of equipment is limited only to some provincial hospitals.

(v) Chemical disinfection: Using disinfectants to treat contaminated materials is very common in provincial and district hospital throughout the region. However, application of chemical disinfection for healthcare waste treatment, particularly for highly infectious waste treatment is still limited to microbiological laboratories and in areas of infectious disease outbreaks.

8. Wastewater collection and treatment

56. Hospital wastewater includes rainwater, wastewater generated from healthcare activities and wastewater from toilets. Old hospitals often have a collection system for storm water, a collection system and septic tanks for wastewater from toilets but no separate collection line and treatment plant for wastewater generated from healthcare activities. As a consequence, wastewater from healthcare activities with a high content of pathogens and certain amount of pharmaceuticals and chemicals is discharged into the storm water system line or discharged onto the land without any treatment. This was observed in some district hospitals where the laboratory staff often discharge liquid waste directly into the wastewater collection systems. This practice can harm the wastewater treatment plant. Often there are blockages of the wastewater collection system as regular and corrective maintenance of wastewater collection system are not routinely carried out.

IV. DESCRIPTION OF THE EXISTING SITUATION (BASELINE DATA)

A. Dien Bien Province

57. Based on the organizational structure of Dien Bien province, the Provincial Preventive Medicine Centre is an independent unit under DOH and perform professional tasks of preventive medicine and disease prevention. However, at the district level, the district hospitals and district preventive medicine centres are combined into a single unit called “The District Health Centre”. The District Health Centre functions both as a treatment and preventive medicine centre. The Consultant and MOH team visited two district hospitals: (i) Dien Bien District Hospital and (ii) Muong Cha District Hospital. Alternatively, the Consultant also visited the Sa Long Communal Healthcare Station where the hazardous waste of the Muong Cha district hospital was burned using a hand-made incinerator.

1. Overall situation in Dien Bien province

58. The healthcare system includes 162 treatment facilities at all levels, of which there are 5

Provincial Hospitals, 1 Leprosy Treatment Centre, 17 Regional Polyclinics and 9 District Health Centres at district-level, and 130 Commune Health Stations (CHS) at commune-level.

a. Current status of medical waste management

59. Medical solid waste separation at source was implemented well at most health facilities according to the regulation of the DOH in Decision No. 43/2007/QD-BYT on promulgating regulations on medical waste management dated 30 November 2007[9]. The total amount of the medical waste generated from the health facilities is estimated at 3,000 kg/day, of which 300 kg of hazardous medical wastes need to be treated by the appropriate measures in compliance with current regulations. Most non-hazardous medical wastes are collected and treated by the local utility company. In some health facilities not serviced by the local utility company, non-hazardous medical wastes are collected by the staff and burned at a separate area within their own grounds. Hazardous medical wastes are collected and stored in prescribed standardized containers. For the health facilities that do not have incinerators, the MONRE requires hazardous medical wastes to be transported to other locations for burning. However, this requirement is not met by most of the health care facilities due to the lack of specialized transport vehicles. Only 50% (7 out of 14 hospitals) in Dien Bien, including 5 provincial hospitals and 2 district hospitals have incinerators (6 incinerators with one or double chambers, and 1 handmade-incinerator at Muong Lay Regional Hospital). Of the 7 remaining hospitals without incinerators, 4 hospitals disposed of their hazardous medical solid waste by burial in concrete pits while the 3 remaining hospitals transported their hazardous medical solid waste to other health centres for treatment. All 17 regional polyclinics have no incinerators for treatment of hazardous medical wastes. Only 8 of the 17 polyclinics have concrete pits for burying sharps and needle sticks. Ninety-five (95) of the 130 CHS (about 73%) have no concrete pits for burying sharps as required.

60. Medical wastewater generated from the health facilities is estimated at 1,300 m^3/day, including about 350 m^3 of hazardous medical wastewater that needs to be treated properly before being discharged into the environment. There are 9 out of 14 hospitals that have wastewater treatment systems. Five (5) remaining hospitals and 17 regional polyclinics have clarifier tanks for hazardous wastewater treatment. All of 130 CHSs have no system for medical wastewater treatment as required. Medical wastewater at these stations are only treated simply by mixing Chloramine B before being discharged into the environment.

b. Current status of preventive medicine system within province

61. The preventive medicine system includes 10 provincial specialized centres (Preventive Medicine; Reproductive Health; Prevention of malaria, parasites; Social diseases prevention; HIV/AIDS prevention; Endocrine; Drugs, cosmetics and food testing; Forensic Medicine; Medical evaluation; and Health communication and education). At the district level, according to the institutional structure, the preventive medicine section is a faculty of the 9 district health centres. This section is responsible for carrying out both the preventive medicine and reproductive health activities.

[9] This Decision will be replaced by a joint circular No. 58/2015/TTLT-BYT-BTNMT regulations on medical waste management from 01 April 2016.

c. Current status of infectious disease prevention activities within province

62. In 2015, Dien Bien province recorded two epidemics (chicken pox and Hepatitis A) with a total of 178 cases at Nam Po district and Dien Bien Phu City. Control measures including verification, diagnosis and treatment were carried in a timely manner to isolate the disease outbreak. The measures to ensure hygiene, infection control, protection of water resources and provision of information on the knowledge about the disease and methods of disease prevention were also disseminated effectively. Alternatively, some types of infectious diseases were also recorded in Dien Bien province in 2015, such as hand-foot-mouth disease (55 cases, no deaths), dengue (2 cases), rabies (1 case fatality), flu (5 cases), encephalitis (65 cases), and anthrax (22 cases, no deaths).

d. Investment needs and expected investment plans

63. The Provincial Preventive Medicine Centre (PPMC) is equipped with a modern laboratory (purchased from capital funds for environmental protection) with the advanced machinery and equipment to meet the analytical capacity and testing of drinking water, groundwater and surface water and food safety. They also proposed to GDMP to consider investing some equipment in the scope of the GMS Health Security Project to strengthen the capacity of laboratory to meet the analytical capacity and testing of ambient environment (air, water, soil, emission) and tests for occupational health diagnosis. However, the collection and treatment system for wastewater and emissions from the laboratory's operation had not been proposed. DOH and PPMC should propose to GDMP to consider investing these additional components to ensure the effectiveness of infection control activities with the laboratory.

2. Dien Bien District Health Centre

64. This Health Centre is classified as District General Hospital level 2 with a designed capacity of 80 beds but which has operated up to a capacity of 110 beds during peak occupancy. The hospital was built in 2009 and put into operation since 2012.

65. The hospital is responsible for treatment and preventive medicine activities for about 110,000 residents of 25 communes/town under Dien Bien district. The majority of population is ethnic minorities, of which Thai ethnic people account for 53%, Hmong Ethnic people account for 27%, Vietnamese people account for 15%, and other ethnic people account for about 5%.

a. Current status of medical waste management

66. Separation at source of medical solid waste is being implemented in the district hospital in compliance with the regulation of the MOH in Decision No. 43/2007/QD-BYT on promulgating regulations on medical waste management dated 30 November 2007. Accordingly, the solid wastes are classified into 4 categories and are contained in different coloured bins, namely: yellow bins for infectious waste, black bins for chemical and radioactive wastes; green bins for non-hazardous waste; and white bins for recyclable waste. The anatomical waste, sharps, and infectious wastes are collected and burned in the hospital's Incinerator.

67. The total amount of the medical waste generated from the hospital is estimated at 500 kg/day, of which about 20 kg of hazardous medical wastes need to be treated by the appropriate measures as per current regulations. The hospital is equipped with an incinerator (FE-15K made in Japan with double chambers) with maximum burning capacity is 20 kg of

medical solid waste per hour. Currently, the incinerator is being operated well and met the requirements on air emissions of the QCVN 02:2012/BTNMT[10] as observed from a monitoring record.

68. Wastewater runoff and storm water are collected in separate sewerage systems and discharged directly into the receiving receptacles/tanks. Medical hazardous wastewater from the clinical and sub-clinical wards (with an average flow of about 43 m^3/day) are collected in a central wastewater treatment system in separate sewerage systems. The hospital's combined wastewater treatment system (K-HC-R-25 brand) is made in Japan. Currently, the wastewater treatment system is being operated well and meets the requirements on emissions of the QCVN 14:2008/BTNMT[11] as per emissions monitoring records.

69. The Dien Bien District Health Centre is also equipped with a standard laboratory with biosafety level 2 and can conduct some decentralized testing required of the hospital. However, this laboratory does not have the collection and treatment system required for the emissions generated from its operation before discharging into the ambient environment.

b. Current status of infection control activities within the hospital

70. As informed by the Director of the district Health Centre, the activities of infection control within the hospital are implemented according to the procedure set out in Decision No. 3671/QĐ-BYT dated 27 September 2012. However, due to the lack of funds for implementation, the effectiveness of these activities are limited.

c. Current status of preventive medicine system within district

71. According to the institutional structure, the preventive medicine section is a faculty of the district health centre. This section is responsible for carrying out both preventive medicine and reproductive health activities. Total personnel allocated for this section is 30 health staff, including 2 medical doctors, and an unknown number of nurses and medical technicians. This faculty mainly implemented the national programs (such as EPI programs, malaria prevention program, HIV/AIDS prevention program, etc.), and other infectious diseases prevention programs with funds allocated from the PPMC (under DOH) and District Health Centre.

d. Investment needs and expected investment plans

72. The PPMC proposed to GDMP to consider investing some equipment in the scope of the GMS Health Security Project to strengthen the capacity of laboratory to meet the requirements of the treatment and preventive medicine activities.

3. Muong Cha District Health Centre

73. The Muong Cha District Health Centre is classified as a District General Hospital level 3 with a designed capacity of 60 beds but can operate at a peak capacity of 80 beds. The hospital was built in 1999 and put into operation since 2002. Currently, some structural parts of the hospital have deteriorated and need to be renovated or upgraded. Some components of the hospital were not designed consistent with its functions such as the delivery room and

[10] QCVN 02:2012/BTNMT - National Technical Regulation on the emission of healthcare solid waste incinerator.
[11] QCVN 14:2008/BTNMT – National Technical Regulation on domestic wastewater.

diagnosed image room. The structures need to be renovated or upgraded with an estimated cost of about 3 VND billion according to the calculation of the District Health Centre to meet the requirements for treatment activities.

74. The hospital is responsible for treatment and preventive medicine activities for about 68,000 residents of 12 communes/town under Muong Cha district (43,000 people) and 5 neighbouring communes of the Muong Nhe district (about 25,000 people). The majority of the population is ethnic minorities, of which Hmong Ethnic people account for 66%, Thai Ethnic people account for 23%, Vietnamese and other ethnicities account for about 11%.

a. Current status of medical waste management

75. Within the district hospital, the separation at source of medical solid waste was implemented well according to the regulation of the MOH in Decision No. 43/2007/QĐ-BYT on promulgating regulations on medical waste management dated 30 November 2007. Accordingly, the solid medical wastes are classified into 4 categories and are contained in different coloured bins, namely: yellow bins for infectious waste, black bins for chemical and radioactive wastes; green bins for non-hazardous waste; and white bins for recyclable waste. However, this District Health Centre has no incinerator. Solid medical hazardous wastes, including anatomical waste, infectious waste and sharps wastes are stored at a separate area within the hospital. Previously, hospitals were expected to invest a standardized incinerator by a different development project funded by the World Bank (Northern Uplands Health Support Project – NUP). However, the construction of incinerators was suspended for unknown reasons since 2012 just after the completion of incinerator's housing. It is now used as a warehouse to store the solid medical hazardous wastes. Solid medical hazardous wastes are stored for a period of 1 or 2 days before being transported by ambulance to a handmade incinerator at Communal Health Station of Sa Long commune through a distance of about 12 km from the hospital. The solid medical wastes are burned in a non-standardized incinerator built of bricks and burning by diesel fuel making combustion efficiency very poor. The glass vials and sharp wastes were contained in 4 concrete tanks with a capacity of about 20 m^3 per tank.

76. Medical hazardous wastewater from the clinical and subclinical wards (with an average flow of about 15 m^3/day) are drained to the central wastewater treatment system and collected by a separate sewerage system to the stored tanks where the wastewater is treated simply by mixing Chloramine B before being discharged into the environment.

77. The Muong Cha District Health Centre is also equipped with a standardized laboratory with biosafety level 2 and can conduct some decentralized testing corresponding to the requirements of the hospital. However, the capacity of laboratory is still lacking both in equipment and personnel, and have not met the requirements of the treatment and preventive medicine activity standards. Simultaneously, this laboratory does not have the collection and treatment system for the emissions generated from its operation before discharging into the ambient environment as prescribed.

b. Current status of infection control activities within the hospital

78. The activities of infection control within the hospital are implemented according to the procedure set out in Decision No. 3671/QD-BYT dated 27 September 2012. However, due to the lack of funds for implementation, the effectiveness of these activities are limited.

c. Current status of infectious disease prevention activities within district

79. According to the institutional structure, the preventive medicine section is a faculty of the district health centre. This section is responsible for carrying out both the preventive medicine and reproductive health activities. Total personnel allocated for this section is 24 health staff, including 1 medical doctor, and an unknown number of nurses and medical technicians. This faculty mainly implemented the national programs (such as EPI programs, malaria prevention program, HIV/AIDS prevention program, etc.), and other infectious diseases prevention programs with funds allocated from the Provincial Preventive Medicine Centre (under DOH) and District Health Centre.

d. Investment needs and expected investment plans

80. Actual results of the survey indicate that the investment of the standardized medical waste treatment system (solid and liquid medical hazardous wastes) is an urgent need of this District Health Centre. As expected, an incinerator and wastewater treatment system will be invested by the DOH by the local fund in 2016. Alternatively, the Provincial Preventive Medicine Centre also proposed to GDMP to consider investing some equipment in the scope of the GMS Health Security Project to strengthen the capacity of laboratory to meet the requirements of the treatment and prevention medicine activities.

B. Tay Ninh Province

81. Similar to the organizational structure in Dien Bien, the District Health Centres in Tay Ninh province undertake both treatment and preventive medicine activities. The national environmental specialist visited three district hospitals: (i) Tan Chau district and (ii) Go Dau district; and (iii) Trang Bang district.

1. Overall situation in Tay Ninh province

82. The healthcare system includes 106 treatment facilities at all levels, of which there are: (i) 4 provincial-level hospitals; (ii) 9 District Health Centres; and (iii) 93 Communal Heath Stations.

a. Current status of medical waste management

83. The medical solid waste separation at source was implemented well at most heath facilities according to the regulation of the DOH in Decision No. 43/2007/QD-BYT on promulgating regulations on medical waste management dated 30 November 2007.[12] According to the figures from reports of the Health Facilities, in 2015, the total amount of the medical waste generated from the health facilities is estimated at about 400 tons, of which 159 tons of hazardous medical wastes need to be treated by the appropriate measures as per current regulations. Non-hazardous medical wastes were collected and treated by the local utility company Tay Ninh Urban Environmental Company – URENCO. Hazardous medical wastes are collected and stored in the standardized containers as prescribed. There are 11 out of 14 hospitals that have incinerators for solid medical hazardous wastes treatment, of which only 8 incinerators are being operated regularly and 3 remaining that are either damaged or

[12] This Decision will be replaced by a joint circular No. 58/2015/TTLT-BYT-BTNMT regulations on medical waste management from 01 April 2016.

unfinished. For the health facilities that do not have incinerators, the transportation of hazardous medical waste to other locations for burning does not met the requirements of the MONRE due to lack of specialized vehicles.

84. According to the figures from reports of the Health Facilities, in 2015, hazardous medical wastewater generated from the health facilities estimated at about 284,000 m^3 and the amount of treated wastewater is 274,000 m^3 (accounting for 96.5%). There are 12 out of 14 hospitals that have wastewater treatment systems. For the 2 remaining, Hoa Thanh District Health Centre is constructing the wastewater treatment system while the Provincial Traditional Medicine Hospital is in process of trial operation of the wastewater treatment system before being put into operation officially.

b. Current status of preventive medicine system within Tay Ninh province

85. The preventive medicine system includes 10 provincial specialized centres (Preventive Medicine; Reproductive Health; Prevention of malaria, parasites; International Health Quarantine Centre; HIV/AIDS prevention; Endocrine; Drugs, cosmetics and food testing; Forensic Medicine; Medical evaluation; and Health communication and education). At the district level, according to the institutional structure, the preventive medicine section is a faculty of the 9 district health centres. This section is responsible for carrying out both preventive medicine and reproductive health activities.

c. Current status of infectious disease prevention activities within province

86. The activities related to the preventive medicine and disease prevention such as application of the measures to ensure hygiene, infection control, protection of water resources and provision of information on the knowledge about the disease and methods of disease prevention have also been carried out effectively.

87. In 2015, the number of dengue cases in Tay Ninh was 947 (no deaths), an increase of 66.5% compared to 2014. Alternatively, some types of infectious diseases were also recorded within province in 2015, such as hand-foot-mouth disease (1,342 cases, no deaths, a decrease of 12.3% compared to 2014), Malaria 98 cases, a decrease of 20.4% compared to 2014). There were no cases of the flu, cholera, diphtheria recorded in 2015.

d. Investment needs and expected investment plans

88. The Tay Ninh People's Committee has planned and is expected to invest in 3 concentrated treatment areas from 2016 to 2020, including standardized incinerators, storage areas, and specialized vehicles to collect and treat the solid medical hazardous wastes at Tay Ninh City (within Provincial General Hospital), Tan Chau district, and Go Dau district.

89. The Provincial Preventive Medicine Centre (PPMC) is equipped with a modern laboratory from capital funds for environmental protection with the advanced machinery and equipment to meet the analytical capacity and testing of drinking water, groundwater and surface water and food safety. They also proposed to GDMP to consider investing in some equipment within the scope of the GMS Health Security Project to strengthen the capacity of laboratories to meet the analytical capacity and testing of ambient environment (air, water, soil, emission) and tests for occupational health. However, the collection and treatment system for

wastewater and emissions from the laboratory's operation had not been invested in. DOH and PPMC should propose to GDMP to consider investing these additional components to ensure the effectiveness of infection control activities with the laboratory.

2. Tan Chau District Health Centre

90. This Health Centre is classified as District General Hospital level 2 with a designed capacity of 100 beds. It is currently being operated within its designed capacity. The hospital was built in 2010 and put into operation since 2012.

91. The hospital is responsible for treatment and preventive medicine activities for about 130,000 residents of 12 communes/town under Tan Chau district. This is a remote and border district of Tay Ninh province within 47 kilometres of the border with Cambodia (4 bordered communes). The district has an International Border Gate (Ka Tum) and many unofficial routes to Cambodia.

a. Current status of medical waste management

92. Within the district hospital, the separation at source of solid medical waste was implemented well according to the regulation of the MOH in Decision No. 43/2007/QĐ-BYT on promulgating regulations on medical waste management dated 30 November 2007. Accordingly, the solid medical wastes are classified into 4 categories and are contained in different coloured bins, namely: yellow bins for infectious waste, black bins for chemical and radioactive wastes; green bins for non-hazardous waste; and white bins for recyclable waste.

93. The total amount of the solid hazardous medical wastes generated from the hospital is estimated at 11 kg/day. Because the hospital has no burial tanks, glass vials and sharps wastes are also collected for burning with the other solid hazardous medical wastes. This health facility was equipped with an incinerator (one chamber) with outdated technology in 2012. As designed, the incinerator has a burning capacity of 100 kg/time but in fact operating capacity is only 30kg/time. The height of the incinerator's chimney is only 5 m and does not meet the requirements of QCVN 02: 2012/BTNMT of at least 25 m. The quality of the incinerator's emission does not meet the requirements. It has been renovated and upgraded in 2014, but now, its operation is unstable due to the frequently damaged fuel nozzle caused by the increase of the temperature inside after its renovation.

94. Medical hazardous wastewater from the clinical and subclinical wards (with an average flow of about 35 m^3/day) are collected in a central wastewater treatment system by the separate sewerage systems. Although the hospital was built and put into operation since 2012, the medical wastewater treatment system was not equipped at the same time. By 2013, a wastewater treatment system with capacity of 45 m^3/day was invested in by the capital funds of the Tay Ninh People's Committee. This work was completed and tested by the end of 2014, however, wastewater from hospital's buildings could not flow to the wastewater treatment system due to collection sewage system which was built beforehand and was not meeting the quality (wastewater was seeping into the ground) and not asynchronous (difference in altitudes). Currently, the wastewater treatment system has been decommissioned because there is no wastewater input and some pumps inside were damaged.

95. The Tan Chau District Health Centre is also equipped with a standard laboratory with biosafety level 2 and it can conduct some decentralized testing as required of the hospital. However, the capacity of laboratory is still lacking both in equipment and personnel (no testing

doctor) and have not met the requirements of the treatment and preventive medicine activities. Simultaneously, this laboratory does not have the collection and treatment system for the emissions generated from its operation before discharging into the ambient environment as prescribed.

b. Current status of infection control activities within the hospital

96. The activities of infection control within the hospital are implemented according to the procedure set out in Decision No. 3671/QD-BYT dated 27 September 2012. However, due to the lack of funds for implementation, the effectiveness of these activities are limited.

c. Current status of infectious disease prevention activities within district

97. According to the institutional structure, the preventive medicine section is a faculty of the district health centre. This section is responsible for carrying out both preventive medicine and reproductive health activities. Total personnel allocated for this section is 25 health staff, including 3 preventive medicine doctors, nurses and medical technicians. This faculty mainly implemented the national programs (such as EPI programs, malaria prevention program, HIV/AIDS prevention program, etc.), and other infectious diseases prevention programs with funds allocated from the Provincial Preventive Medicine Centre (under DOH) and District Health Centre.

d. Investment needs and expected investment plans

98. As mentioned above, the Tay Ninh People's Committee has planned and is expected to invest in the concentrated treatment areas, including standardized incinerators, storage areas and specialized vehicles to collect and treat the solid medical hazardous wastes at Tan Chau district in the period from 2016 to 2020.

99. Alternatively, the PPMC also proposes to GDMP to consider investing some equipment in the scope of the GMS Health Security Project to strengthen the capacity of the laboratory to meet the requirements of the treatment and prevention medicine activities.

3. Go Dau District Health Centre

100. This Health Centre is classified as District General Hospital level 2 with a design capacity of 150 beds and currently operating at design capacity. It has operated at capacity of 180 beds (overloaded by 20%) when the demand calls for it. The hospital was upgraded and renovated in 2008.

101. The hospital is responsible for treatment and preventive medicine activities for about 150,000 residents of 9 communes/town under Go Dau district. Besides, this hospital regularly receives and treats a significant number of Cambodian people from the border districts with Viet Nam. These Cambodian people went to Vietnam through the Moc Bai International Gate under Ben Cau district, Tay Ninh province with the average number of treatment cases of about 3,500 per year.

a. Current status of medical waste management

102. Within the district hospital, the separation at source of solid medical waste is implemented well according to the regulation of the MOH in Decision No. 43/2007/QĐ-BYT on promulgating regulations on medical waste management dated 30 November 2007. Accordingly, the solid medical wastes are classified into 4 categories and are contained in different coloured bins, namely: yellow bins for infectious waste, black bins for chemical and radioactive wastes; green bins for non-hazardous waste; and white bins for recyclable waste.

103. The total amount of the solid hazardous medical wastes generated from the hospital is estimated at 900 kg/month. Because the hospital has no burial tanks and therefore, all of glass vials, sharps wastes are also collected for burning with the other solid hazardous medical wastes. This health facility was equipped an incinerator branded **Inciner 8** – made in England (double chambers) in 2012. As designed, the incinerator has a burning capacity of 50 kg/time, but in fact operating capacity is only 15kg/time. The quality of the incinerator's emission does also not meet the requirements of QCVN 02: 2012/BTNMT. At the time of the survey at the hospital (in the morning on 09 March 2016), the Consultant could assess this issues by observing when the incinerator was emitting black smoke and generating foul odours.

104. Medical hazardous wastewater from the clinical and subclinical wards (with an average flow of about 35 m^3/day) are collected and drained to the central wastewater treatment system by the separate sewerage systems. By 2012, a wastewater treatment system with capacity of 45 m^3/day was invested by the capital of the Tay Ninh People's Committee. According to the monitoring results, the quality of the discharged wastewater has just met the indicators of column B of QCVN 28:2010/BTNMT - National Technical Regulation on Health Care Wastewater whereas under the regulations of the Tay Ninh PC, the discharged wastewater of all Healthcare facilities in Tay Ninh province have to meet the indicators in column A of QCVN 28:2010/BTNMT. As estimated, an amount of 1 VND billion (about $50,000) to upgrade and renovate the wastewater system will be needed to ensure that the discharged wastewater meets the indicators of column B of QCVN 28:2010/BTNMT.

105. The Go Dau District Health Centre is also equipped a standard laboratory with biosafety level 2 and can conduct some decentralized tests corresponding to the treatment's requirements of the hospital. However, this laboratory does not have the collection and treatment system for the emissions generated from its operation before discharging into the ambient environment as prescribed.

b. Current status of infection control activities within the hospital

106. The activities of infection control within the hospital were implemented according to the procedure set out in Decision No. 3671/QĐ-BYT dated 27 September 2012. However, due to the lack of funds for implementation, the effectiveness of these activities are limited.

c. Current status of infectious disease prevention activities within district

107. According to the institutional structure, the preventive medicine section is a faculty of the district health centre. This section is responsible for carrying out both preventive medicine and reproductive health activities. Total personnel allocated for this section is 20 health staff, including 2 preventive medicine doctors, unknown number of nurses and medical technicians. This faculty mainly implemented the national programs (such as EPI programs, malaria

prevention program, HIV/AIDS prevention program, etc.), and other infectious diseases prevention programs with funds allocated from the Provincial Preventive Medicine Centre (under DOH) and District Health Centre.

d. Investment needs and expected investment plans

108. As mentioned above, the Tay Ninh People's Committee has planned and is expected to invest in the concentrated treatment areas, including standardized incinerators, storage areas and specialized vehicles to collect and treat the solid medical hazardous wastes at Go Dau district in the period from 2016 to 2020.

109. PPMC also proposed to GDMP to consider investing some equipment within the scope of the GMS Health Security Project to strengthen the capacity of the laboratories to meet the requirements of the treatment and prevention medicine activities.

4. Trang Bang District Health Centre

110. This Health Centre is classified as District General Hospital level 2 operating with a design capacity of 130 beds which during high demand peaks to a capacity of 150 beds (overloaded about 15%). The hospital was upgraded and renovated in 2010.

111. The hospital is responsible for treatment and preventive medicine activities for about 153,000 residents of 11 communes/town under Trang Bang district (there are 2 border communes with Cambodia with total length of the border is 13 km). This hospital also provides the health care services for about 45,000 workers in the Industrial Parks within the district.

a. Current status of medical waste management

112. Within the district hospital, the separation at source of solid medical waste was implemented well according to the regulation of the MOH in Decision No. 43/2007/QĐ-BYT on promulgating regulations on medical waste management dated 30 November 2007. Accordingly, the solid medical wastes are classified into 4 categories and are contained in different coloured bins, namely: yellow bins for infectious waste, black bins for chemical and radioactive wastes; green bins for non-hazardous waste; and white bins for recyclable waste.

113. The total amount of the solid hazardous medical wastes generated from the hospital is estimated at 600 kg/month. This health facility was equipped with an incinerator (single chamber) in 2010, along with the time that the hospital was put into operation. However, this incinerator was damaged after only 2 hours from starting of operation. Since then, the incinerator could not operate despite being repaired several times. Currently, the solid hazardous wastes generated from the hospital's activities as well as glass vials and sharps wastes are being collected by an environmental services company in Ba Ria – Vung Tau province with monthly costs of the services of about 14 VND million. The areas for storage of the solid medical hazardous wastes and incinerator were severely degraded due to not being used regularly.

114. Medical hazardous wastewater from the clinical and subclinical wards (with an average flow of about 10 m^3/day) are collected and drain to the central wastewater treatment system by separate sewerage systems. By 2012, a wastewater treatment system with capacity of 45 m^3/day was invested by the capital of the Tay Ninh People's Committee. According to the monitoring results, some indicators of the wastewater such as COD, PO_4^{3-}, NH_4^+do not meet the

requirements of column A of QCVN 28:2010/BTNMT - National Technical Regulation on Health Care Wastewater whereas under the regulations of the Tay Ninh PC, all indicators of waste water before discharge into the environment in Tay Ninh province have to meet the indicators in column A of QCVN 28:2010/BTNMT.

115. The Trang Bang District Health Centre was also equipped a standardized laboratory with biosafety level 2 and can conduct some decentralized testing corresponding to the requirements of the hospital. The collection and treatment system for the emissions generated from its operation before discharging into the ambient environment was also equipped.

b. Current status of infection control activities within the hospital

116. The activities of infection control within the hospital are implemented according to the procedure set out in Decision No. 3671/QĐ-BYT dated 27 September 2012. However, due to the lack of funds for implementation, the effectiveness of these activities are limited.

c. Current status of infectious disease prevention activities within district

117. According to the institutional structure, the preventive medicine section is a faculty of the district health centre. This section is responsible for carrying out both the preventive medicine and reproductive health activities. Total personnel allocated for this section is 24 health staff, including 2 preventive medicine doctors, nurses and medical technicians. This faculty mainly implemented the national programs (such as EPI programs, malaria prevention program, HIV/AIDS prevention program, etc.), and other infectious diseases prevention programs with funds allocated from the Provincial Preventive Medicine Centre (under DOH) and District Health Centre.

d. Investment needs and expected investment plans

118. As mentioned above, the Tay Ninh People's Committee has planned and is expected to invest the concentrated treatment areas, including standardized incinerators, storage areas and specialized vehicles to collect and treat the solid medical hazardous wastes at Go Dau district in the period from 2016 to 2020. Because the distance from Trang Bang District Health Centre to Go Dau district is not too far (about 25 km), after completion of concentrated treatment area as planned, the medical hazardous solid wastes can be transported from Trang Bang District Health Centre to Go Dau for treatment. However, in this case, the specialized vehicles need to be equipped to meet the regulations on transport of hazardous wastes.

119. PPMC also proposed to GDMP to consider investing some equipment in the scope of the GMS Health Security Project to strengthen the capacity of laboratory to meet the requirements of the treatment and prevention medicine activities.

C. Nghe An Province

120. Different from Dien Bien and Tay Ninh provinces, in Nghe An, the district policlinic hospitals undertake the medical examination and treatment, and the preventive medicine was performed by the District Health Centres. The specialist visited the Anh Son District Policlinic Hospital and Do Luong district Health Centre.

1. Overall situation in Nghe An province

121. The Healthcare facilities in Nghe An province include 39 hospitals (29 public hospitals and 10 private hospitals); 9 provincial Health Centres, 21 district health centres (19 district health centres only perform the medicine preventive function and 2 perform both preventive medicine and treatment); 480 Commune Health Stations. There are 4 hospitals which are managed by the central departments located in the locality: Military Hospital No. 4, Transport hospital No. 4, Quynh Lap Leprosy hospital; and provincial Police Hospital.

a. Current status of medical waste management

122. The solid medical waste separation at source is implemented well at most heath facilities according to the regulation of the DOH in Decision No. 43/2007/QĐ-BYT on promulgating regulations on medical waste management dated 30 November 2007. According to the figures from reports of the Health Facilities, in 2015, the total amount of the medical waste generated from the health facilities is estimated at about 600 tons, of which 323 tons of hazardous medical wastes need to be treated by the appropriate measures as current regulations. Non-hazardous medical wastes were collected and treated by the local utility companies. Hazardous medical waste was collected and stored in the standardized containers as prescribed. According to the figures provided by the DOH, within Nghe An province, the solid medical hazardous waste was collected and treated under two different models: (i) centralized treatment: medical hazardous waste from Heath Facilities in Vinh City (public hospitals, private hospitals) are treated in the centralized incinerator at Nghi Yen commune, Nghi Loc district; (ii) spot treatment: this model applies for the district hospitals. There are 19 district hospitals, of which only 8 district hospitals have the incinerators that are being operated regularly. The 11 remaining district hospitals either have no incinerators or have them but are already damaged and inoperable. In the remaining 11 district hospitals, 8 are being invested by the Hospital Waste Management Support Project funded by the WB (non-incineration technology), and 3 district hospitals are still looking for the investment sources to equip the solid waste treatment system. In 2015, the total volume of the solid medical hazardous waste generated from the Health Facilities within Nghe An province is 323,341 kg, and the total volume of the solid medical hazardous waste which were treated properly is 295,70 kg, reached about 91.5%.

123. There are 19 hospitals out of 39 hospitals in Nghe An province that have the wastewater treatment systems meeting the discharged standards to environment as prescribed. There are 3 hospitals which are in the process of building the wastewater treatment systems (2 funded by the Hospital Waste Management Support Project; and 1 funded by the state capital). The remaining hospitals (17) and all district hospitals/health centres, regional polyclinics and Communal Healthcare Stations have no wastewater treatment systems.

b. Current status of preventive medicine system within Nghe An province

124. The preventive medicine system includes 10 provincial specialized centres (Preventive Medicine; Reproductive Health; Prevention of malaria, parasites; International Health Quarantine Centre; HIV/AIDS prevention; Endocrine; Drugs, cosmetics and food testing; Forensic Medicine; Medical evaluation; and Health communication and education). At the district level, according to the institutional structure, the district health centres (19) are independent of the district hospitals.

c. Current status of infectious disease prevention activities within province

125. The activities related to the preventive medicine and disease prevention such as application of the measures to ensure hygiene, infection control, protection of water resources and provision of information on the knowledge about the disease and methods of disease prevention have also been carried out effectively.

126. In 2015, number of dengue cases in Nghe An was 144 (no deaths) in 5 communes of 3 districts. Alternatively, some types of infectious diseases were also recorded within the province in 2015, such as flu (51,084 cases, no deaths), mumps (953); chicken pox (1,916 cases); and diarrhoea (17,450 cases, 3 dead). In general, compared to 2014, the cases of infectious diseases have decreased by about 2%. In 2015, within Nghe An province, there are 11 cases of rabies from dogs and cats and all deaths due to non-vaccination, an increase of 1 case compared to 2014.

d. Investment needs and expected investment plans

127. As mentioned above, there are 8 district hospitals that are investing in the solid medical hazardous waste treatment system by the Hospital Waste Management Support Project funded by the WB (non-incineration technology). The DOH has also proposed the PPC to allocate the capital for investment of the wastewater treatment systems for the district hospitals/heath centres. In addition, they are also looking for the investment sources from the development projects to do it.

128. Provincial Preventive Medicine Centre (PPMC) is equipped with a laboratory from the capital funds for environmental protection with the machinery and equipment to basically meet the analytical capacity and testing of drinking water, groundwater and surface water and food safety. The district Health Centres were also equipped the labs with biosafety standard level 2. However, collection and treatment system for wastewater and emission from the laboratory's operation had not been invested in at all district Health Centres.

129. The PPMU under DOH also proposed to GDMP to consider investing some equipment in the scope of the GMS Health Security Project to strengthen the testing capacity of the preventive medicine system. However, collection and treatment system for wastewater and emission from the laboratory operation had not been invested in. DOH and PPMC should propose to GDMP to consider investing these additional components to ensure the effectiveness of infection control activities of the laboratories.

2. Anh Son District General Hospital

130. This Hospital is classified as District General Hospital level 2 with a designed capacity of 130 beds and currently it is being operated with capacity of 130 beds as designed. The hospital is responsible for treatment activities for about 140,000 residents of 21 communes/town under Muong Cha district, of which the ethnic minorities account for about 8%. The hospital was built in 1995 and now all the work items are already degraded.

a. Current status of medical waste management

131. Within the district hospital, the separation at source of solid medical waste is implemented well according to the regulation of the MOH in Decision No. 43/2007/QĐ-BYT on

promulgating regulations on medical waste management dated 30 November 2007. Accordingly, the solid medical wastes are classified into 4 categories and are contained in different coloured bins, namely: yellow bins for infectious waste, black bins for chemical and radioactive wastes; green bins for non-hazardous waste; and white bins for recyclable waste.

132. The total amount of the solid hazardous medical wastes generated from the hospital is estimated at 400 kg/month. This health facility was equipped with a Japanese incinerator (single chamber) in 2011, funded by capital sources from the government bonds. At the time of the survey (09 March 2016), incinerators were damaged and inactive.

133. Medical hazardous wastewater from the clinical and subclinical wards (with an average flow of about 24 m^3/day) are collected and drain to the central wastewater treatment system by the separate sewage.

134. The Anh Son District Hospital is also equipped with a standardized laboratory with biosafety level 2 and can conduct some decentralized tests corresponding to the treatment requirements of the hospital. The collection and treatment system for the emissions generated from its operation before discharging into the ambient environment was also equipped in as prescribed.

b. Current status of infection control activities within the hospital

135. The activities of infection control within the hospital were implemented according to the procedure set out in Decision No. 3671/QĐ-BYT dated 27 September 2012. However, due to lack of funds for implementation, and therefore, the effectiveness of these activities are limited.

c. Current status of infectious disease prevention activities within district

136. According to the institutional structure in Nghe An, at the district level, the district hospital only performs the treatment activities. The preventive medicine activities are implemented by the District Health Centre. The centre mainly implemented the national programs (such as EPI programs, malaria prevention program, HIV/AIDS prevention program, etc.), and other infectious diseases prevention programs with funds allocated from the Provincial Preventive Medicine Centre (under DOH).

d. Investment needs and expected investment plans

137. Through discussions during the survey, the leaders of the Anh Son district hospital and the representatives of the DOH proposed that the GSM Health Security Project should consider to invest in a system of infection control for the Anh Son district hospital. This includes the construction of infrastructures (functional rooms), supply of equipment for infection control and new investment of the treatment system for the solid hazardous wastes.

3. Do Luong District Health Centre

138. The Centre performs the duties of medical care, rehabilitation and preventive medicine through the combination of modern medicine and traditional medicine for the about 200,000 people in 33 towns/communes under the Do Luong district. This centre is currently specialized in the regular treatment of 82 AIDS cases within the Do Luong district and the surrounding areas.

a. Current status of medical waste management

139. Within the district Health Centre, the separation at source of solid medical waste is implemented well according to the regulation of the MOH in Decision No. 43/2007/QĐ-BYT on promulgating regulations on medical waste management dated 30 November 2007. Accordingly, the solid medical wastes are classified into 4 categories and are contained in different coloured bins, namely: yellow bins for infectious waste, black bins for chemical and radioactive wastes; green bins for non-hazardous waste; and white bins for recyclable waste. However, the Centre has no incinerator and the wastewater treatment system.

140. The Do Luong District Health Centre was also equipped with a standardized laboratory with biosafety level 2 that can conduct some decentralized tests corresponding to the treatment requirements of the hospital. The collection and treatment system for the emissions generated from its operation before discharging into the ambient environment was not equipped as prescribed.

b. Current status of infection control activities within the hospital

141. The activities of infection control within the hospital were implemented according to the procedure set out in Decision No. 3671/QĐ-BYT dated 27 September 2012. However, due to the lack of funds for implementation, the effectiveness of these activities are limited.

c. Current status of infectious disease prevention activities within district

142. The preventive medicine activities are implemented by the District Health Centre. The centre mainly implements the national programs (such as EPI programs, malaria prevention program, HIV/AIDS prevention program, etc.), and other infectious diseases prevention programs with funds allocated from the Provincial Preventive Medicine Centre (under DOH).

d. Investment needs and expected investment plans

143. As expected, in 2016 and the following years, the Do Luong District Centre will treat about 200 cases of AIDS and conduct tests for infectious diseases such as HIV, TB and blood testing. However, the means and equipment for collection and disposal of hazardous waste (solid and liquid) were not fully equipped. Moreover, the lack of treatment facilities (solid waste, wastewater) is major obstacle in the implementation of infection control of this heath facility. Therefore, the Provincial Preventive Medicine Centre also proposed to GDMP to consider to equip the treatment systems of solid waste and wastewater for this health facility and strengthen the capacity of laboratory to meet the requirements of the treatment and prevention medicine activities.

D. Preliminary Environmental Situation Analysis

144. From the initial environmental assessments of the sample provinces, there are 5 out of the 7 district hospitals/health centres visited that have incinerators but most of them are outdated, operationally unviable, and some of them were not checked regularly for compliance with the environmental standards. Open burning or soil-bored pit dumping of medical waste is still being practiced at the Muong Cha district hospital of the Dien Bien province. Wastewater treatment facilities are mostly comprised of three or multiple chambers but they are not capable of treating chemical and laboratory wastewater produced by the district hospitals/health centres.

Most of laboratories visited have no separate collection and treatment system for treatment of the wastewater emissions produced by their operation.

145. To meet the project's objectives on infection control within the district hospitals/health centres, investment of treatment facilities (solid and liquid waste, emission) and supplying the equipment for the labs are the urgent requirements. The proposed facilities/equipment, in complying with the environmental law and decrees of Viet Nam and ADB Environmental Policies, will be able to provide positive environmental impacts. Potential negative impacts in the long term are anticipated if the project fails to provide for sustainable facility management and adequate provisions for recurrent costs in repair and maintenance.

V. SCREENING OF POTENTIAL ENVIRONMENTAL IMPACTS AND MITIGATION MEASURES

A. Rapid Environmental Assessment

146. In order to identify potential environmental impacts of the project components, the initial environmental screening was first carried out using the ADB rapid environmental assessment forms (REAs) to screen the proposed activities required for the installation of new or improved laboratory facilities/equipment such as minor repair and improvement works on the provincial and district hospitals at border provinces, districts and towns as the case may be. (Please see Appendix 2 for the form used). While the district and provincial hospitals are all existing facilities and whatever improvements are introduced bring mostly positive impacts for the environment, the REAs categorized most of the project activities as Category B because the project involves the management of infectious, hazardous, medical solid waste and wastewater and the risks inherent in the handling of laboratory wastes, and the diagnostic activities in managing highly infectious diseases at the border towns of the target border district and provincial hospitals.

147. The ADB safeguard policies require that the project's activities need to be carefully considered to avoid and/or to minimize the negative impacts on the natural environment and social environment (including environmental public health and occupational health), and provide the appropriate measures to mitigate such impacts. In accordance with the ADB guidelines, the potential impacts of medical solid and liquid wastes including laboratory wastes, being hazardous along with deficient sanitation and laundry facilities and the lack of effective wastewater equipment and treatment systems categorizes the health facilities as having significant potential negative environmental impacts that need to be mitigated.

B. Environmental Assessment Methodology

148. A survey was conducted by the Consultant and the MOH team at selected border provinces to be representative of the other targeted provinces. The main objectives of the survey were to:

- (i) Assess the current practices and environmental conditions focused on the medical waste (solid and liquid) management of the health care facilities (provincial and district hospitals and/or preventive medicine centres);
- (ii) Organize meetings with the provincial agencies of DOH and DONRE to consult them about their needs and plans about the environmental management of the sub-components of the health security project to institute environmental safeguards from the impacts of laboratory waste, infectious disease bio-hazards,

hospital safety and hygiene for infection prevention and control, and medical solid and liquid waste management; and

(iii) Collect environmental baseline data of the representative provinces included in the target border areas.

149. During the time allotted, the site surveys were carried out by a combination of methods i.e. observation, photo-documentation, data/document review and analysis, and interview or focus group discussions with key informant officials. The survey team earlier developed sets of Rapid Environmental Assessment (REA) checklists for health care facilities. The data and information on environmental issues (focused on medical solid and liquid waste management and hospital safety and hygiene for infection prevention and control) of the selected provinces under the project areas were collected from DOH, DONRE and relevant provincial agencies.

150. The Consultant and the MOH/provincial team conducted surveys in 3 selected provinces (Dien Bien – border province with Laos and China, Nghe An – border province with Laos and Tay Ninh – border province with Cambodia) during period from 24 February 2016 to 10 March 2016. Seven (7) district hospitals/preventive medicine centres were assessed: two (2) in Dien Bien, three (3) in Tay Ninh and two (2) in Nghe An. The meetings with the provincial DOH and DONRE were organized in each province with participation of the relevant staff to discuss the environmental situation in their respective areas focusing on the medical waste management. Similar meetings and consultations at the district hospitals or preventive medicine centres visited were also held with participation of the district hospitals staff to discuss the environmental situation of the district hospitals respectively and open discussions about their views about the project, on the medical waste management and hospital safety and hygiene for infection prevention and control, and om medical solid waste management and wastewater treatment facilities.

C. Potential Environmental Impacts and Mitigating Measures

151. For the purposes of the assessment, the following categories of impacts have been developed:

i. **NO IMPACT:** The potential impact of the project is assessed as NO IMPACT if the project activity is physically removed in space or time from the environmental component, or if the impact is so small as to be un-measurable (i.e. negligible).

ii. **MAJOR IMPACT – POSITIVE OR NEGATIVE:** An impact is said to be MAJOR if the project has the potential to affect an environmental component. The following criteria were used to determine whether a given impact is MAJOR:

  a. spatial scale of the impact (site, local, regional, or national/ international);
  b. time horizon of the impact (short, medium, or long term);
  c. magnitude of the change in the environmental component brought about by the project activities (small, moderate, large);
  d. importance to local human populations;
  e. compliance with international, national, provincial, or district environmental protection laws, standards, and regulations;
  f. compliance with ADB guidelines, policies, and regulations.

iii. **MINOR IMPACT – POSITIVE OR NEGATIVE:** If an impact occurs but does not meet the criteria for a Major Impact it is assigned the category MINOR. Minor impacts occur along a spectrum ranging from those impacts that are close to being major impacts to those that are close to being negligible impacts. The

judgments made in relation to the position of specific impacts along this spectrum are discussed in the text accompanying the environmental screening.

iv. **UNKNOWN IMPACT:** The potential impact of the project will be assessed as being UNKNOWN if the magnitude of the effect cannot be predicted for any of the following reasons:

a. the nature and location of the project activity is uncertain;
b. the occurrence of the environmental component within the study area is uncertain;
c. the time scale of the effect is unknown; or
d. the spatial scale over which the effect may occur is unknown.

152. These categories have been applied to other ADB infrastructure projects and have been adapted from ADB, *1997 Environmental Impact Assessment in Developing Countries.*

D. Screening of Environmental Impacts of Project Components

153. The purpose of this section is to undertake further screening of typical environmental impacts of the project components/sub-components. The screening addresses the potential impacts of the structural processes to be implemented and relevant activities under the loan program, namely: (i) minor repair and improvement works; (ii) laboratory equipment commissioning including infection prevention and control (IPC) services; iii) operation of the existing solid waste management facilities and (iv) operation of existing wastewater treatment facilities. Since the project does not involve civil works construction, the environmental assessment covers the pre-procurement, procurement (including the commissioning stage), and the operation stage of the project as described fully in Section II-G. Only potential impacts that have direct and relevant significance are listed in the environmental screening.

154. The following key is used in the environmental screening

NO impact	O
MINOR NEGATIVE impact	X
MAJOR NEGATIVE impact	XX
MINOR POSITIVE impact	+
MAJOR POSITIVE impact	++
UNKNOWN impact	?

E. Findings of the Environmental Assessment

155. The TOR initially categorized this project as requiring an Initial Environmental Examination (IEE) Report and an Environmental Management Plan both of which are required for a Category B Project. It is understood that this project was tentatively classified as a Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document. This categorization was examined through the representative visits to the different project sites and the proposed project

component descriptions and how the project proponent intends to mitigate the potential negative environmental impacts of the project.

156. In accordance with the ADB's *Environment Policy (2003),* Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or significance than those for Category A projects that require a full-blown Environmental Impact Statement arising from major adverse impacts on the environment. For a Category B project, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

157. In Viet Nam, the final list of target hospitals from the border provinces and districts are still being finalized by GOV and their respective environmental assessments have not been prepared. The project is expected to have positive environmental impacts based on the level of investments in laboratory equipment to improve diagnostics of emerging diseases in support of communicable diseases control. On the other hand, this project is not supporting civil works construction for waste management. It is expected that the existing SWM equipment and wastewater treatment facilities will not be able to meet the environmental standards consistently.

158. During the project's life, the environmental assessment will continue particularly for the medical solid waste and the wastewater treatment facilities. If not upgraded or properly maintained, there will be a good chance that the assessment will also continue to have negative environmental impacts. It is very important therefore to have an environmental management plan in place. Within the plan should be a monitoring framework.

159. Separately, the project will undergo environmental impact assessment in accordance with the following Vietnamese legislation the Environmental Protection Law (52/2005/QH11), Decree No. 80/2006/ND-CP dated 09 August 2006 - guiding the implementation of the Environmental Protection Law and Decree No. 29/2011/ND-CP dated 18 April 2011 - providing for strategic environmental assessment, environmental impact assessment and environmental protection commitment.

VI. INSTITUTIONAL REQUIREMENTS AND ENVIRONMENTAL MONITORING PLAN

A. Institutional Arrangements

160. Table 6.1 summarizes the proposed environmental management responsibilities of key parties involved in the project.

Table 6.1: Environmental Management Institutional Arrangements

Agency	Environmental Management Responsibilities
ADB	Sign loan agreement with GOV including environment-related covenants Review of site specific EAs and environmental monitoring reports
MOH/GDPM	Responsibility for overall project implementation, including environmental management activities and implementation of EMPs Coordination of environment-related activities of provinces/districts/Communes including implementation of aspects of EMPs
MOH/PMU	Responsibility for project operation including operation stage environmental performance Allocation of staff with responsibility for environmental issues during operation

Agency	Environmental Management Responsibilities
PPMU	Responsibility for province level project implementation Responsibility for implementing EMPs including preparation of environmental assessments - and obtaining environmental approvals for works within province Responsibility for pre-procurement stage and procurement stage environmental management, monitoring and reporting
MONRE/DONRE	Provision of advice to PPMUs/districts/communes as required on environmental issues
DONRE	Approval of EMPs for works within districts
Contractors/Suppliers	Implementation of environmental management commitments contained in site specific EMPs Monitoring and reporting of environmental performance

161. Responsible personnel assigned by the MOH would have primary responsibility for environmental issues and activities during project implementation.

B. Environmental Mitigation Plan

162. Table 6.2 contains the proposed typical environmental mitigation plan for the pre-procurement, procurement and operation stages of selected project sub-components as assessed. During project implementation, the EMPs for the site specific project sub-components will be validated as a continuing process. Reference will be made to new site information obtained to update site specific mitigation measures for inclusion in the EMP.

6.2: Typical Environmental Mitigation Plan

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Procurement Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/Contractor
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/Contractor

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/Contractor
Soil contamination	disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/Contractor
Risks to public and worker health and safety	Minimize risk of accidents to public and workers	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	PPMU
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospital health and safety guidelines are established and practiced	MOH
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	PPMU
Operation Stage			
Dust and emissions generation	Minimize emissions of dust and other pollutants	Ensure compliance with relevant Vietnam air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Vietnam on air quality, particulates and odor	PPMU
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the labs regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	PPMU
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours Notify nearby community of schedule and duration of activities	PPMU

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Vietnam and DONRE regulations.	PPMU
		Ensure that wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal. Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Vietnam and DONRE regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable DONRE standards for medical wastewater.	PPMU
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos. Provide safety equipment to construction workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Viet Nam regulations on SWM and wastewater discharge are complied with.	MOH
Emissions generation	Comply with relevant Vietnam Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MONRE
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH

Issue	Performance Objective	Mitigation Measure	Responsibility for Implementation
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Lao PDR standards prior to discharge Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities	MOH
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	Ensure that the applicable Viet Nam regulations on SWM and wastewater treatment particularly on best practices and safety are complied with.	PPMU
		Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

C. Environmental Monitoring Plan

163. Tables 6.3 and 6.4 contain the proposed environmental monitoring plan for the pre-construction, construction and operation stages of the project components. Two types of environmental monitoring are proposed to be implemented:

(i) Environmental effects monitoring is conducted to estimate the impacts of sub-the project on ambient environmental conditions.

(ii) Project environmental performance monitoring is conducted to evaluate compliance with environment-related operating procedures, national standards, and/or contractor specifications including the requirements of the EMP.

164. The following plan identifies the relevant site specific monitoring measures for inclusion in the EMP.

Table 6.3: Environmental Effects Monitoring Plan

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/PPMU
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier/PPMU
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier/PPMU
Operation					
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified in Vietnam standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Vietnam standards	Weekly for first 6 months and then monthly thereafter	MOH

Table 6.4: Environmental Performance Monitoring Plan*

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	Covering of equipment and fixtures & use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/PPMU
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier/PPMU
Operation					
Air emissions control	All criteria in Vietnam – Air quality – odor from solid waste matter – Permitted level.	At solid waste facilities and autoclaves	As specified in Vietnam standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified in Vietnam standards	Weekly for first 6 months and then monthly thereafter	MOH

D. Environmental Monitoring and Reporting

165. Table 8 contains the proposed environmental monitoring and reporting system for the pre-construction, construction and operation stages of the project.

Table 6.5:	Type of Monitoring	Description	Responsibility	Reporting Requirements
Procurement	Supplier/ Contractor's Environmental Performance Monitoring	Self-monitoring of environmental effects of minor repair and improvement works in terms of environmental performance monitoring requirements identified in EMP. Undertaken on an ongoing basis throughout the procurement process with regular monitoring frequencies.	Supplier/ contractor	Commissioning reports to PPMUs
	MP Compliance Monitoring	Monitoring of Supplier/Contractor's compliance with EMP requirements. Undertaken during commissioning of equipment. Monitoring based on combination of observation and review of supplier's environmental performance monitoring results.	PIAs	Commissioning reports to PPMU/ADB

Table 6.5:	Type of Monitoring	Description	Responsibility	Reporting Requirements
Operation	Operation Environmental Monitoring	Monitoring of performance of project operation. Undertaken on a regular basis over life of project and self-reporting of compliance with EMP operation stage commitments.	MOH	1st year: 3 monthly reports to ADB and DONRE Subsequent years: 6 monthly reports to DONRE

E. Environmental Management Budget

166. Environmental management costs include costs both at the level of individual project sub-components as well as project component-wide environmental management costs. An environmental management budget to cover costs for management and monitoring both at the level of the district hospitals and the health centers will be established. A certain percentage of the total project costs can be allocated for this fund upon agreement with the MOH.

167. The EMP budget will include the following components:

(i) Marginal costs for implementation of environmental mitigation measures during pre-construction, construction and operation stages
(ii) Marginal costs for implementation of environmental monitoring measures during pre-construction, construction and operation stages.

VII. PUBLIC CONSULTATION AND INFORMATION DISCLOSURE

A. Public Consultation Undertaken to Date

168. Consultation undertaken to date on the project has involved the following:

(i) Meetings and consultations with Provincial Peoples Committee (PPC) and MOH/DOH representatives in each project province to identify the status of current health care facilities and potential project interventions
(ii) Meetings and consultations with management and staff in each of the health facilities selected for inclusion in project activities to identify the current status of environmental conditions in the vicinity of the health facilities and identify the scope of required project interventions
(iii) Consultation with project affected households (PAHs) in relation to land acquisition and resettlement as documented in the project Resettlement Plan

B. Future Public Consultation and Disclosure

169. In order to ensure that future project activities are conducted in a participatory sense and that community concerns and opinions about potential environmental impacts are taken into account during subcomponents of procurement and operation, a range of public consultation and disclosure activities will be implemented throughout activity preparation, implementation and operation. These activities, which have been developed to meet the requirements of both GOV and ADB safeguards requirements, are summarized in the following sections.

170. The following consultation activities will be implemented during the finalization of the detailed design of project activities:

(i) District level workshops in each district contained in the project area to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops will include stakeholder agencies, mass organizations (Women's Union, Fatherland Front, Youth Union and Farmers Association), other relevant district level organizations such as the District Committee for Ethnic Minorities and CPC and commune representatives.
(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required particularly for the quarantine and border area outbreak response facilities.

171. The public consultation activities carried out and the subsequent outcomes will be documented in the environmental assessment documents to be prepared for each site and records of the public consultation appended to the document as outlined in the Environmental Assessment and Review Procedures for the project.

172. To ensure ongoing community involvement during project procurement and operation, the following activities will be carried out for each project activity.

(i) Community information on procurement and operational activities and details of any expected impacts and measures to control them by means of newspaper and loudspeaker announcements and direct communication by local authorities to affected households
(ii) Establishment of a grievance redress mechanism to allow community members to report concerns regarding operational activities including environmental pollution concerns.

173. The requirements for future consultation activities during procurement and operation will be documented in the site specific environmental assessments to be prepared during project implementation.

VIII. ENVIRONMENTAL CRITERIA FOR PROJECT SUB-COMPONENT SELECTION

174. The following environmental criteria have been developed for the purposes of future project sub-component selection.[13] All project sub-components must:

(i) Avoid direct or indirect significant, negative impacts on protected areas defined as 'special use forests' in Decision 8/2001/QD-TTg 11/01/01 of the Government of Viet Nam, or other known areas of ecological sensitivity including those areas identified in Section III of the IEE
(ii) Avoid loss of significant areas of vegetation or permanent, negative impacts on a known rare or endangered flora or fauna species

[13] Environmental criteria apply only to the following structural project sub-components: Minor repair and improvement works; laboratory equipment installations; solid waste management facilities and wastewater treatment facilities.

(iii) Avoid pollution of waterways, surface waterbodies or groundwater resources with ecological values or which are used for domestic or agricultural water supply
(iv) Avoid direct or indirect significant, negative impacts on important items of cultural heritage, including those sites identified in Section III of the IEE
(v) Not cause any other environmental impacts that would trigger categorization as a 'Category A' project in accordance with the ADB's *Environmental Policy, OM.20 Environmental considerations in ADB operations* and *Environmental Assessment Guidelines* (2003)

175. Once project components have been selected using the defined criteria, they will be subject to further environmental analysis through implementation of the environmental assessment and review procedures (EARPs) presented in Section IX.

IX. ENVIRONMENTAL ASSESSMENT AND REVIEW PROCEDURES

A. Introduction

176. The following Environmental Assessment and Review Procedures (EARPs) document the procedures for the environmental assessment of the project sub-components that will be implemented under Components 2 and 3 of the project. The EARPs have been harmonized with the GOV's environmental assessment requirements as far as possible to ensure a streamlined environmental assessment process for project loan activities. The EARPs have been developed to comply with the ADB's *Environmental Assessment Guidelines* (2003).

B. Overview of Types of Project Sub-Components to be Assessed

177. The project targets 275 border districts in 32 provinces along Viet Nam's borders with China and Lao PDR, and some districts along the economic corridors. The selection of the final provinces would be based on:

(1) economic status of the province
(2) health and health service statistics
(3) regional risks and priority clusters
(4) existing support from other partners

178. All project sub-components at one location will be grouped together to form a 'project activity' for the purposes of the application of the EARPs.

C. Viet Nam's Environmental Assessment and Review Procedures

179. Environmental legislation in Viet Nam has recently been subject to significant modifications with the adoption of the *Law on Environment Protection (Revised) 2005* and associated regulatory instruments. The GOV's environmental safeguards procedures are set out in the following instruments:

(i) *Law on Environment Protection (Revised) 2005*: Sets out the broad framework for environmental impact assessment including the need to prepare environmental impact assessments and carry out public consultation.
(ii) *Decree 80*-2006-*ND-CP Providing detailed regulations for implementation of Law on Environment Protection, 9 August 2006*: requires environmental assessments to be prepared concurrently with project Feasibility Studies / Investment Reports,

sets out the required degree of environmental assessment (Annex 1) and establishes requirements for appraisal of environmental assessment documents by the GOV (i.e. a Commitment on Environmental Protection (CEP) or an Environmental Impact Assessment Report (EIAR) (Annex 2)

(iii) *Circular 08/2006/TT-BTNMT Guidance on SEA, EIA and CEPs, 8 September 2006:* sets out the required structure and content of CEPs and EIARs and provides further details of the requirements for public consultation activities.

180. GOV legislation does not require sector level environmental assessments to be carried out for projects such as this project. Thus, unlike the ADB process, there will not be one overarching environmental document for the project prepared under the GOV environmental assessment framework. Investments financed by the loan will be evaluated by the GOV on a site by site basis. All sub-components at one site will be grouped together to form a 'project activity' for and for each project activity, an environmental assessment report will be required to be prepared. The type of environmental assessment report required will depend on the nature, scale and location of the investment.

181. In general, large projects, projects with the potential to generate significant adverse impacts or projects located in protected areas or sensitive locations will be subject to a detailed Environmental Impact Assessment Report (EIAR)[14]. The appraisal and approval authority for EIARs varies according to the location and scale of the project. Most EIARs under the project will be appraised and approved by the Provincial People's Committee (PPC) of the relevant province.

182. Smaller scale activities, such as those to be carried out under the project loan, without the potential for significant adverse impacts will be subject to a lesser level of assessment in the form of a Commitment of Environmental Protection (CEP). CEPs are required to be submitted for appraisal at the time of Feasibility Study preparation. CEPs are submitted to the District People's Committees (DPCs) for appraisal and issuance of an approval certificate.

D. Specific Procedures to be used for Project Sub-components under the Sector-type Loan

1. Responsibilities and Authorities

183. Table 9.1 sets out the responsibilities and authorities of key organizations involved in the implementation of the EARPs.

Table 9.1: Responsibilities for EARP Implementation

Organization	EARP Implementation Responsibilities
CPMU	Check environmental selection criteria have been applied in selection of project sub-components Provide advice to PPMU on environmental assessment (EA) preparation Review and provide "no-objection" on EAs submitted by PPMUs Submit EA to ADB for review and approval
PPMU	Overall responsibility for EA preparation and submission for approval including engagement of consultants if required to prepare EIAR

[14] Annex 1 of Decree 80 identifies the types of projects that are subject to EIARs. Activities that could require an EIAR include hospitals > 50 beds; incinerators or WWTPs > 1000m^3/day.

Organization	EARP Implementation Responsibilities
	Apply environmental selection criteria to identify future project sub-components
PPC	Ensure that the PPMU is adequately resourced to properly manage project sub-components including safeguards issues Appraise and approve EIARs
DONRE	Provide advice and guidance on environmental issues during project sub-component preparation
District PCs	Approval of project sub-component CEP/EMPs
ADB	Receipt and review of EA for each project sub-component

184. Institutional strengthening for organizations involved in EARP implementation would be carried out as follows:

(i) **Environment Support Consultants:** A national consultant would be engaged to work with the CPMU and PPMU Environment Officers and DOH staff to establish systems and tools to implement their project responsibilities and to provide technical on-the-job training and support. Such systems and tools would include example EA documents and templates for use throughout project implementation and organisation of forums to share lessons learnt between PPMUs. These positions would be implemented intermittently throughout project implementation.

(ii) **CPMU Environment Officer:** The CPMU Environment Officer would be the main point of contact for environmental safeguards issues at the central level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iii) **PPMU Environment Officer:** The PPMU Environment Officer would be the primary point of contact for environmental safeguards issues at the province level. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

(iv) **DOH Environment Officer:** An existing staff member within the DOH would be allocated to have responsibility for environmental issues during project operation. In addition to on-the-job training from the Environmental Support Consultant, formal training will be provided to this Officer on an as-needs basis.

2. Environmental Criteria for Future Project Sub-component Selection

185. The environmental criteria for future project sub-component selection are documented below:

(vi) Avoid direct or indirect significant, negative impacts on protected areas defined as 'special use forests' in Decision 8/2001/QD-TTg 11/01/01 of the Government of Viet Nam, or other known areas of ecological sensitivity including those areas identified in Section III of the IEE

(vii) Avoid loss of significant areas of vegetation or permanent, negative impacts on a known rare or endangered flora or fauna species
(viii) Avoid pollution of waterways, surface waterbodies or groundwater resources with ecological values or which are used for domestic or agricultural water supply
(ix) Avoid direct or indirect significant, negative impacts on important items of cultural heritage, including those sites identified in Section III of the IEE
(x) Not cause any other environmental impacts that would trigger categorization as a 'Category A' project in accordance with the ADB's *Environmental Policy, OM.20 Environmental considerations in ADB operations* and *Environmental Assessment Guidelines* (2003)

3. Procedures for Environmental Assessment of Project Sub-components

a. Environmental Categorization

186. The first step in the EARPs will be the determination of the environmental categorization for each subproject in terms of both ADB and GOV requirements.

187. In terms of ADB environmental categorization, the environmental selection criteria that have been developed for subprojects will ensure that all subprojects will be classified either as:

(i) Category B in accordance with the ADB's *Environmental Assessment Guidelines* and thus subject to preparation of an IEE; or
(ii) Category C in accordance with the ADB's *Environmental Assessment Guidelines* and thus not subject to formal environmental assessment.

188. The determination of whether a subproject is Category B or Category C will be made by the PPMU (with advice from the CPMU as necessary) using guidance from the ADB's *Environmental Assessment Guidelines.*

189. In terms of GOV environmental categorization, reference to Annex 1 of Decree 80 indicates that some subprojects may require one of the following levels of environmental assessment:

(i) **Preparation of EIAR:** A small number of project activities may trigger Annex 1 of Decree 80 and required a detailed EIAR. Types of activities that may be subject to EIARs include hospitals with more than 50 beds; incinerators or WWTPS with capacity greater than 1,000m3/day.
(ii) **Preparation of CEP:** Project activities that do not trigger an EIAR will require a less detailed environmental assessment in the form of a CEP.
(iii) **No environmental assessment:** Some subprojects involving very minor upgrading or improvement works may not require any assessment under GOV safeguards requirements; however there is no clear guidance provided in the GOV legislation as to when no assessment is required and this determination will be made on a case by case basis by DONRE and/or DPC in consultation with the PPMU during the environmental categorization process.

190. The determination of the appropriate environmental categorization of each subproject in accordance with GOV safeguards requirements will be made by the PPMU, based on advice

from CPMU and the relevant DONRE and District PC, at the outset of the environmental assessment process with reference to Annex 1 of Decree 80.

b. Preparation of Environmental Assessment Documents

191. For all project activities[15] an environmental assessment document will be required to be prepared that will incorporate the following elements:

(i) Required contents of EIAR or CEP document as established in *Circular 08/2006/TT-BTNMT Guidance on SEA, EIA and CEPs, 8 September 2006*

(ii) Appendix containing a site specific Environmental Management Plan (EMP) prepared following the format and structure contained in Section V

(iii) Appendix containing the results of public consultation and information disclosure activities

192. The information required to be included in the appendices of the EA document are consistent with, but represents a strengthening of, GOV requirements for addressing environmental management issues and public consultation activities in environmental assessment documentation.

c. Requirements for Environmental Management Plans

193. The EA will be required to include an Environmental Management Plan (EMP) for each project sub-component. The EMP will address environmental mitigation and monitoring activities, institutional arrangements and strengthening requirements, public consultation activities during project implementation and operation and environmental monitoring and reporting requirements.

194. Table 9.2 summarizes the potential impacts and proposed mitigation measures for the project activities that will form the basis of the EMP for each project sub-component.

[15] For the purposes of the EARPs a 'project activity' is defined as all project sub-components being carried out at a particular location.

Table 9.2: Project Environmental Impacts and Mitigation Measures

Issue	Performance Objective	Mitigation Measure	Implementation
Procurement Stage			
Dust and emissions generation	and other pollutants	Use wet rags and vacuum cleaners for dust suppression Contain and minimize of work areas Ensure construction equipment and vehicles are maintained in good condition Utilize temporary protective curtains on existing facilities and equipment Emissions from the labs will be collected and treated to ensure the compliance with relevant environmental standards	Supplier/Contractor
Noise generation	Minimize noise generation	Proper maintenance of tools and equipment Limit noisy construction activities to day time hours Install noise dampers Notify affected rooms of schedule and duration	Supplier/Contractor
Surface water and groundwater quality	Minimize generation of potential water pollutants	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs	Supplier/Contractor
Soil contamination	disturbed soils	Ensure that a barrier between the working surfaces and the soil are used to avoid contamination during the works.	Supplier/Contractor
Risks to public and worker health and safety		Adopt and ensure that the hospitals health and safety guidelines are established and practiced Wear and be trained on personal safety equipment	PPMU
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Guidelines are established and practiced	MOH
Accidents and Injury	Avoid accidents and injury	Adopt and ensure that the hospitals health and safety guidelines are established and practiced	PPMU
Operation Stage			

Issue	Performance Objective	Mitigation Measure	Implementation
Dust and emissions generation	Maximize emissions of dust and other pollutants	Ensure compliance with relevant Viet Nam air quality emissions standards Non-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with the relevant environmental standards of Viet Nam on air quality, particulates and odor	PPMU
Odor generation	Minimize odor generation	Develop and implement guidance and action for operation of the labs and training of personnel in proper operation of the labs Regularly remove of waste from temporary storage areas and train personnel in proper waste management practices.	PPMU
Noise generation	Minimize noise generation	Ensure solid waste equipment and vehicles are maintained in good condition Install noise dampers or erect temporary acoustic shields Limit noisy operational activities to day time hours notify nearby community of schedule and duration of activities	PPMU
Surface water and groundwater quality	Minimize generation of potential water pollutants and maintain water quality	Store chemicals in secure area, with concrete floor and weatherproof roof Prepare temporary drain containment or basins Keep left-over scrap materials in locations removed from the drainage ways Use prescribed O&M standards for the labs Maintain storage areas and provide bins for solid waste collection and prevent leaching Train solid waste collectors and hospital staff in proper health care waste management to protect waterways. Ensure that discharge from solid waste and wastewater treatment facilities will comply with criteria contained in the applicable Vietnam and DONRE regulations.	PPMU
		Ensure that wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.	

Issue	Performance Objective	Mitigation Measure	Implementation
Soil contamination	Avoid adverse impacts from disturbed soils	Ensure sealing and containment of burial pits or dumping grounds prior to external municipal disposal. Ensure that discharge from solid waste facilities will comply with criteria contained in the applicable Vietnam and DONRE regulations. Improve operations of wastewater disposal facilities with discharge that complies with the current applicable DONRE standards for medical wastewater.	PPMU
Risks to public and worker health & safety	Minimize risk of accidents involving public or health care workers Maximize benefits of project operation	Implement safety measures during removal and disturbance of asbestos. Provide safety equipment to construction workers and train them in its use Secure SWM landfill site and restrict access by local community Ensure that the applicable Viet Nam regulations on SWM and wastewater discharge are complied with.	MOH
Emissions generation	Comply with relevant Vietnam Emission standards	Ensure emissions from incinerator operation comply with relevant standards	MOH and MONRE
Odor generation	Maximize benefits of project operation	Develop operating procedures for health care waste management systems based on principles contained in Appendix 1 Train personnel in implementation of operating procedures	MOH
Surface water and groundwater quality	Maximize benefits of project operation	Incorporate lining systems in landfill facilities Ensure effluent from wastewater and solid waste facilities complies with relevant Lao PDR standards prior to discharge Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

Issue	Performance Objective	Mitigation Measure	Implementation
Risks to public & worker health and safety	Maximize benefits of project operation	Secure solid waste and wastewater treatment facilities to avoid public access to facilities Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH
Increase in illness due to environmental pollution	Avoid illness from environmental pollution	Adopt and ensure that the hospitals health and safety guidelines are established and practiced Sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.	MOH
Accidents and Injury	Avoid and prevent accidents and injuries	Ensure that the applicable Viet Nam regulations on SWM and wastewater treatment particularly on best practices and safety are complied with.	PPMU
		Develop operating procedures for health care waste management systems and wastewater treatment facilities based on principles contained in Appendix 1 Undertake regular maintenance of solid waste and wastewater treatment facilities Train personnel in implementation of operating procedures	MOH

195. Tables 9.3 and 9.4 summarize the proposed monitoring measures for the project activities that will form the basis of the EMP for each project sub-component.

Table 9.3: Environmental Effects Monitoring Plan[16]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring required					
Procurement					
Dust suppression	visible dust levels in the laboratory area	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/PPMU
Noise minimization	Noise levels near sensitive receivers	In the laboratory and adjoining rooms	Observation	During noisy activities	Supplier/PPMU
Water quality protection	Visible sediment, waste or other pollutants in waterways	At surface waterways and wells in vicinity of the hospitals	Observation	Weekly or after rain events	Supplier/PPMU
Operation					
Air emissions control	TSP, SOx, NOx,	Ambient conditions at site boundary	As specified in Viet Nam standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease	In waterways and wells in vicinity of effluent discharge from solid waste or wastewater facilities	As specified in Vie Nam standards	Weekly for first 6 months and then monthly thereafter	MOH

Table 9.4: Environmental Performance Monitoring Plan[17]

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Pre-Procurement					
No monitoring					
Procurement					
Dust suppression	Covering of equipment and fixtures & use of dust suppression methods	In the laboratory and adjoining rooms	Visual observation	During windy conditions	Supplier/PPMU
Water quality protection	Condition of erosion and sediment controls	At surface waterways and wells in vicinity of hospitals	Observation	Weekly or after rain events	Supplier/PPMU
Operation					

[16] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table.
[17] Resettlement and livelihood related monitoring is contained in the project Resettlement Plan and is not included in this table.

Mitigation Measure	Parameters	Location	Methods	Frequency	Responsibility
Air emissions control	All criteria in Viet Nam – Air quality – odor from solid waste matter – Permitted level.	At solid waste facilities and autoclaves	As specified in Vietnam standards	Weekly for first 6 months and then monthly thereafter	MOH
Water quality protection	BOD, COD, TSS, total coliform, E. coli, oil/grease, heavy metals	At effluent discharge from solid waste or wastewater facilities	As specified in Vietnam standards	Weekly for first 6 months and then monthly thereafter	MOH

d. Requirements for Public Consultation and Disclosure

196. There is a requirement that public consultation and information disclosure takes place for each project activity during preparation of the EA. The following minimum requirements for public consultation and disclosure must be met for each project activity.

197. At the outset of the preparation of the EA, local authorities and community representatives in the vicinity of, or who are likely to be affected by, the project should be informed of the project activity and given an opportunity to provide feedback on potential environmental issues or required management measures[18]. The following activities will be carried out for each project activity:

(i) District level workshops in each district contained in the project area to discuss project interventions, potential environmental impacts of project activities and required mitigation measures. Representatives at the workshops with include stakeholder agencies, mass organizations (Women's' Union, Fatherland Front, Youth Union and Farmers Association), other relevant district level organizations such as the District Committee for Ethnic Minorities and CPC and commune representatives.

(ii) Meetings with potentially affected households, sensitive receivers (schools, temples etc.) and landowners to discuss specific issues of concern and mitigation measures required.

198. In addition, information on the project activity and consultation activities will be provided to the local community through newspaper notices and/or public announcements.

199. Following approval of the environmental assessment document, a copy of the approval and a summary of the environmental assessment document will be sent to all relevant DPCs and CPCs. Information regarding the approved project and the proposed environmental management measures will be posted at suitable locations on the project site.

200. The public consultation activities carried out and the subsequent outcomes must be documented in the EA and the records of the public consultation appended to the document.

[18] Circular 08 requires that this consultation take the form of a letter to the CPC and Fatherland Front inviting representatives to a meeting with the PPC.

e. Review of Environmental Assessment Documents by GOV and ADB

201. At the same time that the EA is submitted to the relevant GOV authorities (in Vietnamese language), it will be submitted by the CPMU (in English language) to the ADB. The ADB will review the document for compliance with its environmental safeguards requirements.

202. All environmental assessment documents prepared using these EARPs will be reviewed and approved by the GOV. The approval process that will be implemented by the GOV is set out in Decree 80.

203. For sub-projects with a value of more than $1million, approval of environmental assessment documents will be required from the ADB prior to the commencement of construction works.

f. Monitoring and Reporting of EARP Implementation

204. Monitoring and reporting of EARP implementation will be undertaken to ensure that the procedures are being adequately implemented and to identify any modifications or corrective action that may be required to improve the efficiency of the EARPs throughout the project implementation process. The monitoring of EARP implementation will be incorporated into the overall project monitoring and evaluation and reporting system. EARP implementation will be monitored at the province and central levels.

205. Reporting of EARP implementation will take place on a 6 monthly basis. Each PPMU will report to the CPMU on the monitoring parameters contained in Table 9.2, and the CPMU will consolidate these reports, together with the results of the central level monitoring for submission to the ADB.

206. Table 9.5 summarizes the monitoring processes that will be carried out for EARP implementation.

Table 9.5: Monitoring of EARP Implementation

Monitoring Parameter	Monitoring Method	Frequency of Monitoring	Responsibility for Monitoring
Verification of EA preparation and approval before commencement of project component construction	Verification of: (i) EA document produced, (ii) GOV certificate issued, (iii) ADB no-objection issued	Each project sub-component before commencement of construction	PPMU
		Random checks of at least 15% of project sub-components	CPMU
		Random check of small number of project sub-components	CPMU
Adequacy of public consultation / disclosure activities to meet EARP requirements	Number and type of public consultation and disclosure events and key issues raised	For all project sub-components	PPMU

E. Confirmation that the Environmental Assessment and Review Procedures conform to ADB's Requirements

207. The EARPs presented in this section have been developed to take account of the ADB's environmental safeguards requirements. Specifically, the EARPS require development of environmental mitigation and monitoring plans and institutional arrangements, and implementation of public consultation activities to meet the ADB's requirements.

208. The review of the environmental assessment documents for each project activity that will be carried out by the ADB will ensure compliance of the products of these EARPs with ADB safeguards requirements.

F. Staffing Requirements and Budget for EARP Implementation

209. Table 9.6 summarizes the estimated staffing requirements and budget for EARP implementation for each project activity.

Table 9.6: Staffing Requirements and Budget for EARP Implementation

Organization	Responsible Personnel	Human/Financial Resources for EARP Implementation assuming EIAR Level Assessment	Human/Financial Resources for EARP Implementation assuming CEP Level Assessment
CPMU	CPMU Environment Officer	3 person weeks	1-person week
PPMU	PPMU Environment Officer	4 person weeks $20,000	3 person weeks $5,000

X. FINDINGS AND RECOMMENDATIONS

A. Findings

210. The terms of reference initially categorized this project as requiring an Initial Environmental Examination (IEE) report and an Environmental Management Plan (EMP) both of which are required for Category A and B projects. It is understood that this project was tentatively classified as Category B from the ADB project documents during an initial screening of anticipated potential environmental impacts based on the concept document. This categorization was examined through the respective visits to the different project sites and the proposed project component descriptions and how the project component intends to mitigate the potential negative environmental impacts of the project.

211. In accordance with the ADB's *Safeguard Policies Statement (2009)*, Category B Projects are those judged to have some adverse environmental impacts, but of lesser degree and/or significance than those for Category A projects that require a full Environmental Impact Assessment (EIA) arising from major adverse impacts on the environment. For Category B projects, an IEE is required to determine whether or not significant environmental impacts warranting an EIA are likely. If an EIA is not needed, the IEE is regarded as the final environmental assessment report.

212. The final list of the project's subcomponents and the project descriptions for their implementation have indicated that the project will be a Category B. The negative impacts expected to occur during operation stages of the project. Namely:

(i) **During the procurement stage**: Probably some structures of the laboratories and/or other structures of the hospitals need to be repaired and upgraded before assembly of the equipment. However, the negative impacts during this phase will be negligible due to the scale of the activities are limited and these negative impacts will be localized and temporary. Such impacts include generation of noise and dust, deterioration of water quality through sediment laden runoff and will be readily managed to acceptable levels through implementation of standard environmental management practices.

(ii) **During operation stage**: Liquid and solid waste generated by the operation of the laboratories as well as the hospitals as a whole are likely to be the sources of negative impacts on the environment if they are not managed properly. Such pollution sources will include infectious specimens, chemicals for testing, wastewater and emission of the laboratories. These pollution sources are long-term and consecutive, and therefore, mitigation measures should be considered adequately through both structural measures (the technical systems for collection and treatment the wastewater, hazardous waste, infectious waste and emission generate from the laboratory should be equipped synchronously) and management measures (application procedure of separation of wastes at source, procedure of management, collection and treatment of hazardous/infectious wastes, etc.). During the Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices particularly in relation to solid waste and wastewater treatment facilities.

B. Recommendations

213. It is recommended that the Project should ensure that for the selected health facilities the laboratories should be well-managed with trained staff. Based on the field assessment and the project proposals, most of laboratories have standardized biosafety level 3 for the provincial health facilities (hospitals and preventive medicine centres) and standardized biosafety level 2 for the district (health facilities (hospitals and preventive medicine centres). However, most of laboratories in the provinces visited are not equipped with the collection and treatment systems for the waste emissions generated and the wastewater from the laboratories are not treated according to the environmental standards. Therefore, the implementing agencies need to consider the appropriate equipment and structures for further investments to ensure that the operation of the health facilities are sound and will not cause significant impacts to the environment. The mitigation measures will also be managed by the provinces and made part of their operational plans for the health facilities invested.

214. Separately, the project will undergo environmental impact assessment in accordance with the following Vietnamese legislation the Environmental Protection Law 2014, Decree No. 18/2015/ND-CP dated 14 February 2014 on environmental protection planning, strategic environmental assessment and environmental impact assessment, Circular No. 26/TT-BTNMT dated 28 May 2015 regulation on the fully environmental protection scheme and abridged environmental protection scheme; Circular No. 27/2015/TT-BTNMT dated 29 May 2015

providing the detailed guideline for implementation of the strategic environmental assessment, environmental impact assessment and environmental protection plan. The Environmental Impact Assessment is required for all newly improved hospital projects. For the repair, renovation and upgrade of the hospitals, depending on the scale of the construction activities, an EIA or Environmental Protection Scheme have to be prepared in the next phase of the project in accordance with Vietnamese regulations.

XI. CONCLUSIONS

215. The project activities are expected to have a range of benefits on the natural and social environment, and only minor or negligible negative environmental impacts. The majority of minor negative impacts are expected to occur during the procurement and operation phase. These will be localized, minor and temporary and will be readily managed to acceptable levels through the implementation of the appropriate solid waste, wastewater, and environmental management practices. Operation stage environmental impacts can be mitigated to acceptable levels through appropriate design of subprojects and implementation of basic operation and maintenance (O&M) environmental management practices.

216. This IEE Report includes an Environmental Management Plan (EMP) defining the types of environmental mitigation and monitoring measures required to offset potential negative environmental impacts. The development of the EMP takes into account the likely level of technical, financial and human resources available for each of the subproject components. The EMPs will be updated as project implementation progresses beginning with the detailed design. Site-specific conditions may change the nature of the assumptions on the EMPs as the details of the upgrades and improvement projects of the hospitals and health centers become more precise and sensitive to the prevailing environmental conditions of the different project locations.

217. Based on the findings of the Environmental Assessment, it is concluded that that the project will not have a significant effect on the environment. The investments in the health security project, overall, will bring forth more positive than negative environmental impacts and greater health security particularly in the border provinces. In view of this, an EIA is not required to be prepared for this project. Individual project activities will be assessed following the Environmental Assessment Review Procedure as prescribed by ADB for the other sub-project component activities while site-specific environmental mitigation and monitoring measures will be developed and implemented accordingly as set out in the EMPs.

XII. REFERENCES

ADB. 2009. Safeguard Policy Statement
ADB. 2002. Environmental Policy and Operations Manual 20
ADB. 2003. Environmental Assessment Guidelines, Manila
ADB. 1997. Environmental Impact Assessment in Developing Countries

Appendix 1: Environmental Screening of Project Sub-Components

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Impacts on the Natural Environment				
Dust generation and air emissions	O	X	O	**Minor Repair and Improvement Works** During minor repair and improvement work, localized, temporary negative impacts may result from dust generation from removal and installation of existing equipment, frames, cabinets, and supports to clear the way for new laboratory improvements and equipment. Mitigation measures will include use of wet rags and vacuum cleaners for dust suppression, containment and minimization of work areas, and utilizing temporary protective curtains on existing facilities and equipment. No impacts are expected during the operation stage.
	O	X	++	**Laboratory Equipment Commissioning including IPC Services** Negative Impact as above for dust emissions. As a mitigating and control measure, emissions from the labs will be collected and treated to ensure the compliance with relevant the environmental standards of Vietnam as current regulations on air (poison gases and odour) IPC "standard precautions" to be implemented to enhance positive impact during operations. Standard precautions include: use of PPE and environmental cleaning.
	O	O	X	**Solid Waste Management Facilities** Negative impact as above for dust emissions. For IPC, autoclaves will be designed and controlled to ensure compliance with relevant Vietnam air quality emissions standards namely criteria contained in MONRE/DONRE regulations on: air (odor and particulates) and water quality – for steam condensate of medical liquid waste from autoclaves permitted level. on-incinerator technology should be considered for medical solid waste management facilities (if any) to ensure compliance with relevant the environmental standards of Vietnam on air quality, particulates and odor.
	O	O	O	**Wastewater Treatment Facilities** No impact
Odor generation	O	O	O	**Minor Repair and Improvement Works** No impact
	O	O	X	**Laboratory Equipment Commissioning including IPC Services** During operation improper use or maintenance of lab facilities and equipment may result in minor, localized impacts from odour generation. Mitigation measures will include development and implementation of guidance and action for operation of the labs and training of personnel in proper operation of the labs.
	O	O	X	**Solid Waste Management Facilities** During operation improper use or maintenance of waste storage areas may result in minor, localized impacts from odor generation. Mitigation measures will include development of operational procedures for temporary and permanent waste storage areas, regular removal of waste from temporary storage areas and training of personnel in proper waste management practices.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** During operation improper use or maintenance of wastewater treatment facilities may result in minor, localized impacts from odor generation. Mitigation measures will include development of appropriate operational procedures and training for personnel.
Noise generation	O	X	O	**Minor Repair and Improvements Works** During minor repair and improvement work, minor, localized, temporary impacts may result from noise generation from use of tools and installation equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of tools and equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected rooms of the duration and extent of installation works. No impacts are expected during the operation phase of the works.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** Minor negative impacts and mitigating measures as above.
	O	O	X	**Solid Waste Management Facilities** During collection, transport and disposal operations, minor, localized, temporary impacts may result from noise generation from use of containers, vehicles and equipment. Mitigation measures will include restriction of noisy activities to day time hours, installation of noise dampers, proper maintenance of equipment, erection of temporary acoustic shields in the vicinity of sensitive receivers and notification of the affected areas of the duration medical waste management activities.
	O	O	X	**Wastewater Treatment Facilities** Minor negative impacts and mitigating measures during operations as above

POTENTIAL IMPACT	-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Surface water quality deterioration	O	X	O	**Minor Repair and Improvement Works** Minor negative impacts on surface water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from the drainage ways.
	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, surface water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to environment.
	O	O	X	**Solid Waste Management Facilities** During operation stage, surface water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect waterways. Discharge from solid waste facilities will comply with criteria contained in the applicable Vietnam and DONRE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
Ground water quality deterioration	O	X	O	**Minor Repair and Improvement Works** Minor negative impacts on ground water quality as a result of dirt and sediment laden drainage water from cleaning during preparation for lab equipment installation that will seep through ground water sources or wells. This may include cleaning chemicals, fuels or oils used and disposal of litter and general solid waste. Mitigation measures will include preparation of temporary drain containment or basins, and keeping left-over scrap materials in locations removed from ground water sources.

POTENTIAL IMPACT	-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	X	X	**Laboratory Equipment Commissioning including IPC Services** Minor negative impact and mitigating measures same as above during procurement stage. During operation stage, ground water quality may be adversely affected as a result of spills or leakage of chemicals generated from the laboratory activities including bio-wastes and laundry water emissions. Mitigation measures will include protecting groundwater sources permanently and the development and operation of the O&M for the labs. Wastewater from the labs will be collected and treated to ensure compliance with the current standards for the medical wastewater before discharging to the environment.
	O	O	X	**Solid Waste Management Facilities** During operation stage, ground water quality could be adversely affected by improper disposal of solid waste. Mitigation measures will include maintenance of storage areas and provision of bins for solid waste collection and training of solid waste collectors and hospital staff in proper health care waste management to protect ground water sources. Discharge from solid waste facilities will comply with criteria contained in the applicable Vietnam and DONRE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect ground water quality. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.
	O	X	O	**Minor Repair and Improvement Works** During operation, minor impacts of cleaning activities resulting in contamination of soils with cleaning chemicals and agents from repair and improvement activities. Mitigation measures will include ensuring that a barrier between the working surfaces and the soil are used to avoid contamination during the works.
Soil Contamination		O	O	**Laboratory Equipment Commissioning including IPC Services**
	O	O	X	**Solid Waste Management Facilities** During operation stage, soil could be adversely affected by improper disposal of solid waste particularly for hospitals that bury medical wastes into their own grounds. Mitigation measures will include ensuring sealing and containment of burial pits or dumping grounds prior to external municipal disposal Discharge from solid waste facilities will comply with criteria contained in the applicable Vietnam and DONRE regulations.
	O	O	X	**Wastewater Treatment Facilities** Negative impacts during operations of sub-standard wastewater facilities in existing provincial and district hospitals with emissions that could affect surrounding soils. Mitigating measures will include the proper design and improvement in operations of wastewater disposal facilities with discharge that complies with the criteria contained in the current applicable DONRE standards for medical wastewater.

POTENTIAL IMPACT	-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Impacts on the socio-economic environment				
Amenity of surrounding land use	O	X	O	**Minor repair and improvement works** During procurement very minor, localized and temporary impacts to amenity of surrounding land use may occur in the form of dust and noise generation. Such impacts will be readily mitigated through the range of measures previously described on dust, odor and noise.
	O	X	O	**Laboratory Equipment Commissioning including IPC Services** are as above during procurement, the laboratories may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Solid Waste Management Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.
	O	O	X	**Wastewater Treatment Facilities** As above during operations. During operation the facilities may generate small amounts of odor; any such impacts will be minor, temporary and localized.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
Impacts on Public Health and Safety				
Risks to public health and safety	O	X		**Minor Repair and Improvement Works** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks in public safety for nearby receivers if not properly managed. Mitigating measures include adopting and ensuring that the suppliers comply with safety guidelines established by the provincial and district hospitals.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.
	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Viet Nam regulations on SWM are complied with.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Viet Nam regulations on wastewater discharge are complied with.
Risks to health and safety of workers	O	X	O	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals. Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.
	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to the hospital workers. Mitigating measures include ensuring that the applicable Viet Nam regulations on SWM are complied with.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	X	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff. Mitigating measures include ensuring that the applicable Viet Nam regulations on wastewater discharge are complied with.
Increase in illness due to environmental pollution such as: dust, air, water supply contaminants, solid and hazardous wastes, untreated sewage surface water runoff, and wastewater	O	X	O	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for health workers in the form of dust and noise Mitigating measures include adopting and ensuring that the hospitals health and safety guidelines are established and practiced by the provincial and district hospitals.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff, the patients and the public.
	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks to public health and safety. Mitigating measures include ensuring that the applicable Viet Nam regulations on SWM are complied with. Also sustain pollution control measures in operations to avoid/reduce noise, dust, and air emissions. Implement solid and hazardous waste management plans. Ensure that all international and best practice environmental pollution measures on wastewater and surface water runoff, and soil contamination management are in place.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks to hospital staff and the public. Mitigating measures include ensuring that the applicable Viet Nam regulations on wastewater discharge are complied with.
Accidents and injury	O	X	O	**Minor Repair and Maintenance Work** Some demolition or disassembly of existing fixtures in preparation for laboratory equipment installation may cause risks for accidents and injury Mitigating measures include adopting and ensuring that the hospital's safety guidelines are established and practiced by the provincial and district hospitals. Workers will be provided with appropriate personal safety equipment and will be trained in its use prior to commencement of work on the site.
	O	O	++	**Laboratory Equipment Commissioning including IPC Services** Positive impact from improved laboratory equipment and safer laboratory diagnostic services for hospital staff and the public.

POTENTIAL IMPACT	PRE-PROCUREMENT STAGE	PROCUREMENT STAGE	OPERATION STAGE	DISCUSSION OF IMPACT AND MITIGATION MEASURES
	O	O	x	**Solid Waste Management Facilities** Deficient or improperly managed solid waste facilities from storage, collection to disposal will increase the risks of accident and injury. Mitigating measures include ensuring that the applicable Viet Nam regulations on SWM particularly on best practices and safety are complied with.
	O	O	x	**Wastewater Treatment Facilities** Deficient or improperly managed wastewater facilities or the lack of it by the hospitals will increase the risks the risks of accident and injury. Mitigating measures include ensuring that the applicable Viet Nam regulations on wastewater discharge are complied with and safety practices are always observe.

Appendix 2: RAPID ENVIRONMENTAL ASSESSMENT FORM (MODIFIED)

Instructions:

- This checklist focuses on environmental issues and concerns. To ensure that social dimensions are adequately considered, refer also to ADB checklists and handbooks on (i) involuntary resettlement, (ii) indigenous peoples planning, (iii) poverty reduction, (iv) participation, and (v) gender and development.
- Answer the questions assuming the "without mitigation" case. The purpose is to identify potential impacts. Use the "remarks" section to discuss any anticipated mitigation measures.

Project Title: Greater Mekong Subregion Health Security Project
Location: Vietnam
Proposed Environmental Category: B

SCREENING QUESTIONS	Yes	No	REMARKS
A. PROJECT SITING IS THE PROJECT AREA			
▪ DENSELY POPULATED?		X	
▪ HEAVY WITH DEVELOPMENT ACTIVITIES?		X	
▪ ADJACENT TO OR WITHIN ANY ENVIRONMENTALLY SENSITIVE AREAS?		X	
▪ CULTURAL HERITAGE SITE		X	
▪ PROTECTED AREA		X	
▪ WETLAND		X	
▪ ANGROVE		X	
▪ ESTUARINE		X	
▪ BUFFER ZONE OF PROTECTED AREA		X	
▪ SPECIAL AREA FOR PROTECTING BIODIVERSITY		X	
▪ BAY		X	
B. POTENTIAL ENVIRONMENTAL IMPACTS WILL THE PROJECT CAUSE…			
▪ impacts on the sustainability of associated sanitation and solid waste disposal systems and their interactions with other urban services?	X		
▪ deterioration of surrounding environmental conditions due to rapid urban population growth, commercial and industrial activity, and increased waste generation to the point that both manmade and natural systems are overloaded and the capacities to manage these systems are overwhelmed?		X	

SCREENING QUESTIONS	Yes	No	REMARKS
▪ degradation of land and ecosystems (e.g. loss of wetlands and wild lands, coastal zones, watersheds and forests) ?		X	
▪ increase in soil erosion and siltation?		X	
▪ increase in peak and flood flows?		X	
▪ loss of downstream beneficial uses (water supply or fisheries)?	X		Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to stream sources of water. Target district hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with GOV/MONRE emission standards
▪ unnecessary loss of ecological value and decreased biodiversity by replacement of natural forest with plantation with limited number of species?		X	
▪ dislocation or involuntary resettlement of people?		X	
▪ displacement of people or reduce their access to forest resources?		X	
▪ degradation of cultural property, and loss of cultural heritage and tourism revenues ?		X	
▪ encroachment into precious ecosystem (e.g. sensitive habitats like protected forest areas or terrestrial wildlife habitats?		X	
▪ occupation of low-lying lands, floodplains and steep hillsides by informal settlers and low-income groups, and their exposure to increased health hazards and risks due to pollutive industry?		X	
▪ water resource problems (e.g. depletion/degradation of available water supply, deterioration for surface and ground water quality, and pollution of receiving waters?	X		Potential impact of untreated wastewater from improvement works and laboratory operations, and medical solid waste washings to boreholes/wells used as groundwater source. Target district hospitals should mitigate by ensuring that they operate existing drainage and wastewater treatment facilities that comply with GOV/MONRE emission standards
▪ air pollution from fuel gas discharged into the atmosphere ?		X	
▪ social conflicts between construction workers from other areas and local workers ?		X	
▪ road blocking and temporary flooding due to land excavation during rainy season?		X	
▪ noise and dust from construction activities?	X		Potential impacts from minor repair and improvement works in laboratories
▪ traffic disturbances due to construction material transport and wastes?		X	Only minor repair and improvement works for laboratories are anticipated
▪ increased road traffic due to interference of construction activities?		X	
▪ hazardous driving conditions where construction interferes with pre-existing roads?		X	
▪ short-term soil erosion and silt runoff due to construction?		X	
▪ hazards to public health due to ambient, household and occupational pollution, thermal inversion, and smog formation ?		X	

SCREENING QUESTIONS	Yes	No	REMARKS
▪ short-term construction impacts (e.g. soil erosion and silt runoff, deterioration of water and air quality, noise, dust and vibration from construction equipment?	X	☐	Potential minor impacts from repair and improvement works of laboratories within existing hospital building facilities
▪ overdrawing of ground water, leading to land subsidence, lowered ground water table, and salinization ?	☐	X	
▪ contamination of surface and ground waters due to improper waste disposal ?	X	☐	Potential impact for hospitals with deficient and substandard medical solid waste management systems especially if the hospital grounds are used as temporary waste transfer stations. Target district hospitals should mitigate by ensuring that an operational medical waste management system is in place including treatment facilities that comply with GOV/MONRE emission standards.
▪ contamination of soil and groundwater from solid wastes from water treatment sludges, cafeteria or lunchroom wastes, ashes and incineration residues, etc.?	X	☐	Same as above
▪ contamination of air quality from incineration (if incinerator is present at the facility)?	X	☐	Potential impact for hospitals with deficient and substandard incinerators that produce emissions that are not compliant with air emission standards. Target district hospitals should mitigate by ensuring that an operational medical waste disposal system is in place that complies with GOV/MONRE air emission standards.
▪ health and safety hazards to workers from toxic gases and hazardous materials present in the facility?	X	☐	Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management
▪ water pollution from discharge of liquid effluents?	X	☐	Potential impact and mitigating measures as above in dealing with medical solid and liquid waste management
▪ pollution of receiving waters resulting in amenity losses, fisheries and marine resource depletion, and health problems ?	☐	x	
▪ public health and safety hazards due to solid waste disposal in sanitary landfills ?	X	☐	Potential impact by hospitals operating without medical solid waste treatment facilities. Mitigate by ensuring that a compliant disposal system is in place or is worked out with the municipality and no open dumping is allowed at the hospital grounds.
▪ poor sanitation and solid waste disposal in construction camps and work sites, and possible transmission of communicable diseases from workers to local populations?	☐	X	Work is within existing premises
▪ increased noise and air pollution resulting from traffic volume?	☐	X	
▪ creation of temporary breeding habitats for mosquito vectors of disease?	X	☐	Potential impact from hospitals that have deficient and substandard drainage facilities. Mitigating measure is to upgrade, maintain and ensure that no ponding from drainage systems occurs.

Gender Analysis and Action Plan

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

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ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
APSED	Asia Pacific Strategy for Emerging Diseases
CAW	Committee for the Advancement of Women (Viet Nam)
CBO	Community based organizations
CDCD	Communicable Disease Control Department (Cambodia)
CEDAW	United Nations Committee on the Elimination of Discrimination Against Women
CEMA	Committee for Ethnic Minority and Mountainous Area Affairs
CHEC	Community health education center
CPS	Country partnership strategy
DMF	Design and Monitoring Framework
DSW	Department of Social Welfare (Myanmar)
EGM	Effective gender mainstreaming
EHF	Ebola Hemorrhagic Fever
EID	Emerging infectious diseases
GAP	Gender action plan
GDPM	Guidelines for Development Project Management
GEN	Gender Equality Network
GMS	Greater Mekong Subregion
GVN	Government of Viet Nam
HDI	Human Development Index
HFMD	Hand, Foot and Mouth Disease
HIV	Human Immunodeficiency Virus
HPAI	Highly Pathogenic Avian Influenza
IHLCS	Integrated Household Living Conditions Survey (Myanmar)
IHR	International Health Regulations
LWU	Lao Women's Union
MDG	Millennium Development Goals
MERS	Middle East Respiratory Syndrome
MEV	Migrants and mobile people. ethnic minorities, and other vulnerable groups
MOH	Ministry of Health
MOLISA	Ministry of Labor, Invalids, and Social Affairs (Viet Nam)
NCAW	Lao National Commission on the Advancement of Women
NCFAW	National Committee for the Advancement of Women
NIPH	National Institute for Public Health
NSDP	National Strategic Development Plan
NSPAW	National Strategic Plan for the Advancement of Women, 2012-2021 (Myanmar)
NSPS	National Social Protection Strategy
NTD	Neglected Tropical Diseases
PAM	Project Administration Manual
PMU	Project Management Unit
PPMS	Project Performance Monitoring System
PSA	Poverty and Social Analysis
RGC	Royal Government of Cambodia
RRP	Report and Recommendation to the President
RSIII	Rectangular Strategy Phase III (Cambodia)
SARS	Severe Acute Respiratory Syndrome
VWU	Viet Nam Women's Union
WHO	World Health Organization

EXECUTIVE SUMMARY

The Greater Mekong Subregion Health Security Project (the project) for Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam is classified as Category II: Effective Gender Mainstreaming (EGM). The project offers opportunities for addressing women's access to health services, female staff participation in health services, and other potential positive gender effects, but also risks missing these opportunities if not well implemented. The document presents a summary gender analysis of the project with attached four country-specific gender analysis, strategy, and gender action plan (GAP) based on ADB's policy on gender and development.

The project will contribute to improved regional public health security in the four countries, in terms of timely prevention and control of major diseases including emerging infectious diseases (EID), HIV, tuberculosis, malaria, dengue, and drug resistant infections in general, with potentially high mortality and economic impact. The outcome will be strengthened health security systems and communicable disease control in border areas. Outputs are: (i) improved regional cooperation and communicable disease control in border areas; (ii) strengthened surveillance and response systems; and (iii) improved diagnostics and management of infectious diseases. Output 1 specifically targets migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEV) including women and youths in border areas and economic corridors. These populations are at greater risk of infectious diseases and tend not to use regular health services for prevention, reporting, and management of infections.

The patterns of infectious diseases are known to differ substantially among women and men due to differences in exposure and response linked to occupation, habits, constitution, nutrition, reproduction, and child care. Multiple factors contribute to women's access to health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members. While the proportion of female staff working in the health sector is relatively high, they are underrepresented in management, scholarships, and in border and outreach services. Some ethnic minority groups are also under-represented.

In each GMS country, gender legislation provides directives to advance gender equality, but implementation remains weak in the government systems. While there is acknowledgement of the need to move ahead with the gender, there is also a complacency with current state of affairs, often explained from a cultural perspective, and subsequently gender issues are not high on the priority list. Gender focal points have many other responsibilities, and see their role more in terms of advocacy and training among civil servants, rather than in society. A comprehensive sector-wide gender strategy is lacking in the 4 health sectors, and gender and development is not yet mainstreamed in all government activities. Gender action plans are typically linked to programs and projects. But each country has government, non-government, civil society, and grassroots organizations that are more active and competent in addressing gender issues, and it would be beneficial for each Ministry of Health (MOH) to strengthen collaboration with these organizations.

As a project gender strategy, each MOH has agreed to gender mainstreaming in all project activities including for (i) planning, reporting and monitoring activities; (ii) female staff representation; (iii) and assisting ethnic and migrant women and girls who to access health services. The project GAP proposed here is aligned with national gender legislation, strategies and plans, and ADB's policy for gender and country analysis.

Past ADB projects show an improving trend in terms of implementing the project GAP. Project Directors are committed to provide the necessary leadership and inputs to fully implement the GAP. GAP indicators are included in the project design and monitoring framework, and ministries are in different stages in setting up disaggregated monitoring systems. Within each project management unit (PMU), a gender and social safeguards specialist will be engaged to help plan, provide capacity building for, and monitor GAP implementation. Linkages will be established with organizations outside MOH as needed.

I. Introduction

1. This document presents the four-country project-specific gender analysis, strategy, and gender action plan (GAP) for the GMS Health Security Project of Cambodia, Lao PDR, Myanmar and Viet Nam based on ADB's policy on gender and development[1]. It analyzes potential gender effects of the project, and proposes actions to enhance gender equity, mitigate risks, and monitor performance. It has been formulated to maximize benefits for women, especially the poor and ethnic minorities. It builds on the project specific outputs and actions including measures to (i) promote participation of female beneficiaries and other stakeholders at all levels in project planning, implementation and monitoring; (ii) ensure gender aspects are addressed in project planning, implementation, and in project-supported government strategies and plans; (iii) ensure that women have equal access to health care, workshops, training, and promotions supported by the project; and (iv) ensure gender-disaggregated monitoring and evaluation. The project has been classified as Category II: "effective gender mainstreaming" (EGM) in all four countries at all levels and at all stages of the project cycle.

2. According to ADB's Guidelines on Gender Mainstreaming Categories, 2012, a project is assigned EGM classification if the project outcome is not gender equality or women's empowerment, but project outputs are nonetheless designed to directly improve women's access to social services, and/or economic and financial resources and opportunities, and/or basic rural and urban infrastructure, and/or enhancing voices and rights, which contribute to gender equality and women's empowerment2.

3. The requirements for projects with an EGM classification include:

(i) A social analysis conducted during project preparation included careful consideration of gender issues highlighting both constraints and opportunities;

(ii) Specific gender design features are included in the majority of project outputs and/or components to facilitate and ensure women's participation and access to project benefits. Most of these outputs/components should have at least three gender design features and targets;

(iii) Gender targets and performance and monitoring indicators are included in the project design and monitoring framework (DMF);

(iv) A GAP is included as a linked document of the "report and recommendations to the president" (RRP) of ADB and included in the related project administration manual (PAM);

(v) The RRP main text discusses how the project will contribute to improving women's access to or benefits from the project, at a minimum in the Poverty and Social subsection under the due diligence section; and,

(vi) A covenant or a condition in the policy matrix to support implementation of the GAP.

4. During the project design, five gender specialists conducted a gender analysis in the four project countries. Key policies and institutions are listed in Appendix 1. Indicators are summarized in Appendix 2. Country specific GAPs are presented in Appendix 3. It is noted that countries are in the project of developing sector- or subsector-wide GAP. As such, each individual country GAP may need to be adjusted during project implementation to more closely align with country GAP.

[1] ADB. 1998. *Policy on Gender and Development*. 2003. Manila

[2] ADB. 2012. *Guidelines for Gender Mainstreaming Categories of ADB Projects*. Manila

II. Project Summary

a. The GMS Health Issues

5. Globally, all countries are at risk of outbreaks of emerging infectious diseases (EID) such as Ebola hemorrhagic fever with epidemic potential that may result in major mortality and economic slowdown. Located in Southeast Asia, an area with mega cities, associated environmental and biosafety problems, and intense connectivity, the GMS has experienced several outbreaks of EID including severe acute respiratory syndrome (SARS) and avian influenza. The four project focus countries are particularly vulnerable due to shortcomings in health service delivery due to issues around access (geographic and social), quality of services and financing. Vulnerable groups in rural areas including ethnic minorities and migrants, the poor and women in general, access services less frequently and this constitutes both an individual and a public health risk. Government health services, being constrained by general government conditions, remain ill equipped to reach these priority groups.

6. The World Health Organization's (WHO) International Health Regulations (IHR), 2005,[3] mandates all countries to improve public health security. The Asia Pacific Strategy for Emerging Diseases (APSED), 2010, developed by WHO regional offices, identifies 10 strategic areas for compliance by not later than 2016.[4] At present, compliance has reached about 70-80% in the region, with specific gaps mainly relating to laboratory services, hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.5 WHO has further requested countries to implement other regional strategies for the control of communicable diseases of regional importance including HIV, tuberculosis, malaria, dengue, and neglected tropical diseases (NTD), and related laboratory services.

7. While the burden of communicable diseases have declined overall in the GMS, their continuing control is a major challenge because of (i) high costs, (ii) changes in life style with better income and connectivity, (iii) urbanization, migrants and slum formation, and (iv) drug resistance and misuse of antibiotics. Investment in control measures for (re)-emerging diseases is needed. Dengue has become a major public health problem in the GMS and is spreading across the world. Hand, foot and mouth disease, cholera, and several dengue-related viral diseases are causing outbreaks. In the meantime, common diarrheal diseases and respiratory infectious diseases continue to be the major burden of diseases in children below five years of age. While countries have mostly achieved their Millennium Development Goals (MDG), they are facing new challenges that will require further disease prevention. Populations particularly affected by infectious diseases include poor people living in border areas and along GMS economic corridors, who infrequently access regular health services for prevention, reporting, and management of infections. Of particular concern are migrants, young women and girls, and poor ethnic minorities living in isolated segments of GMS borders and corridors.6

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[3] World Health Organization. 2005. *International Health Regulations*. Geneva.
[4] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*. Manila.
[5] WHO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.
[6] WHO. 2007*. Addressing Sex and Gender in Epidemic Prone Infections*. Geneva.

b. The Project

8. The project goal is strengthened GMS health security. Key impacts include: (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased use of public health services in border areas by MEV. The project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED and (ii) increased communicable disease control coverage of MEV in border areas. The project outputs are: (i) improved GMS collaboration and MEV access to communicable disease control in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases. Outputs are summarized below:

9. Each country MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. These efforts, however, still need to be mainstreamed and formalized. In addition, some groups of MEV who, due to factors such as cultural practices, geographic location or occupational hazards, may be at greater risk of acquiring and transmitting infectious diseases are not using regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries; (ii) develops regional disease control strategies and evidence-based communicable disease control; and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Output 1 will specifically target migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEV) including women and youth in border areas and economic corridors.

10. Each MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong. The system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH also needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level; (ii) web-based reporting including information technology support; (iii) integration of surveillance systems; (iv) risk analysis, communication, and community preparedness; (v) improving capacity of outbreak response teams; and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

11. Laboratory facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial or hospital-acquired infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance; (ii) in-service training; (iii) improving district laboratory services; and (iv) equipment and training for infection control and case management of dangerous diseases.

12. The project is estimated to cost $132.0 million including $117 million in loan and $8 million in grant from ADB, and $7 million in government contributions. The Ministries of Health are the executing agencies, and public laboratories and provincial health departments (states/region in Myanmar) are implementing agencies. The details of the project locations, beneficiaries, implementation arrangements and financing are in the country GAPs (Appendix 3). The project

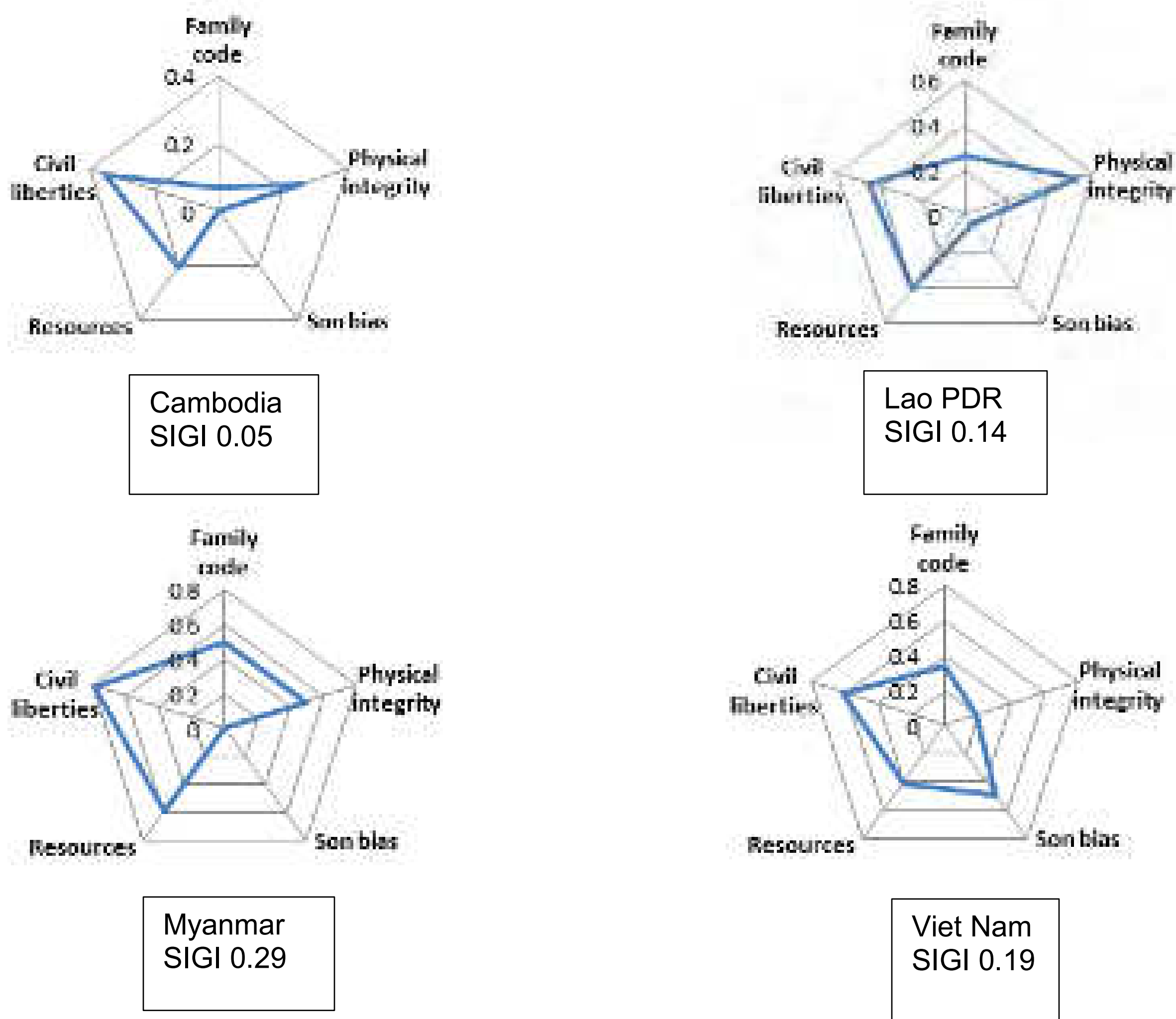
will be implemented over a period of five year period beginning early 2017. The project completion date is 30 June 2022.

III. Gender Environment

a. Country Gender Performance

13. The overall country gender performance based on the OECD Social Institutions and Gender Index (SIGI) 2014 is shown in figure 1.[7] A smaller overall score is better.

Figure 1: SIGI Gender Index 2014 for Cambodia, Laos PDR, Myanmar and Viet Nam



Source: http://www.genderindex.org/country/

14. In summary, all four countries perform well compared to, for example, South Asian countries. Cambodia has a more favorable gender index compared to the other three project focus countries, with Myanmar performing least well. There is a strong son bias in Viet Nam, which is evident in the male/female birth ratio. Cambodia and Viet Nam performed better in

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7 OECD Reference Center. 2016. *Social Institutions and Gender Index 2014.*

physical integrity indicators, which include, for example, domestic and gender-based violence. Cambodia also performed well in the family code indicators – including inheritance laws and customs, as well as in civil liberties. Myanmar performed least well in equitable control of resources.

15. The four countries share some similar beliefs and customs, and many ethnic groups live in two or more of the focus countries. Gender performance, however, is also shaped by their own political history, which introduced or failed to introduce gender reforms as part of a broader social process. Despite its political history during the late 20th and early 21st centuries, Myanmar has long-standing traditions of respect for individuals and opinions, and will no doubt rapidly improve its gender equity performance in the coming years.

16. In this context, major gendered concerns for the health sector include women not accessing services or participating in service delivery, and the continued exploitation of women. Unwillingness to access services is often linked to social stigma and lack of privacy and response for women. Inequitable access to services compared to men is frequently linked to lack of information (due in part to lower levels of education among women and girls), control over financial resources, and lack of time due to work and child care commitments. Exploitation of young women, including migrant laborers, brings increased risk of infectious diseases. These women, often working in labor camps, also have limited access to health services. This cohort will require tailored interventions to address these issues, as well as the cooperation of the country governments to access labor camps and other special economic zones. Participation of women in higher positions and rural services will require attention from the relevant MOH. All countries have improved access to reproductive health services as part of global policy. These initiatives now need to be extended to other services, through interventions tailored to ensure gender-equity and inclusion of MEV.

b. Gender Progress and Issues in Cambodia

17. The Government of Cambodia is committed to gender equality and the overall country performance in this area is favorable compared to other GMS countries. Progress is, however, held back by limited recognition of gender issues and limited capacity to roll out legislation.8

18. Cambodia's MOH has contributed to gender equality by giving consistently high priority to maternal and child care and reproductive health in general, including the control of HIV and AIDS among women and children. The country has made major progress in improving women's health indicators (Appendix 2). To further strengthen gender effort in the sector, in 2014, the Ministry of Women's Affairs Government of Cambodia launched the Five Year Strategic Plan for Gender Equality and Women's Empowerment (2014-2018) called "Neary Rattanak IV".9 The Neary Rattanak IV proposes to move from project-based gender activities to a program-based approach to deal with fragmentation of gender efforts in projects; and to enhance capacity for gender analysis, advocacy and policy advice in all sectors. In addition, MOH has started to roll out gender-disaggregated monitoring of health services. While MOH currently employs more women than men, MOH recognizes the need to improve participation of women at higher levels.

19. ADB's Cambodia Country Partnership Strategy (CPS) 2014-2018[10] supports the Government's Rectangular Strategy III (RSIII) to reduce poverty and vulnerability in three strategic areas: (i) inclusive economic growth; (ii) environmentally sustainable growth; and (iii)

8 ADB 2012. *Country Gender Analysis*.

9 Ministry of Women's Affairs. 2014*. Neary Rattanak IV. Five Year Strategic Plan for Gender Equality and Women's Empowerment. 2014-2018.* Phnom Penh.

10 ADB. 2008. *Country Partnership Strategy* (2014-2018). Manila.

regional cooperation and integration. Increased connectivity, industrialization, migrant labor, and income have aggravated gender and health concerns including increased risks of infectious diseases and exploitation. Specific strategies need to be developed to mitigate these risks, which will often require collaboration with other ministries. Under the GMS economic development program, ADB has been supporting various projects for mitigating risks of communicable diseases linked to regional integration and connectivity.[11]

c. Gender Progress and Issue in the Lao PDR

20. The Government of Lao PDR is committed to gender equity and equality. Lao society, however, maintains strong stereotypes regarding the traditional role of women as caretaker of the family and gender issues are insufficiently recognized. Due to Lao's ethnic variety, there are also major gender role variations between communities. As such, a one-fit approach is not appropriate.[12]

21. The National Growth and Poverty Reduction Strategy, 2003, includes a gender strategy linked to all priority sectors including health.13 It has established a mechanism to mainstream gender priorities. The 2004 Law on the Development and Protection of Women was issued to (i) promote the knowledge, capability and revolutionary ethics of women; (ii) promote gender equality; (iii) eliminate all forms of discrimination against women; and (iv) prevent and combat trafficking of women and children and domestic violence against women and children.[14] A number of institutional arrangements have been put in place to move the gender agenda forward. Leading entities are the Lao National Commission on the Advancement of Women (NCAW) established in 2003, and the Lao Women's Union (LWU) dating from 1995.15

22. A 2012 Country Gender Assessment for the Lao PDR states "the country has also made impressive gains in promoting gender equality. Human development indicators for women and men alike in both education and health are improving. More women than ever before are participating actively in the labor market, and women's voices are increasingly heard in national decision making".[16] MOH has given high priority to reproductive health, and the country has seen a major drop in maternal mortality. Issues in accessing maternal care and HIV and AIDS services remain ongoing in several provinces. Women's access to tuberculosis control is still inadequate as they often lack the information, time and resources to access these services.

23. ADB has been a major supporter of the Lao health sector and has contributed to the country's reduction in maternal and child mortality. ADB's Lao PDR CPS 2012-2016[17] is aligned with the 7th National Socio-Economic Plan. Regional connectivity, industrialization, integration, and urbanization bring major migration and changing behavior that carry health and gender risks. ADB supports health sector capacity, management and financing, and communicable diseases control under the GMS economic development program.[18]

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[11] ADB. 2004. *GMS Regional Communicable Diseases Control Project.* Manila; ADB. 2009. *Second GMS Communicable Diseases Control Project.* Manila.

[12] ADB, WB, 2012. Country Gender Assessment for Lao PDR.

[13] ADB. 2004. *Lao PDR Country Gender Strategy Gender, Poverty and the MDGs.*

[14] Lao National Assembly. 2004. *Law on the Development and Protection of Women, National Assembly No.08/NA, 22 October 2004,*

[15] ADB. 2012. *Lao People's Democratic Republic: Strengthening National Commission for Advancement of Women Network in the Ministry of Public Works and Transport/*

[16] Country Gender Assessment for Lao PDR, Reducing Vulnerability and Increasing Opportunity, Asian Development Bank and The International Bank for Reconstruction and Development/The World Bank, 2012.

[17] ADB. *Lao PDR Country Partnership Strategy 2012-2016*. 2012. Manila.

[18] ADB. 2004. *GMS Regional Communicable Diseases Control Project.* Manila; ADB. 2009. *Second GMS Communicable Diseases Control Project.* Manila.

d. Gender Progress and Issues in Myanmar19

24. Historically, the role of women in Myanmar society has been more restricted than in Cambodia, Lao and Viet Nam. The new government has a vision for the inclusion of women as leaders, to form the foundation upon which to build a new, democratic and just society. There are many hurdles to overcome, including traditional values, cultural discrimination, male domination, lack of access to information and education, and inequalities that have become entrenched by law. There is currently little legal basis for women's empowerment and participation in decision-making processes.

25. The Department of Social Welfare (DSW) is the focal point for all matters related to women. The Myanmar National Committee for Women's Affairs is the national women's machinery for implementation. DSW is currently finalizing a ten-year National Strategic Plan for the Advancement of Women 2012-2021 (NSPAW). The first challenge will be to convince government officials that gender equality is low and needs to be addressed in all sectors.

26. Myanmar has several major gender related health problems including high maternal mortality, due largely to the lack of access to obstetric services for complications in pregnancy. Illegal abortion is estimated to cause 10% of all maternal mortality. The adolescent fertility rate is high at 17%. After Thailand, Myanmar also has the highest prevalence of HIV infection in Southeast Asia.

27. The current ADB Myanmar CPS extension, 2015-2016,[20] builds on the interim CPS 2012-2014 which focuses on capacity building in ministries in core areas of ADB involvement. The interim CPS also supports regional connectivity and development and addressing related health and gender issues. More recently, ADB started supporting malaria and HIV projects.[21]

e. Gender Progress and Issues Viet Nam

28. The Government of Viet Nam has a strong ideology of gender equality and substantial gender legislation is in place. Implementation of this legislation, however, needs strengthening. Vietnamese society remains strongly patriarchal, with important differences in the perception of the value and role of men and women. Males tend to assume authority and control of resources, while women tend to assume the role of house manager and family caretaker. Young women are particularly vulnerable to male harassment both inside and outside the family setting. Gender-based violence, often linked to peer pressure and alcoholism, remains a major issue.

29. The 2007 Law on Gender Equality[22] guarantees equal rights to women. The National Strategy on Gender Equality 2011-2020[23] requires all sectors and ministries to mainstream gender in their work. The National Commission for the Advancement of Women (NCFAW) is responsible for national gender mainstreaming.[24] The Gender Equality Department, within the Ministry of Labor, Invalids, and Social Affairs (MOLISA), was created to function as a center and secretariat for NCFAW work and to help implement the Law on Gender Equality. The Viet Nam Women's Union is mandated to represent women of all ethnic groups and to protect women's rights and interests. It is a quasi-governmental organization with representation at all

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[19] ADB *Myanmar Interim Country Partnership Strategy 2012-2014*

[20] ADB. 2012. *Myanmar Interim Country Partnership Strategy, 2012-2014*. Manila

[21] ADB. 2015. *Malaria and Communicable Diseases Control in the Greater Mekong Subregion*. Manila; ADB. 2013. *Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention*. Manila; ADB. 2014. Expand HIV Services to Vulnerable Groups in Remote Areas. Manila.

[22] https://www.wcwonline.org/pdf/lawcompilation/Viet NamGenderEqualityLaw.pdf

[23] http://www.chinhphu.vn/portal/page/portal/English/strategies/strategiesdetails?categoryId=30&articleId=10050924

[24] JICA. 2011. *Country Gender Profile. Viet Nam Final Report*. Tokyo. .

administrative levels, from central government down to village and hamlet, and has substantial local powers.

30. In July 2011, the government adopted the National Program on Gender Equality 2011-2015. The Viet Nam Women's Union implements an array of programs to support women's development.

31. Viet Nam has made major progress in gender related health indicators including reducing maternal and child mortality. However, rural maternal mortality remains approximately twice as high as urban maternal mortality. Strong son bias and high rate of gender-selective abortion is another issue of concern. There is currently a 12% imbalance in sex ratio at birth, stemming from the traditional role of males as the ancestral caretaker and family landholder. The very high rate of "menstrual regulation" (early abortion) as a form of family planning also needs to be addressed, as does the potential resurgence of HIV transmission. Despite Viet Nam's strong and effective response to HIV prevention over the past decade and a half, there are indications that prevalence may once again be on the increase.

32. ADB's Viet Nam CPS 2012-2015[25] is aligned with the government's 9th Five-Year Socio-Economic Development Plan, 2011-2015,[26] and focuses on Viet Nam's transitional constraints to a modern economy. In the health sector, the Viet Nam CPS supports sector management, improving quality of services, and support for the disadvantaged, in particular ethnic minorities in border areas. Under the GMS economic development program, ADB has supported communicable diseases control in connection with GMS connectivity, industrialization, migrant labor and changing health behavior and risks.[27]

f. Governance and Institutions

33. As summarized by country in section (a), above, each country has a central institutional and legal framework aiming for gender equality by empowering women and reducing gender gaps. A list of major legislation and institutions by country is also provided in Appendix 1. In Cambodia, Lao PDR and Viet Nam, sufficient legislation is in place, and Myanmar is expected to follow soon. Nonetheless, implementation within government systems remains weak in all four countries due to a general lack of acceptance of gender as an issue and subsequent limited efforts to address gender inequality and to ensure gender equity. While each MOH has a central focal point for gender, this is often lacking at provincial level. Implementation of gender action plans tends to be weak due to insufficient effort and/or resources. A commonly held view among many government officials is that gender is not a major issue. While there is often awareness of the need to address gender inequality, these issues are often given only superficial attention and not addressed in any meaningful manner. This may be due to a combination of traditional views of the roles of women and men, the greater empowerment of employed urban women, and the invisibility of gender issues.

34. Each country also has some presence of NGOs, grassroots organizations and other community-based organizations (CBO), which tend to be more active in addressing gender issues. Only the Government of Myanmar, however, is highly supportive of using NGOs for improving women's access to health services.

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[25] ADB. *Viet Nam Country Partnership Strategy 2012-2015*. 2012. Manila.

[26] Government of Viet Nam *9th Socio-Economic Development Plan 2011-2015*. 2010. Hanoi.

[27] ADB. 2004. *GMS Regional Communicable Diseases Control Project.* Manila; ADB. 2009. *Second GMS Communicable Diseases Control Project.* Manila.

35. Each country should aim to develop subsector- or sector-wide gender strategies and to promote gender mainstreaming into all facets of routine public health planning, administration, and services, as well as into all projects and programs. This should also include the development of gender-disaggregated indicators into the regular health management information systems (HMIS) including routine inpatient and outpatient, and other major diagnostics. Progress in this respect is slow due to lack of effort.

36. Regional connectivity, integration and industrialization has generated employment and resulted in rapid increase in migration and urbanization. Gender equality and public health take on special dimensions for migrants, including poor ethnic minorities, that require specific analysis and for which special strategies need to be developed.

37. While women do currently fill important political leadership roles in each of these countries, gender disparities are common at director and management level in the government system. Female government staff tend to be involved less in decision-making processes within the administration. Slowly changing cultural norms and a lack of open and transparent recruitment and promotion practices are key causes for the low representation of women in leadership positions. Fewer educational opportunities of women at local level also restrict women's career opportunities.

38. As articulated in ADB's 1998 Policy for Gender and Development and Strategy 2020, ADB remains committed to equality in all its operations.28 ADB's Country Partnership Strategies for Cambodia, Lao PDR, Myanmar and Viet Nam are all focused on poverty reduction through inclusive growth, and regional cooperation and integration (Appendix 3). Issues of insufficient gender legislation and institutional capacity are high on the priority list of ADB, in particular in the context of migrant labor.

g. Gender and Public Health

39. Within each MOH, there appears to be a general complacency that MOH is not doing so badly in addressing gender inequality, and that gender is not a top priority among many other competing priorities. Each MOH already feels that they have addressed gender inequality by employing more women than men, and by prioritizing maternal and child health. Each country has had major progress towards reducing maternal and child mortality and achieving MDG 5: Improve maternal health (Appendix 2, Table 7). Nonetheless, with the exception of Viet Nam, maternal mortality remains high and in each country there are also issues of access among ethnic minorities. There are other gender-related issues that need more support, in particular the risks of migrants for infectious diseases including HIV, tuberculosis, malaria, and dengue. For most indicators, gender-disaggregated data are not available at central level. Based on available, non-representative data, however, there are no substantial differences between genders for most indicators (it should be noted, however, that these results are likely to be misleading). One notable exception is gender-selective abortion in Viet Nam.

40. While there is a lack of gender-disaggregated health indicators at central level, non-representative data suggest that for many indicators such as for immunization services there are no major differences by gender except for rural women accessing non-maternal and child care services less than men. Given traditional values, it would be expected that boys receive more services than girls, but current data does not support this assumption. Governments are planning to introduce gender-disaggregated health information systems, which should help in documenting any gender bias.

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[28] ADB. 1998. *Policy on Gender and Development*. 2003. Manila

41. In all four countries, women form the majority of health staff but tend to be employed in the lower levels and underrepresented in management positions. All four country MOH are set up to implement a gender strategy and mainstream gender awareness into all activities (Appendix 2, Table 6), but on the whole, implementation remains weak due to a combination of cultural perception, leadership, and lack of enforcement and funding. Ethnic minorities are particularly under-represented among health staff, despite past implementation of initiatives to increase the proportion of ethnic minority people working in health care.

42. The patterns of infectious diseases may differ substantially among women and men, due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Women doing the cooking are more at risk of some zoonotic disease. Conversely, men more involved in the slaughter of animals may also be at increased risk. Those living in mountainous and remote communities, many of them belonging to ethnic minorities, have a significantly higher burden of diseases, in particular tuberculosis and common respiratory and intestinal infections. Migrant women and men, in particular those working in the sex industry and being trafficked, are at higher risk of HIV, hepatitis, and other sexually transmitted infections. Migrant men working in forests are more exposed to malaria. A list of possible risk factors by type of infectious disease is detailed in Appendix 2, Table 9.

43. A wide range of health system factors affect women's health including (i) lack of information on disease prevention and care; (ii) social acceptability of health services in particular among ethnic minorities; (iii) issues arising from workload and child care; (iv) (perceived) high cost of services or cash flow challenges; (v) less access to appropriate care due to a lack of female staff, language problems or attitude; and (vi) problems of physical access. All these may result in risky behaviors and delays in seeking health care.

44. Several studies have been conducted in these countries to identify the main factors affecting health-seeking behaviors. It appears that the perceived cost of health services compared to perceived benefits is a major factor in deciding to avoid or bypass local services. For maternal mortality reduction, a key challenge is that only few hospitals provide life saving obstetric surgery. For infectious diseases, health service determinants vary by target population. It is evident that for isolated communities with high burden of communicable diseases, a major issue is a lack of engagement with health professionals and educators, lack of physical access, lack of information, and, given these are often very poor communities, the relatively high cost of transport and services. For migrants, two key issues identified are (i) that laborers may not be allowed to access disease control programs; and (ii) may not be eligible for free health services.

45. Regional connectivity and development bring prosperity but also carry additional health risks. Based on ADB's Regional Partnership Strategy, ADB is committed to regional cooperation in the GMS as one of the pillars of Strategy 2020, including communicable diseases control and mitigation of other possible negative impacts related to regional connectivity and development, such as trafficking.[29]

IV. Project Gender Analysis (Due Diligence)

a. Consultations, Issues and Actions

i. Cambodia

[29] ADB. 2008. *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. Manila

46. The gender and social safeguards experts conducted consultations with officers of MOH, international agencies and NGOs, and field visits to Banteay Meanchey and Svay Rieng provinces to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used to collect information. Findings are summarized in Appendix 2, Table 6.

47. The patterns of infectious diseases differ substantially among women and men, due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.

48. The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas. Sufficient gender legislation is in place although implementation is still weak. MOH has a central focal point for gender, but this may be lacking at provincial level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level.

49. For Cambodia, the project gender classification is "Category II: effective gender mainstreaming", as it will directly improve access of women to health services and opportunities for women. Active engagement of women's associations is proposed to mobilize communities and reach at risk groups. Cambodia has developed a sector-wide gender plan. Accordingly, the project's gender action plan needs to follow the overall GAP or equivalent for the health sector, which is still being prepared.

50. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, to ensure effective gender mainstreaming provisions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), the Project Administration Manual (PAM), the Poverty and Social Analysis (PSA), the Project Performance Monitoring System (PPMS), and covenants.30 The project GAP has been agreed with MOH that is aligned with sector-wide gender equality commitments (Appendix 3, Table 10). MOH will fully incorporate the various gender mainstreaming features of GAP in the government's project design documents, and provincial operational plans. National gender and social safeguards expert will be engaged. Disaggregated monitoring by gender has been proposed where feasible. The project GAP may need to be adjusted based on future developments.

ii. Lao PDR

51. The gender and social safeguards experts conducted consultations with officers of MOH, international agencies and NGOs, and field visits to Bokeo and Luang Namtha provinces to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used to collect information. Findings are summarized in Appendix 2, Table 6.

[30] ADB. 1998. *Policy on Gender and Development*. Manila; ADB. 2010. *Manual Bank Policies Section.* Manila.

52. The patterns of infectious diseases differ substantially among women and men, due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's' access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.

53. As reported in the ADB World Bank Country Gender Assessment of 2012,31 increased economic links with neighboring countries present a number of opportunities and risks. Both cross-border and domestic migration are more often undertaken by women. Those who go to work in Thailand are mostly young people from border areas aged 15-25 years old. Women from Mon-Khmer and Tibeto-Burman ethnic groups are disproportionately represented among migrants. Precise figures are unavailable because the majority of people migrate through irregular channels. Reports indicate that young women and girls who are trafficked often end up in forced prostitution and domestic labor. The proportion of female staff working in the health sector is relatively high but they tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas.

54. Sufficient gender legislation is in place although implementation remains weak. MOH has a central focal point for gender, but this may be lacking at provincial level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. Substantial capacity for gender-related support is available through mass organizations at community level.

55. The Lao Women's Union (LWU) is mandated to represent women of all ethnic groups and to "protect women's rights and interests". It is a quasi-governmental mass organization with representation in all villages and has substantial local powers. The National Commission for the Advancement of Women (NCAW) was established in 2003 as the national focal agency for gender mainstreaming in development policies and programs. The Lao PDR has no Ministry of Women's Affairs. Gender equality is an important national goal, which is reflected in the Constitution, in major international commitments and in the establishment of the NCAW. One major concern is the fragmentation of gender efforts across projects.

56. For Lao PDR, the project gender classification is "Category II: effective gender mainstreaming", as it is not specifically targeting women as beneficiaries, but aims to ensure that women benefit equally or more from project interventions. Gender mainstreaming will directly benefit women, help improve communicable disease control outcomes, and address gender imbalances such as in training and in outreach services. Priority will be given to the education of women and girls as the usual custodians for the prevention, detection and care of sick family members, and to training female staff.

57. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, to ensure effective gender mainstreaming provisions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), the Project Administration Manual (PAM), Poverty and Social Analysis (PSA), the Project Performance Monitoring System (PPMS), and covenants. The project GAP has been agreed with MOH and is aligned with sector-wide gender equality commitments (Appendix 3). MOH will fully incorporate the various gender mainstreaming features of GAP in the government's project

[31] ADB and World Bank. *Country Gender Assessment for Lao PDR – Reducing Vulnerability and Increasing Opportunity*. 2012. Vientiane.

design documents, and provincial operational plans. National gender and social safeguards expert will be engaged. Disaggregated monitoring by gender has been proposed where feasible. The project GAP may need to be adjusted based on future country GAP developments.

iii. Myanmar

58. The gender and social safeguards experts conducted consultations with officers of MOH, international agencies and NGOs, and field visits to Shan, Mon and Kayin states to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used the collect information. Findings are summarized in Appendix 2, Table 6.

59. Social indicators have also shown improvement in Myanmar but are still among the lowest in the region. The United Nations Development Program's Human Development Index (HDI), which measures achievements in terms of life expectancy, educational attainment and adjusted real income, ranked Myanmar at 149 out of 187 countries in 2012.[32] Social isolation is a particular problem for upland ethnic peoples, who are marginalized in many ways due to their languages, customs and religious beliefs. The "excluded" poor are a group of particular concern: these people live in conflict zones with restricted access to services, including emergency services, particularly at night.

60. Women are more vulnerable to sexually transmitted diseases, and pregnant women are more vulnerable to malaria. Ethnic women and girls, especially those in the highlands, and in particular those in conflict zones, are the most vulnerable members of rural communities. Women of ethnic minorities comprise about 80% of the illiterate population and have less physical, social and financial access to services. They often do not speak the national language and have difficulty communicating with health staff. They often prefer to deliver at home. These women are often not reached by the backbone of the Myanmar health system, the community midwife.

61. The ethnic majority Burmese have consistently enjoyed higher average level of expenditure per person. Minority ethnic groups have higher poverty ratios. Villages subsist in relatively stable agro-ecosystems, so the perception of endemic poverty has been created by reliance on a numerical definition of poverty. To most villagers, poverty is an issue of livelihood: if villages are able to meet their consumption needs they do not consider themselves poor. When agro-systems are disrupted or natural or man-made disaster upheavals occur, poverty often follows.

62. The Integrated Household Living Conditions Survey (IHLCS) shows poor families tend to have lower access to education and other public services, such as proper sanitation and electricity. They also have limited access to credit, and poorer outcomes in education, as reflected in lower net enrollment rates for primary and secondary school compared to the non-poor. Chronic and severe underinvestment in education has limited the options available for the poor to escape from poverty and move to higher-paying jobs. While overall literacy rates are around 90%, there are substantial differences between poor (84%) and non-poor (93%), and also in primary net enrollment rates between poor (81%) and non-poor (90%). Only 35% of children from poor households proceed to secondary school, compared with 59% of children from non-poor households. These gaps in access to assets, services, and education also appear across regions, with populations in the poorest regions having lower rates of access to services and education than better-off states and regions. For example, Rakhine state has one

[32] UNDP. 2014. *Human Development Report*.

of the lowest net primary school enrollment rates of 71.4% (the union average is 87.7%) and 32.0% for secondary school (the union average is 52.5%).

63. For Myanmar, the project gender classification is “Category II: effective gender mainstreaming”, as it is not specifically targeting women as beneficiaries, but aims to ensure that women benefit equally or more from project interventions. Gender mainstreaming will directly benefit women, help improve communicable disease control outcomes, and address gender imbalances such as in training and in outreach services. Priority will be given to education of women and girls as the usual custodians for the prevention, detection and care of sick family members, and to training female staff.

64. In accordance with ADB’s Policy on Gender and Development and Operations Manual for Bank Policies, to ensure effective gender mainstreaming provisions have been incorporated in the project documentation including the scope and due diligence of the RRP, DMF, PAM, PSA, PPMS, and covenants. The project GAP has been agreed with MOH that is aligned with sector-wide gender equality commitments (Appendix 3, Table 12). MOH will fully incorporate the various gender mainstreaming features of GAP in the government’s project design documents, and state/region annual operational plans. National gender and social safeguards expert will be engaged. Disaggregated monitoring by gender has been proposed where feasible. The project GAP may need to be adjusted based on future developments.

iv. Viet Nam

65. The gender and social safeguards experts conducted consultations with officers of MOH, international agencies and NGOs, and field visits to Ha Giang and Tay Ninh provinces to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used to collect information. Findings are summarized in Appendix 2, Table 6.

66. The project has been ranked as Category II: effective gender mainstreaming (EGM), as it will directly improve access of women to health services and improve opportunities for women. The patterns of infectious diseases differ substantially among women and men, due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women’s access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members. Increased economic links with neighboring countries present a number of opportunities and risks for women.

67. The proportion of female staff working in the health sector is relatively high but female health staff tend to be concentrated in the lower-levels of the system and there is a shortage of female health staff in remote areas.

68. Sufficient gender legislation is in place although implementation is still weak. MOH has a central focal and provincial focal point for gender, but this may be lacking or inactive at district level. Implementation of gender action plans in previous health projects tended to be less satisfactory as gender is not perceived as a major issue in MOH. However, substantial capacity for gender-related support is available in mass organizations at community level.

69. The Viet Nam Women’s Union (VNWU) is mandated to represent women of all ethnic groups and to protect women’s rights and interests. It is a quasi-governmental organization with representation at all administrative levels, from central to village and hamlet, and has substantial local powers. Instead of a Ministry of Women’s Affairs, Viet Nam has opted for a crosscutting

National Commission for the Advancement of Women (NCFAW) for gender mainstreaming in development policies and programs. Its recommendations are implemented through five-year plans but often lack funding. Gender equality is reflected in the Constitution and in multiple international commitments. One major concern is the fragmentation of gender efforts in projects. Unlike in Cambodia, there has not been a movement to articulate comprehensive sector gender programs. Accordingly, the project GAP may need to be adjusted based on future developments.

70. The Government of Viet Nam (GOV) has paid attention to the welfare of ethnic minority groups. There is a ministerial-level government body, the Committee for Ethnic Minority and Mountainous Area Affairs (CEMA), which is in charge of management functions for ethnic minorities and mountainous areas. In geographically strategic areas or areas with an ethnic minority population of 5,000 or more, CEMA has its own representative agency down to the district-level. Programs that specially target ethnic minority groups are numerous and diverse. While progress is being made, there are still instances of involuntary resettlement and assimilation into mainstream society, with resultant loss of cultural identity.

71. For Viet Nam, the project gender classification is “Category II: effective gender mainstreaming”, as it is not specifically targeting women as beneficiaries, but aims to ensure that women benefit equally or more from project interventions. Gender mainstreaming will directly benefit women, help improve communicable disease control outcomes, and address gender imbalances such as in training and in outreach services. Priority will be given to education of women and girls as the usual custodians for the prevention, detection and care of sick family members, and to training female staff.

72. In accordance with ADB’s Policy on Gender and Development and Operations Manual for Bank Policies, to ensure effective gender mainstreaming, provisions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), PAM, PSA, PPMS, and covenants. The project GAP has been agreed with MOH and is aligned with sector-wide gender equality commitments (Appendix 3.3). MOH will fully incorporate the various gender mainstreaming features of the project GAP into the government’s project design documents, and state/region annual operational plans. National gender and social safeguards expert will be engaged. Disaggregated monitoring by gender has been proposed where feasible.

v. Proposed actions for the four countries

73. The project, based on general good practice for gender endorsed by MOH, will enhance participation of women in all its activities:

- The executing and implementing agencies have active gender focal points for project activities;
- The project engages a gender and social development expert with a focus on community activities;
- Project implementation plans and annual operational plans (AOP) will address gender dimensions;
- The project will collect, analyze and report gender-disaggregated data;
- All project reports report on gender issues;
- The project will proactively target youth and women at increased risk of infectious diseases;

- Education materials and care procedures will be gender-sensitive;
- Outbreak response and outreach services will ensure female participation;
- Participation of female and male staff in training programs and scholarship will be equitable;
- Refurbishment of laboratories and isolation wards will be gender sensitive;
- All regional, cross-border and intersectoral events will maximize female participation and increase gender awareness, identify gender issues, and advocate and monitor gender actions.

b. Beneficiaries and Impact Channels

74. Selected provinces are primarily targeted because these are at increased risk of communicable diseases, not because these are mostly poor provinces. The larger part of investment of the project will benefit the general public, while a small part of the project is targeting high risk groups, often but not always poor, with communicable diseases control. A small part of the project will specifically help improve coverage of migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEV). In general, MEV have less access to health services and, due to geographic location and/or occupation, may be at greater risk of acquiring and transmitting some infectious diseases. Targeting economic corridors will help safeguard gains in connectivity by reducing possibilities for disease outbreaks along these routes.

75. In Cambodia, some project interventions are at national and regional levels. The project targets 13 mostly poor border provinces out of a total of 25, in the northeast, the southeast, and the northwest of Cambodia.[33] Those in the northeast have significant ethnic minority populations. The other two clusters are along the main east-west corridor. This is one of the major avenues for the movement of migrants to and from industrial zones and related services. The total population in the targeted provinces is 7.6 million, with a population of 3.6 million in targeted border districts. The total population in districts with large ethnic minority populations is 3.7 million. The actual number of ethnic minorities in these districts is not known, however, in part because large groups of ethnic minorities are mainstreamed and call themselves Khmer. The total number of poor people is estimated at 1.5 million. While a large number of poor people live in central Cambodia, the northeastern provinces are the poorest provinces within the project scope.

76. In Lao PDR, some project interventions are at national and regional levels. The project largely focuses on 12 provinces out of a total of 18 provinces34. Eleven of these 12 provinces are border provinces, with a total of 36 border districts out of 55 districts.35 With the exception of Champasack, these are among the poorest and less developed provinces of Lao PDR. The total catchment population in these 12 provinces is estimated at 3.0 million (2015), with about 1.5 million living in the 36 border districts, a population average of about 40,000 people per district.

[33] Palin, Batttambang, and Banteay Meanchey in the north-west bordering Thailand; Preah Vihear, Stung Treng, Ratanakiri, Mondulkiri, and Krati in the north-east bordering Thailand, Lao and Viet Nam; and Kandal, Tbong Khmum, Prey Veng, Svay Rieng, and Kampot provinces in the south-east bordering Viet Nam. See appendix 3.1

[34] Bokeo, Huapanh, Luangnamtha, Phongsaly, Udomxay, and Xiengkhuang provinces in the north bordering Thailand, Myanmar, China (Yunnan), and Viet Nam; Bolikhamsay and Khammuane provinces in the center bordering Thailand and Viet Nam, and Attapeu, Champasack, Saravane, and Sekong provinces in the south bordering Thailand, Cambodia and Viet Nam. See appendix 3.2.

[35] The targeted districts are mostly located in remote, forested areas. The selected districts largely overlap with the 72 poor districts and 47 poorest districts identified by the government for priority investments.

77. In Myanmar, some project interventions are at national and regional levels. The project targets five states and one region out of a total of 15[36]. Specifically, the project targets 12 townships including six state/region capitals and six border towns in the east part of the country along the borders with Thailand, Lao PDR and PCR. The five states have a majority ethnic minority population, and Tanintharyi region has a large migrant labor population. The total population in the five states and one region is 7.7 million. The directly targeted population in 12 townships is 2.2 million (28%). This includes 10% of the population that lives in border townships in project focus areas.

78. In Viet Nam, some project interventions are at national and regional levels. The project focuses on 36 of 64 provinces in Viet Nam.[37] Twenty-five of these 36 provinces are border provinces. Within the 36 provinces, there are 250 focus districts, including 82 border districts and 56 poor districts. On average, approximately 23% of the population in the provinces belong to ethnic minorities, and some 17% is classified as poor. The total catchment population in these 36 provinces is estimated at 40 million (2014), with about 23 million living in the 250 border districts, a population average of about 92,000 people per district. Proposed spending is about $2 per person in the 36 provinces, and about $8 per person directly targeting MEV in communicable disease control in border areas. By targeting border areas, the project is disproportionally targeting the poor.

79. The project includes three major impact channels. Firstly, regional and national activities will help improve disease control through improving control strategies, coordination of disease control, enhancing leverage and visibility, and challenging and motivating health officials. Secondly, the majority of resources will be used to improve rural public health services in targeted provinces. This entails support for better disease prevention, timely disease outbreak reporting and control, laboratory diagnostics, and case management. This will help contain the spread of infectious diseases and reduce the morbidity, mortality and financial impact. Thirdly, poor and vulnerable groups will be targeted directly through outreach in targeted provinces/states, to improve community preparedness and prevention and link them to disease surveillance, health services, and disease control program system.

c. Participation and Disclosure

80. For the planning of this project, stakeholders were consulted at central, provincial, state, district and commune levels. Based on this assessment, it is evident that a provincial/state-based project implementation planning is required, as each area will face unique challenges and opportunities during project implementation, and also to ensure buy-in from local government and beneficiaries. Each province/state/region will propose project investment as part of its regular annual health plan. These proposals will be supported through needs assessment consultations and detailed preparation. Investments will need to satisfy project criteria in terms of agreed scope, target groups, social dimensions, facilities, staff capacity, security, and sustainability. The geographical scope in Myanmar is limited for this project as Myanmar and ADB are still developing terms of engagement.

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[36] The eastern border of Myanmar including Shan North, Shan East, Kayah, Kayin, and Mon states; and Tanintharyi (region) bordering China, Lao and Thailand. See appendix 3.3.

[37] In the north Lai Châu, Lào Cai, Hà Giang, Cao Bằng, Lạng Sơn, Quảng Ninh, Bac Kan, Phú Thọ, Bắc Giang, Yên Bái, and Vĩnh Phúc provinces. In the north-west Diện Biên, Sơn La, Hòa Bình, Hà Nam, Nam Định, Ninh Binh, Thanh Hóa, Nghệ An, and Hà Tĩnh provinces; in the center Quảng Bình, Quảng Trị, Quảng Nam, Quảng Ngãi, Kontum, Dăk Lăk, Đăk Nông, Gia Lai, Kon Tum, Lâm Đồng Bình Phước, and Ninh Thuận provinces; and in the south Tây Ninh, An Giang, Kiên Giang, Bạc Liêu, Vĩnh Long, and provinces. See appendix 3.4

81. The project concept has been shared with beneficiaries at the planning stage, and will be shared during implementation and evaluation. Beneficiaries generally endorsed the project concept and expressed their readiness to participate in implementation. However, some of those interviewed flagged several implementation concerns including possible delay and issues of affordability of services. Throughout the life of the project, periodic workshops will be held with representatives from a diverse range of stakeholders, including beneficiaries. These workshops will help to inform all stakeholders of project achievements and challenges and to ensure the ongoing endorsement of all. In addition, the project design and implementation progress will be accessible on the website of the regional coordination unit: gmshealthsecurityprojectrcu@gmail.com and ADB website (URL address to be provided).

V. Project Gender Action Plan

a. Gender Strategy and Gender Action Plan

82. The project has been classified as "Category II: effective gender mainstreaming" (EGM). The project gender strategy aims to (i) promote gender dimensions in all project activities; (ii) target vulnerable groups including poor women and ethnic minorities; (iii) enhance equal opportunity in the sector and (iv) synchronize with the subsector gender strategy.

83. Gender mainstreaming will improve project outcomes, benefit women at least equally, and address gender imbalances in, for example, training and outreach services. The four ministries of health are considering following the example of other countries to develop one overall gender strategy and GAP for the sector or each subsector. These may then be fine-tuned according to specific project needs. As each MOH is still in the process of updating its gender strategy, the project GAP may need to be adjusted in the future.

84. Each MOH will fully incorporate the project GAP in the government's project design documents, and state/region annual operational plans. Each MOH proposes to maximize benefits for poor and ethnic women and other vulnerable groups at increased risk of infectious diseases in border areas. MEV will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

85. The summary project GAP presented below has been agreed with each MOH and is aligned with the relevant national context, policies and plans, MOH sector-wide commitments, and ADB policy. The following actions have been agreed:

(i) All regional, cross-border and intersectoral events will increase female participation, promote gender equality, identify and address gender issues, and monitor gender actions;
(ii) The project will proactively target MEV including youth and women;
(iii) Education materials and care procedures will be gender-sensitive;
(iv) Outbreak response and outreach services will ensure female participation;
(v) Equitable participation of female and male staff in scholarships and training programs;
(vi) Refurbishment of laboratories and isolation wards will be gender sensitive;
(vii) There will be active focal points in all implementing agencies;
(viii) Gender and social development experts will be engaged for capacity building;
(ix) Project annual operational plans (AOP) will address gender dimensions;
(x) The project will collect, analyze and report gender-disaggregated data;
(xi) All project reports report on gender issues.

86. The project GAP with overall indicators is shown below (1). Country specific GAP were also drafted (Appendix 3), to be updated by each project management unit (PMU), as appropriate, with specific indicators, baselines and targets, at the onset of project implementation.

Table 1: Project Gender Action Plan

Actions	Targets/Indicators/Source	Responsible
Output 1: Improved Regional Cooperation and CDC in Border Areas		
Increase and enhance participation of women in regional, cross-border, and intersectoral events and outreach services.	Participation of women in these events and services reaches at least 30% in all four countries, from less than xx% to date, (RCU baseline and annual reports)	MOHs, PMUs, local health offices
Raise gender awareness and address issues in CDC workshops.	All workshops address gender issues in CDC workshops (event reports).	MOHs, PMUs
Proactively target ethnic and migrant girls and women with outreach services and referral to health services in border areas.	At least 50% of outreach services targets remote ethnic groups and migrants including girls and women in border areas, from nil to date (facility reports).	Local health offices and health facilities
Output 2: Strengthened national surveillance and response		
Collect, analyze, and report gender-disaggregated surveillance data.	Gender disaggregated surveillance data are available at national level in four countries from nil now (report of national data collection centers).	National surveillance centers
Ensure participation of women in field epidemiology training.	At least 25% of participants in field epidemiology training are female, from less than 10% at present (PMU report).	MOHs, PMUs
Increase participation of female staff in any outbreak response teams.	Each outbreak response team has at least one female staff member, from less than 50% at present (CDC report).	Local health offices and health facilities
Output 3: Improved diagnostics and management of infectious diseases		
Ensure equitable participation of female staff in laboratory management and quality assurance training programs.	Female participants in laboratory management and quality assurance training programs are about 50% (national laboratory annual report).	National laboratories
Ensure equitable participation of female and male doctors and nurses in scholarships for hospital infection prevention and control.	Female participation in hospital infection prevention and control scholarship reaches approx 50% from xx% to date (PMU annual report).	Departments of Hospital Services
Improve hygiene and sanitation facilities for female patients in hospitals.	All female wards have proper hygiene and sanitation facilities for patients, from about 50% at present (to be based on baseline and end-of-project survey).	Hospitals
Project Management		
Improve annual operational plans and budgets in project-supported provinces to adequately address gender dimensions.	All annual operational plans address gender dimensions adequately (PMU reports).	PMUs, local health offices
Fully engage gender focal points in implementing agencies.	All implementing agencies have a fully engaged gender focal point (PMU report, based on participation in events).	PMUs, local health offices
All quarterly and annual reports.	All quarterly reports adequately report on gender issues (PMU reports).	PMUs, local health offices
Advance participation of female consultants	Female consultants represent at least 30% of project consultants (PMU reports).	PMUs

CDC: communicable diseases control; MOH: ministry of health; PMU: project management unit

Source: Ministries of Health of Cambodia, Lao, Myanmar and Viet Nam.

b. Implementation, Monitoring and Evaluation

87. Each MOH is committed to provide the necessary inputs to fully implement the GAP. The project director will provide leadership and ensure that the executing agency and provincial/state/region implementing agencies implement the GAP in terms of gender mainstreaming and prioritizing women's services and opportunities in general and MEV in particular. Gender focal points will be activated at central and provincial/state/region levels. These focal points will ensure gender training/orientation and GAP implementation of all staff involved in the project.

88. Within the project management unit (PMU) of the project, gender and social safeguards specialists will be engaged to help plan, provide capacity building for, and monitor GAP implementation. Linkages will be established with women's organizations as needed. Active engagement of women's associations is proposed to mobilize communities and to reach MEV. Engagement of NGOs in areas where MOH has reduced capacity may also be considered by MOH. Gender disaggregated indicators will be used for project monitoring.

89. In accordance with ADB's Policy on Gender and Development and the Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), project administration manual (PAM), project performance monitoring system (PPMS), and assurances and covenants. The project GAP has been agreed with the various MOH and is aligned with sector-wide gender equality commitments.

90. An appropriate GAP monitoring system, linked to the health management information system and PPMS, will be set up, and performance reported as part of the quarterly and annual project report system to the Government, ADB, and key partners. Gender, MEV, and poverty indicators follow overall project indicators as described in the DMF, but need to be tailored, with specific targets, for each focus population. Even general project baselines and targets will vary considerably by province and are yet to be established through the provincial planning process. General indicators for the DMF will need to be disaggregated by gender, ethnic minority status, or migrant status (as appropriate). Where this is not feasible, ethnic minority or migrant populations may be inferred through disaggregation by location. Suggested project indicators are in presented in Table 2 below:

Table 2: Suggested Project Indicators

a) Disease outbreaks and economic impact
Source: national CDC reports, economic reports, disaggregated by gender and affected groups;
b) Increased APSED compliance
Verified with WHO/IHR assessment;
c) All hospitals, 80% of health centers, and 5% of private clinics implement web-based disease reporting
Verified with web-based surveillance and reporting system reports, by gender;
d) Labs and hospitals meet national quality and biosafety standards
Source: Baseline and end-of-project assessments;
e) Coverage of vulnerable groups with outreach and campaigns
Source: outreach team reports by gender and ethnic groups;
f) Use of health services by MEV
Source: health program and health facility statistics by gender and ethnic group;
g) Regional, cross-border and intersectoral events
Event reports with participation by gender;

h) Female and male participation in workshops, training and other events
Source: event reports by gender;
i) Results-based planning and management
Source: Management assessment, with information on beneficiaries by gender and ethnic group.

c. Risk Assessment and Mitigation

The project builds on the experiences gained in CDC1, CDC2, and HIV projects and is considered low risk for Cambodia, Lao PDR and Viet Nam. MOH Myanmar has limited ADB experience, and is considered moderate to high risk. Regional technical assistance will be provided to engage international consultants during the first project year to ensure a quick project start-up. The project will provide for international consultants for chief technical adviser, gender and social safeguards, and other areas. In addition, Myanmar MOH will be assisted with upfront project implementation orientation and training. Several risk and mitigating measures are summarized in the RRP. Following the format of the overall project risk assessment,

91. Table 3 below indicates project risks for gender and ethnic groups, and mitigating actions.

Table 3: Project Risks and Mitigating Actions

Project Sub-Outputs	Channel	Risks for Vulnerable Groups including Women, Youth, Poor, Migrants, and Ethnic Groups	Suggested Actions
1.1 Regional Cooperation	Regional meetings and workshops	No attention and no agreed strategies to address needs of vulnerable groups.	RCU to propose milestones to regional steering committee and follow up workshop plans of action. ADB to mobilize additional TA.
1.2 Cross-border cooperation	Provincial* and district meetings	No serious effort to address health needs of ethnic groups and cross-border migrants in border areas	Provinces include activities in AOPs and budgets
1.3 Intersectoral cooperation	Provincial meetings	No effort in addressing high risk behavior such as for HIV in youth	Inclusion of activities in provincial AOPs and budgets
1.4 Outreach for vulnerable groups	District and health center staff	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Tracking of vulnerable groups reached based on mapping. Inclusion of activities in provincial AOPs and budgets.
1.5 CDC in border areas	Provincial campaigns	Risk of not reaching vulnerable groups due to capacity constraints or other reasons	Monitor and report beneficiaries being reached with various campaigns
1.6 Regional knowledge sharing and strategic planning	Regional office and workshops	Lack of focus on vulnerable groups	Regional workshops, presentations and reports address gender, poverty and social dimensions
2.1 Surveillance	Provincial staff	Difficult to get reports from hard to reach places	Introduction of syndromic reporting, tracking of vulnerable groups being reached
2.2 Risk Analysis	Provincial staff	Lack of information from hard to reach communities including migrants	Information received from vulnerable groups including migrants
2.3 Outbreak Response	Provincial staff	Difficult to access remote places and labor camps	Tracking of vulnerable groups being reached including migrants
2.4 Community preparedness	District and Health center team	Difficult to access remote places and labor camps	Community preparedness sessions conducted by grassroots organizations
3.1 Laboratory Planning and Management	MOH, NHL, PHOs, hospitals	Insufficient attention to setting up transport system to obtain samples from health centers	Tracking of specimens received from other health facilities
3.2 Laboratory Quality Improvement	MOH, NHL, PHO, hospitals	Insufficient competencies of peripheral laboratory staff	Training of laboratory staff from district hospitals and health centers
3.3 Laboratory quality audit and assurance	NHL	Insufficient efforts in audit and QA for smaller laboratories	Pilot audit of smaller laboratories to understand the scale of the problem
3.4 Laboratory Upgrading Services	MOH, NHL, PHO, hospitals	Insufficient effort to include tests that benefit vulnerable groups	Assuming cost effectiveness, range of tests provided
3.5 Laboratory Studies	NHL	Sample doesn't include vulnerable groups including poor women, ethnic minorities and migrants	Survey using stratified sampling generates specific data by gender, ethnic minorities and migrants
3.6 Hospital Infection Prevention and Control	DHS, hospitals	Cultural and language barriers to behavior of patient and visitors	Ensure IPC focal points, hospital IPC mechanisms, female staff and ethnic minority staff where feasible. Information dissemination for patients and visitor. Apply protocols (also staff)
3.7 Control and	DHS,	Cultural and language barriers to	Ensure IPC focal points, hospital IPC

Project Sub-Outputs	Channel	Risks for Vulnerable Groups including Women, Youth, Poor, Migrants, and Ethnic Groups	Suggested Actions
management of highly infectious diseases	hospitals	behavior of patient and visitors	mechanisms, female staff and ethnic minority staff where feasible. Information dissemination for patients and visitor. Apply protocols (also staff)
4.1 Mainstreaming project in AOPs and Budget Cycle	MOH, PMU, provinces	Insufficient attention to vulnerable groups for CDC in border areas	Ensure AOPs meet standards and are implemented through regular inspection
4.2 Implement GAP, and safeguards	MOH, PMU, provinces	Insufficient interest of PMU and provinces in implementing these	Track, inspect, and report GAP and safeguards implementation
4.3 Efficient financial management and procurement	MOH, PMU, provinces	Insufficient capacity	Monitoring financial management and procurement

*Provincial also refers to state/region for Myanmar
AOP: Annual Operational Plan; DHS: Department of Hospital (Medical) Services; GAP: Gender Action Plan; IPC: Infection Prevention and Control; MOH: Ministry of Health; NHL: National Health Laboratory; PMU: Project Management Unit; RCU: Regional Coordination Unit; QA: Quality Assurance.

VI. Conclusions and Recommendations

a. Conclusions

92. Due diligence, for gender provisions in health services and among target groups, was carried out during the project preparation process. Gender issues were of greater concern for migrants, ethnic minorities and other vulnerable groups. Improvements in staffing patterns could also assist these groups. The foremost gender concern remains the high residual mortality for women, often related to reproductive health, which stems from a comparative lack of information and reduced access to services, in particular for these vulnerable groups in rural areas, but increasingly also for new migrants in urban slums.

93. The project gender classification is Category II: Effective Gender Mainstreaming. The project's gender strategy is to mainstream gender in all project activities to (i) enhance equal opportunity; (ii) increase benefits for vulnerable groups; and (iii) raise gender awareness. Country specific GAP will need to be updated by each PMU, as appropriate, with specific indicators, baselines and targets, at the onset of project implementation.

94. While the overall project is rated low risk in view of past experiences (except in Myanmar), there is a genuine concern that gender and social safeguard concerns and opportunities will be insufficiently addressed due to the current focus of governments or mainstream populations and government constraints in engaging hard-to-reach groups. As such, the GAP should be strictly adhered to during implementation and monitored throughout the life of the project.

b. Recommendations

95. Given the overall complacency regarding gender dimensions other than prioritizing reproductive health in the health sector, the project should promote mainstreaming gender equality in all activities, through planning, training, services and monitoring activities. Where possible, the government should seek to increase female staff, including from ethnic minorities, in remote rural areas, and for outreach, campaigns, and disease outbreak control.

96. The governments and each focus province (state or region in Myanmar) should carefully analyze, prioritize and plan how to reach vulnerable groups, include this in the annual operational plan, and mobilize resources to do so. In view of government constraints to reach out, all options, including engagement of NGOs, should be considered to more effectively reach women and other vulnerable groups.

VII. Appendix 1: Country Gender Information

Table 4: Gender Legislation, by country

Global legislation and policies Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979 Beijing Declaration and Platform for Action, 1995 International Conference on Population and Development Programme of Action 1994
Cambodia Constitution 2010: Chapter III, Article 31,45,46 and Chapter VI; Article 72 CEDAW ratification, 1992 Law on the Prevention of Domestic Violence and Protection of the Victims, 2005 Law on the Suppression of Human Trafficking and Sexual Exploitation, 2008. Neary Rattanak IV: Five-year Strategic Plan for Gender Equality and the Empowerment of Women in Cambodia (2014-2018), the Ministry of Women's Affairs of the Government of Cambodia. Gender Mainstreaming Strategy and Action Plan (2014-2018) of the Ministry of Health, Cambodia National Strategy for Reproductive and Sexual Health (2012-2016)
Lao PDR Constitution 1991, Chapter IV: para 25, 29,35,37,39. Revised Constitution, 2003: "the State, society and family should attentively implement the policy on development and promotion of women's advancement, protecting women's and children's rights and benefits". CEDAW ratification Family Law (1990) on equal rights of husband and wife Labor Law (1994), on non-discrimination in employment and equal pay for equal work (Article 39). Law on Development and Protection of Women, National Assembly No.08/NA, 22 October 2004 Decree on Non-profit Associations, 2009 National Strategy for the Advancement of Women 2011-2015
Myanmar Constitution of the Republic of the Union of Myanmar, 2008: Chapter VIII, para 350,351,367 CEDAW ratification, 1997 (but Constitution and many laws do not meet CEDAW requirements) Anti-trafficking in Persons Law 2005 Myanmar Maternal and Child Welfare Association Law (1990) (Revised in 2010 Prevention and Control of communicable Diseases Law (1995) (Revised in 2011) Education for All National Action Plan Myanmar National Reproductive Health Strategy 2009-2013 The National Strategic Plan for the Advancement of Women 2012-2021, 2013
Viet Nam Constitution 2013: Articles, 20,26,30,38 CEDAW ratification Marriage and Family Law 2000 Amended Land Law 2004 making women co-owner of family properties Law on Gender Equality, 2006 Law on Domestic Violence, 2007 Law on Anti-Human Trafficking, 2011 National Policy Framework for Gender Equality 2011-2020 National Targeted Program on Gender Equality 2011-2015 Amendment on the Labor Code on Sexual Harassment, 2013

Table 5: Institutions and committees relating to gender, by country

Cambodia Ministry of Women's Affairs Technical Working Group on Gender Cambodia National Council for Women Women's and Children's Consultative Committee
Lao PDR Ministry of Labor and Social Welfare Lao Women's Union (LWU). National Commission for the Advancement of Women Gender and Development Group representing LWU, NGOs and Partners, since 1991 Coordinated Mekong Ministerial Initiative Against Trafficking
Myanmar Department of Social Welfare, the Ministry of Social Welfare, Relief and Resettlement. Focal point fomr women's affairs and leading reforms to enhance gender equality and empowerment Myanmar National Committee for Women's Affairs 1996 Myanmar Women's Affairs Federation 2003 Gender Equality Network
Viet Nam The National Committee for the Advancement of Women (NCFAW) The Viet Nam Women's Union (VWU) Gender Equality Department (GED) in MOLISA National Academy for Politics and Administration Women's Entrepreneurs Council

VIII. Appendix 2: Gender and Health Indicators

Table 6: Gender assessment of health agencies[38]

Indicator	Cambodia	Laos	Myanmar	Viet Nam
MOH health staff Female %	20,811 49%	14,964	88,975	360,000
MOH leaders	Mostly male	Mostly male	Mostly male	Mostly male
MOH medical officers Female %	2340 18%			
MOH nurses Female %	2340 82%			
MOH policy on zero-tolerance gender discrimination in staff recruitment and promotion	Yes	Yes	Yes	Yes
MOH policy of zero-tolerance of sexual harassment of staff in the work place	Yes	Yes	Yes	Yes
MOH policy women recruitment policy	Yes	No	No	No
MOH policy on gender balance in positions, training, scholarships	Yes	Yes	No	No
MOH incentives for female staff to work in remote areas	No	No	Double salary for any staff	No
MOH has gender focal person	Yes	Yes	Yes	Yes
MOH has gender policy	Yes		On violence	--
Responsible for gender mainstreaming	Focal points		Focal point	--
Recent gender training of MOH staff	Yes		Focal points	--
Has MOH mainstreamed gender concerns in its policies on CDC?	Yes	No	No	No
MOH compiles gender disaggregated data on communicable diseases	Yes	Partly	No	Partly
MOH mainstreamed gender concerns into health services procedures	Yes	Yes.	Only for HIV counseling	Only for HIV counseling
MOH has gender quota for village health workers and volunteers	No	Yes	No	No
% Female village health workers and volunteers in the country	--	20%	20%	30%
Village health workers and volunteers trained in gender issues and safe labor migration	No	No	No	No
Village health workers and volunteers trained in detection of communicable diseases	No	Yes	Yes	Yes
Gender concerns included in CHEC	Yes	Yes	No	No
Safe labor migration in CHEC	Yes	Yes	No	No
MOH works with other line ministries	Yes	Yes	Yes,	Yes
MOH willing to contract/outsource	INGO	--	Yes	If MOH can't
MOH prioritizes ethnic concerns	Low	High	High	Low
Health facilities have separate toilets and showers for women	Hospital level	Hospital level	Hospital level	Hospital level
Female staff participate in outbreak response	Yes	Yes	Yes	Yes

[38] Based on data collected between 05-25 November 2015

Table 7: Key health indicators by gender, changes over time

	Cambodia		Laos PDR		Myanmar		Viet Nam	
Year of estimate	*1996*	*2010*	*1993*	*2006*	*1990*	*2009*	*1993*	*2011*
% of children under 5 who are underweight	42.6	28.3	39.8	31.6	32.5	22.6	36.9	11.7
Year of estimate	*1999*	*2011*	*1999*	*2011*	*1999*	*2010*	*1999*	*2011*
% eligible children who have complete primary school	40.9	89.9	71.0	92.6	74.1	103.6	98.2	104.3
Year of estimate	*1990*	*2011*	*1990*	*2011*	*1990*	*2011*	*1990*	*2011*
Under five mortality rate per 1,000 live births	116.7	42.5	147.0	41.9	107.4	62.4	49.9	21.7
Year of estimate	*1990*	*2011*	*2000*	*2011*	*1990*	*2011*	*1990*	*2011*
Infant mortality rate per 1,000 live births	85.1	36.2	102.0	33.8	76.7	47.9	36.1	17.3
Year of estimate	*1995*	*2015*	*1995*	*2015*	*1995*	*2015*	*1995*	*2015*
Adolescent fertility rate birth per 1,000 women 15-19 years	58	51	94	40	28	17	31	38
Year of estimate	*1990*	*2015*	*1990*	*2015*	*1990*	*2015*	*1990*	*2015*
Maternal mortality ratio per 100,000 live births	830	161	1600	197	520	178	240	54
Year of estimate	*1990*	*2015*	*1990*	*2015*	*1990*	*2015*	*1990*	*2015*
Incidence of tuberculosis	584	390	492	189	395	369	251	140
Year of estimate	*1990*	*2014*	*1990*	*2014*	*1990*	*2014*	*1990*	*2014*
HIV prevalence (%)	0.5	0.7	0.1	0.2	0.2	0.6	0.1	0.4
Women 15-24 years	1.3	0.2	0.1	0.2	0.4	0.4	0.1	0.2
Men 15-49 years	0.1	0.1	0.1	0.1	0.3	0.4	0.1	0.3

Source: ADB. Asia Pacific Regional MDGs report 2012/2013. World Bank

Table 8: Key health service indicators, by gender

	Cambodia		Laos PDR		Myanmar		Viet Nam	
Year of estimate	*2000*	*2014*	*2000*	*2012*	*1998*	*2010*	*2000*	*2014*
Births attended by skilled health staff	32	89	19	42	56	71	70	94
Year of estimate	*1995*	*2014*	*1995*	*2012*	*1991*	*2009*	*1994*	*2014*
Contraceptive Prevalence (%)	13	56	20	50	17	46	65	76
Year of estimate	*1990*	*2015*	*1990*	*2015*	*1990*	*2015*	*1990*	*2015*
DPT three-dose immunization coverage (%)	38	97	18	88	88	75	88	95
% Girls								

Source: World Bank

Table 9: Gender-based risk factors for communicable diseases

Exposure	Women	Men	Children
EID such as avian influenza, SARS, MERS, and hand, foot and mouth disease	Lack of information Handling livestock at home/in market Exposure preparing food	Lack of information Handling livestock at home/in market Butchery	Lack of information Attending school/hospital Playing/taking care of livestock Children assisting parents in cooking
Dengue	Living in (peri-)urban slums Indoor or outdoor stagnant water Lack of knowledge Not practicing vector control Less access to health services	Living in (peri-)urban slums Indoor or outdoor stagnant water Lack of knowledge Not practicing vector control Occupational exposure	Living in (peri-)urban slum Indoor or outdoor stagnant water Not attending school Playing near mosquito infested sites Sleeping without mosquito net
Neglected tropical diseases and zoonosis	Poor personal hygiene Poor waste management Lack of clean water Lack of sanitation Infected livestock Exposed to mosquitos breading sites	Poor personal hygiene Poor waste management Lack of clean water Lack of sanitation Infected livestock Travel Exposed to mosquitos breading sites Occupational exposure	Poor personal hygiene Poor waste management Lack of clean water Lack of sanitation Infected household pets Children not attending school Exposed to mosquitos breading sites Lack of vaccination services Not using bed nets
Malaria	Pregnant women Forest workers and gatherers Lack of access to health services Not using impregnated bed net Villages without vector control	Forest workers, plantation workers Border guards , army, night shifts No vector control measures Use of fake drugs Villages without vector control	Young children lacking immunity No breastfeeding Not using impregnated bed nets/mosquito repellent Villages without vector control
HIV/AIDS and other STI	Physical vulnerability Lack of awareness of partner infection as STI are often asymptomatic Lack of awareness of HIV infection risks Low education, poverty, migration, member of ethnic minority group Sex work Trafficking and abuse No condom in casual sex Less access to prevention services	Mobile men such as truck drivers Customers of sex-workers Not using condoms in casual sex Men having sex with men Injecting drug use Untreated STI Lack of awareness of HIV infection risks	HIV positive mother Parents lack awareness of mother to child transmission of HIV

Tuberculosis (TB)	Old age TB in family HIV infection Occupational exposure (e.g. health staff) Malnutrition Lack of access to health services	Old age Former military service Diabetes, malnutrition, and other chronic diseases HIV infection Poor work and living conditions Occupational exposure (e.g. health staff)	Parents with no awareness of TB risks Not immunized against TB infection TB positive family members Crowded dormitories/living areas Children living with AIDS Malnutrition

STI: sexually transmitted disease, TB: tuberculosis,

IX. Appendix 3: Country Gender Action Plans

3.1 Cambodia Gender Action Plan

Introduction

1. The Government of Cambodia and the Asian Development Bank have agreed on the GAP for the Greater Mekong Subregion Health Security Project for Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam. The project has been classified as Category II: Effective Gender Mainstreaming as it improves women's participation and access to health services. This appendix presents the gender analysis, strategy, action plan, implementation, and monitoring arrangements as per ADB requirements.[39]

GMS Health Issues

2. Globally, all countries are at risk of outbreaks of emerging infectious diseases (EID) such as Ebola hemorrhagic fever, with epidemic potential that may result in major mortality and economic slowdown. The GMS is located in Southeast Asia, which has major population hubs and intensive livestock husbandry, with associated environmental and biosafety problems, and intense connectivity. In recent years, the GMS has experienced several outbreaks of EID including severe acute respiratory syndrome (SARS) and avian influenza. The four project focus countries are particularly vulnerable due to low demand and shortcomings in health services arising from problems of access, quality and financing. Vulnerable groups, such as ethnic minorities and migrants who live in rural areas, and the poor and women in general, tend to use services less than the mainstream population. This constitutes both an individual and a public health risk. In general, government health services, constrained by a lack of capacity, funding and, in some cases, political will, are ill equipped to reach these priority groups.

3. The World Health Organization's (WHO) International Health Regulations (IHR), 2005,40 mandates all countries to improve public health security. WHO Regional Office's Asia Pacific Strategy for Emerging Disease (APSED), 2010, identifies 10 strategic areas for compliance by not later than 2016.41 At present, compliance has reached about 70-80% in the region, with specific gaps mainly relating to laboratory services, hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.42 WHO has also requested countries to implement other regional strategies for the control of communicable diseases of regional importance including HIV, tuberculosis, malaria, dengue, and neglected tropical diseases (NTD), and related laboratory services.

4. While the burden of communicable diseases have declined overall in the GMS, their continuing control is a major challenge due to (i) high costs; (ii) changes in life style with better income and connectivity; (iii) urbanization, migrants and slum formation; and (iv) drug resistance and misuse of antibiotics. Investment in control measures for (re)-emerging diseases is needed. Dengue has become a major public health problem in the GMS and is spreading globally. There have been recent outbreaks of foot and mouth disease, cholera, and several dengue-related

[39] ADB. 1998. *Policy on Gender and Development*. 2003. Manila

[40] World Health Organization. 2005. *International Health Regulations*. Geneva.

[41] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*. Manila.

[42] WHO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.

viral diseases. Common diarrheal diseases and respiratory infectious diseases continue to be the major burden of diseases in children below five years of age. While countries have mostly achieved their Millennium Development Goals (MDG), they are facing new challenges that will require continued focus on disease prevention. Populations most notably affected by infectious diseases tend to be poor people – in particular migrants, young women and girls, and ethnic minorities – who live in isolated segments along GMS borders and economic corridors. These populations do not frequently access regular health services for prevention, reporting, and management of infections.

The Project

5. The project goal is strengthened GMS health security. Key indicators include (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased use of public health services in border areas by MEV. The project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED; and (ii) increased CDC coverage of MEV in border areas. The project outputs are: (i) improved GMS collaboration and MEV access to CDC in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases. The proposed project focuses on 13 provinces in Cambodia, largely along the borders and economic corridors with Lao PDR, Thailand and Viet Nam. Outputs are summarized below:

6. MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. This still needs to be mainstreamed and formalized. In addition, some groups of MEV that are more likely to acquire and spread infectious diseases are not being reached through regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries; (ii) develops regional disease control strategies and evidence-based communicable disease control; and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring, as well as outreach and community mobilization to reach and engage MEV.

7. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong, due in large part to investments from the Global Fund for HIV, AIDS, Malaria and Tuberculosis (the Global Fund) with additional investments from the government. The system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH also needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level, (ii) web-based reporting including information technology support, (iii) integration of surveillance systems, (iv) risk analysis, communication, and community preparedness, (v) improving capacity of outbreak response teams including transport, and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

8. District facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory

audit system. Nosocomial infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance; (ii) in-service training; (iii) improving district laboratory services; and (iv) equipment and training for infection control and case management of dangerous diseases.

9. In Cambodia, the project is estimated to cost $22.8 million including $21 million in loan from ADB. The project will be implemented by MOH, with the Department of Planning and Health Information Systems acting as the Executing Agency, in conjunction with the Communicable Disease Control Department (CDCD), the National Institute for Public Health (NIPH) and relevant agencies in the 13 project focus provinces in the northwest, northeast, and southeast of the country. The project will be implemented over a five-year period, beginning early 2017. The project completion date is 30 June 2022.

10. Project provinces were selected primarily because they are at increased risk of communicable diseases. The larger part of investment of the project will benefit the general public, while a small part of the project is focusing on migrants and other mobile populations, ethnic minorities, and other vulnerable groups (MEV) in border areas and economic corridors. The 13 project provinces are largely poor border provinces.43 The total population in the targeted provinces is 7.6 million, with a population of 3.6 million in the focus border districts. The total number of poor people living in the project area is estimated at 1.5 million.

Gender Analysis (Due Diligence)

11. The gender and social safeguards experts conducted consultations with officers of MOH, international agencies and NGOs, and field visits to Banteay Meanchey and Svay Rieng provinces to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used to collect information on policy and institutions (Appendix 1), as well as health indicators and services (Appendix 2).

A. Gender Policy and Institutions

12. The Constitution of the Kingdom of Cambodia, 1993, provides the framework for the provision of social protection to Cambodian citizens. The Rectangular Strategy Phase III (RSIII) of the Royal Government of Cambodia (RGC) (2013-2018) reaffirms a strong commitment to sustainable development and poverty reduction strategies that respond to the people's will and to the emerging contexts of national and international developments.44 The RSIII aims at promoting economic growth, creating jobs, equitable distribution of the fruits of growth, and ensuring effectiveness of public institutions and management of resources. The RSIII is implemented through a comprehensive National Strategic Development Plan (NSDP), 2014-2018,[45] which calls for strengthened national capacity for gender analysis, research, and advocacy. Persistent challenges include the harmonization of gender mainstreaming plans, sector strategic plans, and monitoring mechanisms, as well as resource mobilization for sector gender mainstreaming.

[43] Palin, Batttambang, Banteay Meanchey, Preah Vihear, Stung Treng, Ratanakiri, Mondulkiri, Kratie, Kandal, Tbong Khmum, Prey Veng, Svay Rieng, and Kampot provinces.

[44] Government of Cambodia, Fifth Legislature of the National Assembly. *Rectangular Strategy for Growth, Employment, Equity and Efficiency. Phase III*. Phnom Penh. September 2013.

[45] Ministry of Planning. 2014. *National Strategic Development Plan 2014-2018*. Phnom Penh.

13. The National Social Protection Strategy (NSPS) for the Poor and Vulnerable,46 approved in 2011, aims to (i) protect the poorest and most disadvantage who cannot help themselves; (ii) mitigate risks that could lead to negative coping strategies and further impoverishment; and (iii) promote the poor to move out of poverty by building human capital and expanding opportunities. Main NSPS features for the health sector are to develop a nationwide social insurance and provide social safety nets for the poor and other vulnerable groups.

14. In 2014, the RGC Ministry of Women's Affairs launched the Five Year Strategic Plan for Gender Equality and Women's Empowerment (2014- 2018) called "Neary Rattanak IV".47 Neary Rarttanak IV articulates the move from project-based gender activities to a program-based approach in order to address project-based fragmentation of gender efforts. The aim is to have a single gender strategy and action plan for each sector. In addition, the strategy aims to enhance capacity for gender analysis and to improve advocacy and policy advice across the whole of government. Neary Rarttanak IV emphasizes that changing attitudes and behavior regarding gender equality and women's rights will require strong and long-term commitment from all stakeholders.

15. The goal of the Asian Development Bank (ADB) is poverty reduction and it is committed to regional cooperation as one of the pillars of Strategy 2020.48 As articulated in ADB's Policy for Gender and Development and Strategy to 2020, ADB remains committed to equality in all its operations.

16. ADB's Cambodia CPS 2014-2018[49] supports the RSIII in three strategic areas: (i) inclusive economic growth; (ii) environmentally sustainable growth; and (iii) regional cooperation and integration. It prioritizes agriculture, natural resources, and rural development; water and other urban infrastructure and services; transport; education; and finance and public sector management. It focuses on rural-urban links, targeting the areas where poorest people live, and promoting connectivity. It also supports regional connectivity and mitigating related health and gender issues. Under the GMS economic development program, ADB has been supporting various projects for communicable diseases control.[50]

B. Gender Issues

17. Implementing the NSDP and mainstreaming gender has been held back by several constraints including (i) limited awareness of gender issues; (ii) limited capacity to analyze and assess how policies and projects differentially impact men, women, girls, and boys; and (iii) persistent stereotypes about what women can and cannot, or should not do.[51]

18. While the government has a strong commitment to gender equality and sufficient gender legislation is in place, major challenges are harmonization of gender mainstreaming plans, monitoring indicators, and resource mobilization. In line with the NSDP and Neary Rattanak IV, MOH has been making efforts to harmonize various gender strategies and action plans linked to

[46] Royal Government of Cambodia. 2011. *National Social Protection Strategy for the Poor and Vulnerable.* Phnom Penh.
[47] Ministry of Women's Affairs. 2014. *Neary Rattanak IV. Five Year Strategic Plan for Gender Equality and Women's Empowerment. 2014-2018.* Phnom Penh.
[48] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila
[49] ADB. *Country Partnership Strategy* (2014-2018). November 2008. Manila
[50] ADB. 2004. *GMS Regional Communicable Diseases Control Project.* Manila; ADB. 2009. *Second GMS Communicable Diseases Control Project.* Manila.
[51] ADB 2012. *Country Gender Analysis.* Manila

specific program and projects. As the MOH gender strategy and action plan are still being prepared, the project GAP may need to be adapted to align with the country GAP at a later stage.

19. MOH has given consistent high priority to maternal and child care, and to reproductive health in general. This includes priority being given to treatment of HIV infection among women and children. Cambodia has shown substantial improvement in women's health indicators: the maternal mortality ratio reduced from 1020 to 161 per 100,000 live births between 1990 and 2015;52 and HIV prevalence of females aged 15-24 years fell from 1.3% to 0.2% between 2000 and 2015.53

20. The patterns of infectious diseases differ substantially among women and men due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members.54 While MOH engages more female than male health staff, women are underrepresented at higher levels, in remote rural health centers, and in meetings and outreach services.

21. Gender issues stem in part from traditional Cambodian societal beliefs, in part from social disintegration during the civil war, and in part from the recent economic transition. The modern economy brought improved communication, industrialization, migrant labor, and increased income. Economic development and migration had had a largely positive impact on improving health - including increased nutrition and better maternal and child survival - and increased economic opportunities for rural women. There are, however, associated health risks; both direct, such as road injuries, malaria, dengue and avian influenza, and indirect, including increased rural-urban migration and the well-documented associated social and health impacts..

22. MOH has a central focal point for gender, but this is often functionally lacking at provincial level. Gender focal points may be less active, and GAP implementation tends to be isolated and incomplete. Implementation of project GAP in previous health projects was less than satisfactory but has shown gradual improvement over time. Gender inequality is not perceived as a major issue in MOH, and, as such, the public system remains weak in addressing this inequality. MOH has planned to start gender-disaggregated monitoring of health services to better understand this issue.

23. Cambodia has many government, non-government, civil society, and grass-roots organizations and these entities are more active in addressing gender issues. It would be beneficial for MOH to strengthen collaboration with these organizations in gender-related work.

C. Gender Strategy, Actions and Monitoring

24. The project has been classified as "Category II: effective gender mainstreaming". Gender mainstreaming will improve project outcomes, benefit women at least equally, and address gender imbalances, such as in training and in access to outreach services.

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[52] http://www.who.int/gho/maternal_health/countries/khm.pdf
[53] http://data.worldbank.org/indicator/SH.HIV.1524.FE.ZS
[54] WHO. 2007. *Addressing Sex and Gender in Epidemic Prone Infections*. Geneva.

25. The government is mainstreaming gender in all sectors. Following the lead of other countries, MOH is considering the development of one overall gender strategy and GAP for each subsector, including related projects, which may be fine-tuned according to specific project needs.

26. Accordingly, the project gender strategy aims to (i) promote gender dimensions in all project activities; (ii) target vulnerable groups such as poor women and ethnic minorities; (iii) enhance equal opportunity in the sector; and (iv) synchronize with the subsector gender strategy. As the Guidelines for Development Project Management (GDPM) are in the process of updating its gender strategy, the project GAP may need to be adjusted in the future to align with this strategy.

27. MOH will fully incorporate the project GAP in the government's project design documents, and state/region annual operational plans. MOH proposes to maximize benefits for poor and ethnic women and other vulnerable groups at increased risk of infectious diseases in border areas. MEV will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

28. MOH is committed to provide the necessary inputs to fully implement the GAP. The project director will provide leadership and ensure that the GDPM and provinces implement the GAP in terms of gender mainstreaming and prioritizing women's services and opportunities in general and among MEV in particular. Gender focal points will be activated in the GDPM and at provincial and district levels. These focal points will ensure gender training/orientation and GAP implementation training for all staff involved in the project.

29. Within the Project Management Unit (PMU), gender and social safeguards specialists will be engaged to help plan, provide capacity building for, and monitor GAP implementation. Linkages will be established with the Ministry of Women's Affairs and other organizations as needed. Active engagement of women's associations is proposed to mobilize communities and reach MEV. Engagement of NGOs in areas where MOH has less capacity may also be considered by MOH. Gender disaggregated indicators will be used for project monitoring.

30. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), Project Administration Manual (PAM), Project Performance Monitoring System (PPMS), and assurances and covenants. The project GAP has been agreed with MOH and is aligned with sector-wide gender equality commitments.

31. The summary project GAP presented below has been agreed with MOH and is aligned with the national context, policies and plans, MOH sector-wide commitments, and ADB policy.[55] In summary, following actions have been agreed to:

(i) All regional, cross-border and intersectoral events will increase female participation, promote gender equality, identify and address gender issues, and monitor gender actions;
(ii) The project will proactively target MEV including youth and women;
(iii) Education materials and care procedures will be gender-sensitive;
(iv) Outbreak response and outreach services will ensure female participation;

[55] ADB. 1998. *Policy on Gender and Development*. Manila; ADB. 2010. *Operations Manual Bank Policies*. Manila.

(v) Equitable participation of female and male staff in scholarships and training programs;
(vi) Refurbishment of laboratories and isolation wards will be gender sensitive;
(vii) There will be active focal points in all implementing agencies;
(viii) Gender and social development experts will be engaged for capacity building;
(ix) Project annual operational plans (AOPs) will address gender dimensions;
(x) The project will collect, analyze and report gender-disaggregated data;
(xi) All project reports report on gender issues.
(xii)

Table 10: Cambodia Gender Action Plan

Actions	Targets/Indicators/Source	Responsible
Output 1: Improved Regional Cooperation and CDC in Border Areas		
Increase and enhance participation of women in regional, cross-border, and intersectoral events and outreach services.	Participation of women in these events and services reaches at least 30%, from less than xx% to date	MOH, PMU, local health offices
Raise gender awareness and address issues in CDC workshops.	All CDC workshops address gender issues (event reports).	MOH, PMU
Proactively target ethnic and migrant girls and women with outreach services and referral to health services in border areas.	At least 50% of outreach services targets remote ethnic groups and migrants including girls and women in border areas, from nil to date (facility reports).	Local health offices and health facilities
Output 2: Strengthened national surveillance and response		
Collect, analyze, and report gender-disaggregated surveillance data.	Gender disaggregated surveillance data are available at national level from nil now (report of national data collection centers).	National surveillance centers
Ensure participation of women in field epidemiology training.	At least 25% of participants in field epidemiology training are female, from less than 10% at present (PMU report).	MOH, PMU
Increase participation of female staff in any outbreak response teams.	Each outbreak response team has at least one female staff member, from less than 50% at present (CDC report).	Local health offices and health facilities
Output 3: Improved diagnostics and management of infectious diseases		
Ensure equitable participation of female staff in laboratory management and quality assurance training programs.	Female participation in laboratory management and quality assurance training programs is approx. 50% (national laboratory annual report).	National laboratories
Ensure equitable participation of female and male doctors and nurses in scholarships for hospital infection prevention and control.	Female participation in hospital infection prevention and control scholarship reaches approx. 50% from xx% to date (PMU annual report).	Departments of Hospital Services
Improve hygiene and sanitation facilities for female patients in hospitals.	All female wards have proper hygiene and sanitation facilities for patients, from approx. 50% at present (to be based on baseline and end-of-project survey).	Hospitals
Project Management		
Improve annual operational plans and budgets in project-supported provinces to adequately address gender dimensions.	All annual operational plans address gender dimensions adequately (PMU reports).	PMU, local health offices
Fully engage gender focal points in implementing agencies.	All implementing agencies have a fully engaged gender focal point (PMU report, based on participation in events).	PMU, local health offices
All quarterly and annual reports.	All quarterly reports adequately report on gender issues (PMU reports).	PMU, local health offices
Advance participation of female consultants	Female consultants represent at least	PMU

Actions	Targets/Indicators/Source	Responsible
	30% of project consultants (PMU reports).	

CDC: communicable diseases control; MOH: ministry of health; PMU: project management unit
Source: Ministries of Health of Cambodia; ADB

3.2 Lao Gender Action Plan

Introduction

1. The Government of the Lao People's Democratic Republic (Lao) and the Asian Development Bank (ADB) have agreed on the GAP for the Greater Mekong Subregion Health Security Project for Cambodia, Lao, Myanmar, and Viet Nam. The project has been classified as Category II: Effective Gender Mainstreaming as it improves women's participation and access to health services. This appendix presents the gender analysis strategy, action plan, implementation and monitoring arrangements as per ADB requirement.

GMS Health Issues

2. Globally, all countries are at risk of outbreaks of emerging infectious diseases (EID) such as Ebola hemorrhagic fever, with epidemic potential that may result in major mortality and economic slowdown. The GMS is located in Southeast Asia, which has major population hubs and intensive livestock husbandry, with associated environmental and biosafety problems, and intense connectivity. In recent years, the GMS has experienced several outbreaks of EID including severe acute respiratory syndrome (SARS) and avian influenza. The four project focus countries are particularly vulnerable due to low demand and shortcomings in health services arising from problems of access, quality and financing. Vulnerable groups, such as ethnic minorities and migrants who live in rural areas, and the poor and women in general, tend to use services less than the mainstream population. This constitutes both an individual and a public health risk. In general, government health services, constrained by a lack of capacity, funding and, in some cases, political will, are ill equipped to reach these priority groups.

3. The World Health Organization's (WHO) International Health Regulations (IHR), 2005,[56] mandates all countries to improve public health security. WHO Regional Office's Asia Pacific Strategy for Emerging Disease (APSED), 2010, identifies 10 strategic areas for compliance by not later than 2016.[57] At present, compliance has reached about 70-80% in the region, with specific gaps mainly relating to laboratory services, hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.[58] WHO has also requested countries to implement other regional strategies for the control of communicable diseases of regional importance including HIV, tuberculosis, malaria, dengue, and neglected tropical diseases (NTD), and related laboratory services.

4. While the burden of communicable diseases have declined overall in the GMS, their continuing control is a major challenge due to (i) high costs; (ii) changes in life style with better income and connectivity; (iii) urbanization, migrants and slum formation; and (iv) drug resistance and misuse of antibiotics. Investment in control measures for (re)-emerging diseases is needed.

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[56] World Health Organization. 2005. *International Health Regulations*. Geneva.
[57] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*. Manila.
[58] WHO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.

Dengue has become a major public health problem in the GMS and is spreading globally. There have been recent outbreaks of foot and mouth disease, cholera, and several dengue-related viral diseases. Common diarrheal diseases and respiratory infectious continue to be the major burden of diseases in children below five years of age. While countries have mostly achieved their Millennium Development Goals (MDG), they are facing new challenges that will require continued focus on disease prevention. Populations most notably affected by infectious diseases tend to be poor people – in particular migrants, young women and girls, and ethnic minorities – who live in isolated segments along GMS borders and economic corridors. These populations do not frequently access regular health services for prevention, reporting, and management of infections.

The Project

5. The project goal is strengthened GMS health security. Key indicators include (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased use of public health services in border areas by MEV. The project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED; and (ii) increased CDC coverage of MEV in border areas. The project outputs are: (i) improved GMS collaboration and MEV access to CDC in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases. Twelve provinces are targeted.[59] Outputs are summarized below:

6. MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. This still needs to be mainstreamed and formalized. In addition, some groups of MEV that are more likely to acquire and spread infectious diseases are not being reached through regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries; (ii) develops regional disease control strategies and evidence-based communicable disease control; and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring, as well as outreach and community mobilization to reach and engage MEV.

7. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong, due in large part to investments from the Global Fund for HIV, AIDS, Malaria and Tuberculosis (the Global Fund) with additional investments from the government. The system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH also needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level; (ii) web-based reporting including information technology support; (iii) integration of surveillance systems; (iv) risk analysis, communication, and community preparedness; (v) improving capacity of outbreak response teams; and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

[59] Bokeo, Luangnamtha, Oudomxay, Phongsaly, Huaphan, Xiengkhuang, Borikhamsay, Khammuane, Saravane, Sekong, Attapeu, Champasack.

8. District facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial or hospital-acquired infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance; (ii) in-service training; (iii) improving district laboratory services; and (iv) equipment and training for infection control and case management of dangerous diseases.

9. In Lao PDR, the project is estimated to cost $12.6 million including $8 million in grant and $4 million in loan from ADB. The project will be implemented by MOH through the Department of Planning and International Cooperation acting as the EA, in conjunction with the Departments of Communicable Diseases and Health Services, the National Center for Laboratory and Epidemiology, and relevant agencies in the 12 project provinces in the north, center and south of the country. The project will be implemented over a period of 5-year period beginning early 2017. The project completion date is 30 June 2022.

10. The selected 12 provinces have a population of 3.0 million people, and the 36 focus districts have a population of 1.4 million people. There are approximately one million ethnic minority people living in the project focus districts and approximately 0.5 million poor. Output 1 specifically targets migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEV) in border areas and economic corridors.

Gender Analysis (Due Diligence)

11. The gender and social safeguards experts conducted consultations with officers of MOH, international agencies and NGOs, and field visits to Bokeo and Luang Namtha provinces to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used to collect information. Findings are summarized in Appendixes 1 and 2. The project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve women's opportunities and access to health services.

A. Gender Policy and Institutions

12. Gender equality is reflected in the Lao Constitution and in multiple international commitments of the Lao Government. The Constitution states "*the State, society and family should attentively implement the policy on development and promotion of women's* advancement, protecting women's and children's rights and benefits". The National Growth and Poverty Reduction Strategy of 2003 includes a gender strategy linked to all priority sectors including health and has established a mechanism to mainstream gender.[60] The 2004 Law on the Development and Protection of Women was issued for i) promoting the knowledge, capability and revolutionary ethics of women; ii) gender equality; iii) eliminating all forms of discrimination against women; and iv) preventing and combating trafficking in women and children and domestic violence against women and children, in order to create conducive conditions for women to participate and to be a force in national defense and development.[61] The principle of equality is further reflected in the Labor Law (1994), which requires nondiscrimination in employment (Article 2) and equal pay for work of equal quantity, quality,

[60] ADB. 2004. *Lao PDR Country Gender Strategy Gender, Poverty and the MDGs.*

[61] Lao National Assembly. 2004. *Law on the Development and Protection of Women, National Assembly No.08/NA, 22 October 2004,*

and value (Article 39); and the Family Law (1990), which states that "the husband and wife have equal rights in all aspects within the family". The Lao Government is a state signatory to the United Nations Committee on the Elimination of Discrimination Against Women (CEDAW).[62]

13. A number of institutional arrangements have been put in place to move the Lao Government's gender agenda forward. Leading entities are the Lao National Commission on the Advancement of Women (NCAW) established in 2003, and the Lao Women's Union (LWU) dating from 1995. The LWU is a grassroots organization with representation in all villages. Its objectives are to respond to women's development needs; promote the status and role of women; and promote unity amongst women of different ethnic groups and social strata throughout the country.63

14. The NCAW is the national focal agency for gender mainstreaming in development policies and programs, and is represented in all ministries and provinces. It comprises four main programs including (i) developing an information system with gender-disaggregated statistics and dissemination and awareness raising; (ii) institutional and personnel strengthening for the advancement of women; (iii) ensuring gender equality and women empowerment to participate in all fields; and (iv) fulfillment of the obligations of Lao PDR under CEDAW conventions and other international conventions pertaining to women. NCAW is tasked with implementing the National Strategy for the Advancement of Women, which outlines gender related goals and targets for each sector. However, NCAW lacks the capacity to provide assistance to sector ministries to integrate these goals into sector strategies and plans. As such, gender has not been well integrated into the planning, budgeting and monitoring cycle of most line ministries.64 The Lao PDR has few national and international non-government organizations, and only recently started to encourage these organizations to participate in the development process.

15. The goal of the ADB is poverty reduction and it is committed to regional cooperation as one of the pillars of Strategy 2020.[65] As articulated in ADB's 1998 Policy for Gender and Development and Strategy 2020, ADB remains committed to equality in all its operations, and requires due diligence of all its projects. ADB's Lao PDR CPS 2012-2016[66] is aligned with the 7th National Socio-Economic Plan and aims to reduce poverty and promote inclusive growth by focusing on rural areas and rural-urban links, particularly the areas where most poor people live, and promoting connectivity for isolated areas through rural roads. For the health sector, it supports public sector management. It also aims to increase responsiveness to emerging issues in a rapidly changing economy. Industrialization and connectivity, with associated migration and changing behavior carry health and gender risks. Under the GMS economic development program, ADB supports various projects for communicable diseases control.[67]

B. Gender Issues

16. The Government of the Lao PDR has made major progress in gender and development. Gender issues stem in part from traditional Laotian societal beliefs, in part from war and revolution, and in part from the recent transition to a modern economy. Patriarchal Lao society

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[62] United Nations. 2013. *CEDAW - Committee on the Elimination of Discrimination Against Women*
[63] http://www.unwomen-eseasia.org/projects/Lao/lao.htm
[64] ADB. 2012. *Lao People's Democratic Republic: Strengthening National Commission for Advancement of Women Network in the Ministry of Public Works and Transport/*
[65] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila
[66] ADB. *Lao PDR Country Partnership Strategy 2012-2016*. 2012. Manila.
[67] ADB. 2004. *GMS Regional Communicable Diseases Control Project.* Manila; ADB. 2009. *Second GMS Communicable Diseases Control Project.* Manila.

maintains strong stereotypes regarding the traditional role of women as caretaker of the family. Due to Lao's ethnic variety, there are also major variations in these roles and rights between communities. As such, a one-fit approach is not appropriate.[68] Illiteracy among ethnic minority women is also a major problem in Lao. Conflict and communism helped uplift the role of women in the production process. Legislation has allowed women to have assets, and have relative social liberty (at a social cost). Lao women are increasingly represented in the National Assembly, but not in senior government positions. In the health sector, MOH engages more females than males, but women are underrepresented at higher levels, in remote rural health centers, and also in meetings and outreach services. This is explained by stating that women are unwilling to be away from home due to family responsibilities.

17. The Lao health sector has contributed to achieving gender related goals. The maternal mortality ratio has reduced from 905 to 197 per 100,000 live births between 1990 and 2015.69 However, there is still significant gender equality within the health sector. While women are more vulnerable in terms of health risks, their use of services remains low due to problems of access, quality, acceptability, and affordability of health services. The patterns of infectious diseases are known to differ substantially among women and men due differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's' access to health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually the primary caregivers and are responsible for the prevention, detection and care of infectious diseases amongst family members

18. The ADB / World Bank Country Gender Assessment of 2012,[70] notes that increased economic links with neighboring countries present a number of opportunities and risks. The modern economy has brought better connectivity, industrialization, migrant labor, and increased income. Economic development and migration has had a largely positive impact on improving health - including increased nutrition and better maternal and child survival - and increased economic opportunities for rural women. There are, however, associated health risks; both direct, such as road injuries, malaria, dengue and avian influenza, and indirect, including increased rural-urban migration and the well-documented associated social and health impacts.

19. Both cross-border and domestic migration are more often undertaken by women. Those who go to work in Thailand are mostly young people from border areas aged 15-25 years old. Poor Mon-Khmer and Tibeto-Burman ethnic groups are overrepresented among migrants. Precise figures are unavailable because the majority of people migrate through irregular channels. Cross-border migrant labor, mostly to Thailand, has brought additional risks: labor exploitation and poor working conditions are common.[71] About 15% of female migrants were girls below 18 years of age.

20. Government officials in the health sector often demonstrate a general complacency regarding gender as an issue, which may be routed in traditional views and few role models, a view of women as beneficiaries, and the perception that MOH already gives priority to women's health.

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68 ADB, WB, 2012. *Country Gender Assessment for Lao PDR*.
69 http://www.who.int/gho/maternal_health/countries/lao.pdf
70 ADB and World Bank. *Country Gender Assessment for Lao PDR – Reducing Vulnerability and Increasing Opportunity*. 2012. Vientiane.
71 http://www.asia-pacific.undp.org/content/dam/rbap/docs/Research%20&%20Publications/democraticgovernance/RBAP-DG-2015-UN-ACT-Lao-PDR-Deportation-Research.PDF

21. MOH has demonstrated less effort in mainstreaming gender in the sector, and has limited capacity to analyze and address gender dimensions of projects. Very little effort has been made to analyze the health implications of migrants, and develop plans to address these. MOH has central and provincial focal points for gender, but their main role appears to be gender awareness training.

22. Implementation of project GAP is solely the responsibility of the PMU. Implementation of GAPs in previous ADB health projects tended to be less satisfactory as they were not given great priority. GAP implementation has, however, improved in recent projects. Substantial capacity for gender-related support is available in mass organizations at community level such as the Women's Union, which also facilitates implementation in rural areas.[72]

C. Gender Strategy, Actions, and Monitoring

23. The project has been classified as "Category II: effective gender mainstreaming". Gender mainstreaming will improve project outcomes, benefit women equally or more, and address gender imbalances such as in training and in outreach services.

24. The government is mainstreaming gender in all sectors. Following the example of other countries, MOH is considering developing one overall gender strategy and GAP for each subsector, including related projects, which may be fine-tuned according to specific project needs.

25. Accordingly, the project gender strategy aims to (i) promote gender dimensions in all project activities; (ii) target vulnerable groups such as poor women and ethnic minorities; (iii) enhance equal opportunity in the sector; and (iv) synchronize with the subsector gender strategy. As the GDPM is in the process of updating its gender strategy, the project GAP may need to be adjusted in the future to align with this strategy.

26. MOH will fully incorporate the project GAP in the government's project design documents, and state/region annual operational plans. MOH proposes to maximize benefits for poor and ethnic women and other vulnerable groups at increased risk of infectious diseases in border areas. MEV will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

27. MOH is committed to provide the necessary inputs to fully implement the GAP. The project director will provide leadership and ensure that the GDPM and provinces implement the GAP in terms of gender mainstreaming and prioritizing women's services and opportunities in general and among MEV in particular. Gender focal points will be activated in the GDPM and at provincial and district levels. These focal points will ensure gender training/orientation and GAP implementation training for all staff involved in the project.

28. Within the project management unit (PMU) of the project, gender and social safeguards specialists will be engaged to help plan, provide capacity building for, and monitor GAP implementation. Linkages will be established with LWU and other organizations as needed. Active engagement of women's associations is proposed to mobilize communities and reach MEV. Engagements of NGOs in areas where MOH has less capacity may also be considered by MOH. Gender disaggregated indicators will be used for project monitoring.

[72] ADB. 2013. *PCR GMS Communicable Diseases Control Project*.

29. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), Project Administration Manual (PAM), Project Performance Monitoring System (PPMS), and assurances and covenants. The project GAP has been agreed with MOH and is aligned with sector-wide gender equality commitments.

30. The summary project GAP presented below has been agreed with MOH and is aligned with the national context, policies and plans, MOH sector-wide commitments, and ADB policy. In summary, following actions have been agreed to:

(i) All regional, cross-border and intersectoral events will increase female participation, promote gender equality, identify and address gender issues, and monitor gender actions;
(ii) The project will proactively target MEV including youth and women;
(iii) Education materials and care procedures will be gender-sensitive;
(iv) Outbreak response and outreach services will ensure female participation;
(v) Equitable participation of female and male staff in scholarships and training programs;
(vi) Refurbishment of laboratories and isolation wards will be gender sensitive;
(vii) There will be active focal points in all implementing agencies;
(viii) Gender and social development experts will be engaged for capacity building;
(ix) Project annual operational plans (AOPs) will address gender dimensions;
(x) The project will collect, analyze and report gender-disaggregated data;
(xi) All project reports report on gender issues.

Table 11: Laos PDR Gender Action Plan

Actions	Targets/Indicators/Source	Responsible
Output 1: Improved Regional Cooperation and CDC in Border Areas		
Increase and enhance participation of women in regional, cross-border, and intersectoral events and outreach services.	Participation of women in these events and services reaches at least 30% from less than xx% to date, (RCU baseline and annual reports)	MOH, PMU, local health offices
Raise gender awareness and address issues in CDC workshops.	All workshops address gender issues in CDC workshops (event reports).	MOH, PMU
Proactively target ethnic and migrant girls and women with outreach services and referral to health services in border areas.	At least 50% of outreach services targets remote ethnic groups and migrants including girls and women in border areas, from nil to date (facility reports).	Local health offices and health facilities
Enhance participation, capacity building and decision-making opportunities for women in regional, cross-border, and intersectoral events. All joint studies integrate gender issues and report sex disaggregated data Use workshops for gender advocacy and increasing gender awareness among workshop participants and stakeholders/governments. Ensure full participation of female staff for outreach activities using gender-sensitive education and care procedures. Proactively target youth and women at increased risk of infectious diseases with CDC activities in border areas.	Participation of women in these events reaches at least 35% Workshop materials clearly demonstrate mainstreaming of gender issues and promotion of gender-sensitive strategies. Participation of female staff in outreach activities at least 40% Decreased prevalence of infections among vulnerable youth and women in border areas based on health statistics.	
Output 2: Strengthened national surveillance and response		
Collect, analyze, and report gender-disaggregated surveillance data.	Gender disaggregated surveillance data are available at national level from nil now (report of national data collection centers).	National surveillance centers
Ensure participation of women in field epidemiology training.	At least 25% of participants in field epidemiology training are female, from less than 10% at present (PMU report).	MOH, PMU
Increase participation of female staff in any outbreak response teams.	Each outbreak response team has at least one female staff member, from less than 50% at present (CDC report).	Local health offices and health facilities
Collect, analyze and report gender-disaggregated data. Ensure participation of female staff in any surveillance teams. Ensure participation of female staff in any outbreak response teams.	Sex disaggregated data on current staff at the central, provincial and; Each outbreak surveillance team and response team has at least one female staff member. At least 30% of participants in field epidemiology training are female.	

Actions	Targets/Indicators/Source	Responsible
Increase participation of women in field epidemiology training.		
Output 3: Improved diagnostics and management of infectious diseases		
Ensure equitable participation of female staff in laboratory management and quality assurance training programs.	Female participation in laboratory management and quality assurance training programs is approx. 50% (national laboratory annual report).	National laboratories
Ensure equitable participation of female and male doctors and nurses in scholarships for hospital infection prevention and control.	Female participation in hospital infection prevention and control scholarship reaches approx. 50% from xx% to date (PMU annual report).	Departments of Health Care Services
Improve hygiene and sanitation facilities for female patients in hospitals.	All female wards have proper hygiene and sanitation facilities for patients, from approx. 50% at present (to be based on baseline and end-of-project survey).	Hospitals
Ensure equitable participation of female and male staff in laboratory training programs. Ensure equitable participation of female and male nurses in scholarships for hospital infection prevention and control. Ensure mobile clinics for remote ethnic populations and border areas have a basic knowledge about diagnostics and management of infectious diseases	At least 30% of participants in laboratory management and quality assurance training programs are female. At least 50% of participants in hospital infection and control training are female. Integrate gender issues related to infectious diseases to the media programs 80% male and female mobile clinics are trained a basic knowledge about diagnostics and management of infectious diseases	Dept. Human Resource Development and Dept. of Training Academies
Project Management		
Improve annual operational plans and budgets in project-supported provinces to adequately address gender dimensions.	All annual operational plans address gender dimensions adequately (PMU reports).	PMU, local health offices
Fully engage gender focal points in implementing agencies.	All implementing agencies have a fully engaged gender focal point (PMU report, based on participation in events).	PMU, local health offices
All quarterly and annual reports.	All quarterly reports adequately report on gender issues (PMU reports).	PMU, local health offices
Advance participation of female consultants	Female consultants represent at least 30% of project consultants (PMU reports).	PMU

CDC: communicable diseases control; MOH: Ministry of Health; PMU: project management unit
Source: Ministries of Health of Lao PDR; ADB

3.3 Myanmar Gender Action Plan

Introduction

1. The Government of Myanmar and the Asian Development Bank (ADB) have agreed on the GAP for the Greater Mekong Subregion Health Security Project for Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam. The project has been classified as Category II: Effective Gender Mainstreaming as it improves women's participation and access to health services. This appendix presents the gender analysis strategy, action plan, implementation and monitoring arrangements as per ADB requirement.[73]

GMS Health Issues

2. Globally, all countries are at risk of outbreaks of emerging infectious diseases (EID) such as Ebola hemorrhagic fever, with epidemic potential that may result in major mortality and economic slowdown. The GMS is located in Southeast Asia, which has major population hubs and intensive livestock husbandry, with associated environmental and biosafety problems, and intense connectivity. In recent years, the GMS has experienced several outbreaks of EID including severe acute respiratory syndrome (SARS) and avian influenza. The four project focus countries are particularly vulnerable due to low demand and shortcomings in health services arising from problems of access, quality and financing. Vulnerable groups, such as ethnic minorities and migrants who live in rural areas, and the poor and women in general, tend to use services less than the mainstream population. This constitutes both an individual and a public health risk. In general, government health services, constrained by a lack of capacity, funding and, in some cases, political will, are ill equipped to reach these priority groups.

3. The World Health Organization's (WHO) International Health Regulations (IHR), 2005,[74] mandates all countries to improve public health security. WHO Regional Office's Asia Pacific Strategy for Emerging Disease (APSED), 2010, identifies 10 strategic areas for compliance by not later than 2016.[75] At present, compliance has reached about 70-80% in the region, with specific gaps mainly relating to laboratory services, hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.[76] WHO has also requested countries to implement other regional strategies for the control of communicable diseases of regional importance including HIV, tuberculosis, malaria, dengue, and neglected tropical diseases (NTD), and related laboratory services.

4. While the burden of communicable have declined overall in the GMS, their continuing control is a major challenge due to (i) high costs; (ii) changes in life style with better income and connectivity; (iii) urbanization, migrants and slum formation; and (iv) drug resistance and misuse of antibiotics. Investment in control measures for (re)-emerging diseases is needed. Dengue has become a major public health problem in the GMS and is spreading globally. There have been recent outbreaks of foot and mouth disease, cholera, and several dengue-related viral diseases. Common diarrheal diseases and respiratory infectious continue to be the major burden of diseases in children below five years of age. While countries have mostly achieved their Millennium Development Goals (MDG), they are facing new challenges that will require continued focus on disease prevention. Populations most notably affected by infectious

[73] ADB. 1998. *Policy on Gender and Development*. 2003. Manila
[74] World Health Organization. 2005. *International Health Regulations*. Geneva.
[75] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*. Manila.
[76] WHO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.

diseases tend to be poor people – in particular migrants, young women and girls, and ethnic minorities – who live in isolated segments along GMS borders and economic corridors. These populations do not frequently access regular health services for prevention, reporting, and management of infections.

The Project

5. The project goal is strengthened GMS health security. Key indicators include (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities; (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year; and (iii) increased use of public health services in border areas by MEV. The project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED; and (ii) increased communicable disease control coverage of MEV in border areas. The project outputs are: (i) improved GMS collaboration and MEV access to communicable disease control in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases. Outputs are summarized as follows.

6. MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. This still needs to be mainstreamed and formalized. In addition, some groups of MEV that are more likely to acquire and spread infectious diseases are not being reached through regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries; (ii) develops regional disease control strategies and evidence-based communicable disease control; and (iii) improves communicable disease control for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring, as well as outreach and community mobilization to reach and engage MEV.

7. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong. The system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH also needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level; (ii) web-based reporting including information technology support; (iii) integration of surveillance systems; (iv) risk analysis, communication, and community preparedness; (v) improving capacity of outbreak response team; and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

8. District facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial infections are becoming a major public health issue. Under the third output, the project supports (i) improving quality assurance; (ii) in-service training; (iii) improving district laboratory services; and (iv) equipment and training for infection control and case management of dangerous diseases.

9. In Myanmar, the project is estimated to cost $12.6 million including $12 million in loan from ADB, and will be implemented by MOH through the Departments of Public Health and

Hospital Services acting as the EA, in conjunction with the National Health Laboratory and the state health offices in the one project regional and five project states on the eastern border of Myanmar. The project will be implemented over a period of 5-year period beginning early 2017. The project completion date is 30 June 2022.

10. The selected region and five states have a population of 11.2 million,[77] with a population of 2.2 million (including 2 million ethnic minorities) in 12 targeted townships, and 0.7 million living in six border townships. The total number of poor people is not known. Output 1 specifically targets migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEV) in border areas and economic corridors.

Gender Analysis (Due Diligence)

11. The gender and social safeguards experts conducted consultations with officers from MOH, international agencies and NGOs, and field visits to Shan, Mon and Kayin States to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used to collect information. Findings are summarized in Appendix 2. The project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve women's opportunities and access to health services.

A. Gender Policy and Institutions

12. Myanmar is giving increasing attention to gender inequality as an impediment to development and the attainment of human rights. In 1997, the Government acceded to the Convention of Elimination of All Forms of Discrimination Against Women (CEDAW).[78]

13. The Ministry of Social Welfare and Relief and Resettlement is leading reforms to enhance gender equality and empowerment. It is cooperating with other government agencies, civil society, academia, and the international community. The Department of Social Welfare (DSW) is the focal point for all matters related to women. The Myanmar National Committee for Women's Affairs is coordinated by DSW and is the national mechanism for implementation of female-focused activities. DSW is currently finalizing a ten-year National Strategic Plan for the Advancement of Women 2012-2021 (NSPAW), in line with the Beijing Platform for Action. The first challenge, however, will be to convince government officials that gender equality is low and needs to be addressed in all sectors. In 2011, DSW also requested the Gender Equality Network (GEN), to help develop a "Women's Protection Law".

14. The goal of the Asian Development Bank (ADB) is poverty reduction and it is committed to regional cooperation as one of the pillars of Strategy 2020.[79] As articulated in ADB's 1998 Policy for Gender and Development and Strategy 2020, ADB remains committed to gender equality in all its operations, and requires due diligence of all its projects. ADB has not had operations in Myanmar from 1988 to 2010. The current Myanmar CPS extension, 2015-2016,[80] builds on the interim CPS 2012-2014 which focuses *inter alia* on capacity building in ministries in core areas of ADB involvement, and creating access and connectivity (rural livelihoods and infrastructure development). ADB's Myanmar interim partnership strategy emphasizes transport; energy; agriculture and natural resources; education; and urban development, including water and

[77] Tanintharyi region, and Shan North, Shan East, Kayin, Kayah, and Mon States.
[78] United Nations. 2013. *CEDAW - Committee on the Elimination of Discrimination Against Women*
[79] ADB *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. April 2008. Manila
[80] ADB. 2012. *Myanmar Interim Country Partnership Strategy, 2012-2014*. Manila

sanitation. The interim CPS also supports regional connectivity and development and addressing related health and gender issues. Myanmar has received assistance for Avian Influenza control and knowledge sharing in communicable disease control.[81] More recently, ADB started supporting malaria and HIV projects.[82]

B. Gender Issues

15. The Myanmar Government has basic gender legislation in place and ratified the CEDAW in 1997, but legal gaps remain. For example, the country lacks specific legislation against gender-based violence except for penal code provisions against sexual assault and rape. Public awareness of the issue is low. Traditional cultural beliefs, the low social value of women, women's lack of knowledge about their rights, and insufficient support services collude to ensure that cases are underreported and settled out of court. Human trafficking is also a major tragedy and challenge.[83]

16. Women continue to experience difficulties in being able to drive change towards a gender-equal Myanmar. The role of women in Myanmar society has historically been more restricted. In addition, the military regime considered the status of women to be satisfactory. Daw Aung San Suu Kyi said, "*Women are generally regarded as homemakers, tenders of the hearth around which the family gathers, weavers of the gentle ties that bind faster than the strongest iron chains*".[84] The new government has a vision of Myanmar women as leaders and as the foundation to build a new, democratic and just society. There are many hurdles to overcome, including traditional values, cultural discrimination, male domination, lack of access to information and education, and inequalities that have become entrenched by law. The most critical factor in the transition to a new society in Myanmar is the lack of provisions in law for the empowerment of women and their participation in decision-making processes[85].

17. Implementation of gender strategies and plans remains weak due to a general lack of acceptance of gender as an issue, capacity constraints, and limited resources. Implementation of various GAP tends to be isolated and incomplete.

18. Social indicators have also shown improvement in Myanmar but are still among the lowest in the region. The United Nations Development Program's Human Development Index (HDI), which measures achievements in terms of life expectancy, educational attainment and adjusted real income, ranked Myanmar at 149 out of 187 countries in 2012.[86] Social isolation is a particular problem for upland ethnic peoples, who are marginalized in many ways due to their languages, customs and religious beliefs. The "excluded" poor are a group of particular concern: these people live in conflict zones with restricted access to services, including emergency services, particularly at night.[87]

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[81] ADB. 2004. *GMS Regional Communicable Diseases Control Project.* Manila; ADB. 2009. *Second GMS Communicable Diseases Control Project.* Manila.

[82] ADB. 2015. *Malaria and Communicable Diseases Control in the Greater Mekong Subregion*. Manila; ADB. 2013. *Greater Mekong Subregion Capacity Building for HIV/AIDS Prevention*. Manila; ADB. 2014. *Expand HIV Services to Vulnerable Groups in Remote Areas*. Manila.

[83] ADB. *Interim Country Partnership Strategy*: Myanmar, 2012-2014

[84] Sen B, Burma Lawyers' Council. 2015. *Women and Law in Burma*.

[85] Sen B, Burma Lawyers' Council. 2015. *Women and Law in Burma*

[86] UNDP. 2014. *Human Development Report*.

[87] United Nations Development Program. 2011. *Human Development Report 2011: Sustainability and Equity: A Better Future for All*. New York.

19. MOH has given consistent high priority to maternal and child care and reproductive health in general, including the control of HIV. Myanmar has shown substantial improvement in health indicators, including women's health indicators. The maternal mortality ratio fell from 453 to 178 per 100,000 live births between 1990 and 2015.[88] Even so, about three quarters of deliveries take place at home, where nearly 90% of maternal deaths occur. Nearly 10% of all maternal deaths are abortion-related. Myanmar also has a high adolescent fertility rate at 16.9%, due largely to the lack of sex education.[89]

20. The HIV prevalence among women aged 15 to 24 years declined from 0.5% to 0.3% between 2005 and 2015.[90] Women's vulnerability to HIV is increased by the high-risk behavior of their spouses or partners, as well as their inability to negotiate safe sexual practices. Mother-to-child transmission accounts for nearly 3% of new HIV infections. A report on gender and HIV in Myanmar noted several factors that may limit women's access to HIV services.[91]

21. The country is also facing a high burden of other communicable diseases such as tuberculosis, malaria and dengue. The patterns of infectious diseases differ substantially among women and men, due to differences in exposure and response linked to occupation, habits, workload, nutrition, reproduction, and child care. Multiple factors contribute to women's access to and affordability of health services including cultural perceptions, travel distance, security, workload, and resources. Women are usually primary caregivers and responsible for the prevention, detection and care of infectious diseases amongst family members. MOH has planned to start with gender-disaggregated monitoring of health services.

22. Gender issues are also a particular concern in relation to improved communication, industrialization, migrant labor, and income. These projects have had a largely positive impact on improving health - including increased nutrition and better maternal and child survival - and increased economic opportunities for rural women. There are, however, associated health risks; both direct, such as road injuries, malaria, dengue and avian influenza, and indirect, including increased rural-urban migration and the well-documented associated social and health impacts. Although the government has launched special health programs for migrants at risk (both internal and cross-border) through collaboration with INGOs, there is still a need for appropriate policies and programs to address the needs of migrants.

23. The health workforce has a high proportion of 75% female health workers, but half of these work in urban areas. Women are underrepresented in rural areas, at higher levels, and participating in regional meetings and outreach services.

24. While Ministry of Health (MOH) is expected to have focal points for gender at all levels, the functionality of these focal points may be limited. Implementation of gender action plans tends to be weak due to fragmentation, insufficient effort, and budget. Sex-disaggregated data is lacking.

25. Gender is not perceived as a major issue in MOH, and gender mainstreaming remains weak in the public system.

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88 http://data.worldbank.org/indicator/SH.HIV.1524.FE.ZS
89 United Nations Country Team (Myanmar). 2011. *Thematic Analysis 2011: Achieving the Millennium Development Goals in Myanmar*. Yangon
90 World Bank HIV data at http://data.worldbank.org/indicator/SH.HIV.1524.FE.ZS?view=chart
91 MOH, UNAIDS. *National Strategic Plan 2011-2015*.

26. The Ministry of Health has been making efforts to harmonize various gender strategies and action plans linked to specific program and projects, as these are demanding requiring different indicators, often contradicting, and difficult to implement. Based on the national gender strategy, it is expected that MOH will want to develop sector-wide or subsector strategies GAPs. Should this happen, the project GAP may need to be changed accordingly.

27. Myanmar has strong non-government, civil society, and grass-roots organizations competent in providing health services for women in rural areas, and MOH has been successfully collaborating with these organizations. However, the new government needs to provide structure and direction to this collaboration.

C. Gender Strategy, Actions, and Monitoring

28. The project has been classified as "Category II: effective gender mainstreaming". Gender mainstreaming will improve project outcomes, benefit women equally or more, and address gender imbalances such as in training and in outreach services.

29. The government is mainstreaming gender in all sectors. Following the lead of other countries, MOH is considering the development of one overall gender strategy and GAP for each subsector, including related projects, which may be fine-tuned according to specific project needs.

30. Accordingly, the project gender strategy aims to (i) promote gender dimensions in all project activities; (ii) target vulnerable groups such as poor women and ethnic minorities; (iii) enhance equal opportunity in the sector; and (iv) synchronize with the subsector gender strategy. As the GDPM is in the process of updating its gender strategy, the project GAP may need to be adjusted in the future to align with this strategy.

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33. Within the Project Management Unit (PMU) of the project, gender and social safeguards specialists will be engaged to help plan, provide capacity building for, and monitor GAP implementation. Linkages will be established with National Committee for Women's Affairs and other organizations as needed. Active engagement of women's associations is proposed to mobilize communities and reach MEV. Engagements of NGOs in areas where MOH has less capacity may also be considered by MOH. Gender disaggregated indicators will be used for project monitoring.

34. In accordance with ADB’s Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), Project Administration Manual (PAM), Project Performance Monitoring System (PPMS), and assurances and covenants. The project GAP has been agreed with MOH and is aligned with sector-wide gender equality commitments.

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Raise gender awareness and address issues in CDC workshops.	All workshops address gender issues in CDC workshops (event reports).	MOH, PMU
Proactively target ethnic and migrant girls and women with outreach services and referral to health services in border areas.	At least 50% of outreach services targets remote ethnic groups and migrants including girls and women in border areas, from nil to date (facility reports).	Local health offices and health facilities
Promote the increased training of women in CDC surveillance and	All female surveillance and response staff trained at all levels	
Output 2: Strengthened national surveillance and response		
Collect, analyze, and report gender-disaggregated surveillance data.	Gender disaggregated surveillance data are available at national level from nil now (report of national data collection centers).	National surveillance centers
Ensure participation of women in field epidemiology training.	At least 25% of participants in field epidemiology training are female, from less than 10% at present (PMU report).	MOH, PMU
Increase participation of female staff in any outbreak response teams.	Each outbreak response team has at least one female staff member, from less than 50% at present (CDC report).	Local health offices and health facilities

Actions	Targets/Indicators/Source	Responsible
Promote training of women in CDC surveillances	At least 50% of all female staff trained in CDC surveillance, sex education	
Output 3: Improved diagnostics and management of infectious diseases		
Ensure equitable participation of female staff in laboratory management and quality assurance training programs.	Female participants in laboratory management and quality assurance training programs are approx. 50% (national laboratory annual report).	National laboratories
	At least 70% of female laboratory staff in the project area is trained	
Ensure equitable participation of female and male doctors and nurses in scholarships for hospital infection prevention and control.	Female participation in hospital infection prevention and control scholarship reaches approx. 50% from xx% to date (PMU annual report).	Departments of Hospital Services
Improve hygiene and sanitation facilities for female patients in hospitals.	All female wards have proper hygiene and sanitation facilities for patients, from approx. 50% at present (to be based on baseline and end-of-project survey).	Hospitals
Project Management		
Tailor GAPs to need of State/Region	Prepare State/Regional GAP to ensure loan effectiveness	
Improve annual operational plans and budgets in project-supported provinces to adequately address gender dimensions.	All annual operational plans address gender dimensions adequately (PMU reports).	PMU, local health offices
Provide gender training for staff	100% of project staff receive gender sensitivity and GAP training	
Improve Gender balance in project implementation teams	At least 30% of PMU staff and state/region project teams are female	
Fully engage gender focal points in implementing agencies.	All implementing agencies have a fully engaged gender focal point (PMU report, based on participation in events).	PMU, local health offices
All quarterly and annual reports.	All quarterly reports adequately report on gender issues (PMU reports).	PMU, local health offices
Advance participation of female consultants	Female consultants represent at least 30% of project consultants (PMU reports).	PMU

CDC: communicable diseases control; MOH: ministry of health; PMU: project management unit
Source: ADB; Ministries of Health of Myanmar

3.4 Viet Nam Gender Action Plan

Introduction

1. The Government of Viet Nam and the Asian Development Bank have agreed on the GAP for the Greater Mekong Subregion Health Security Project for Cambodia, the Lao People's Democratic Republic, Myanmar, and Viet Nam. The project has been classified as Category II: Effective Gender Mainstreaming as it improves women's participation and access to health services. This appendix presents the gender analysis strategy, action plan, implementation and monitoring arrangements as per ADB requirement.[92]

GMS Health Issues

2. Globally, all countries are at risk of outbreaks of emerging infectious diseases (EID) such as Ebola hemorrhagic fever, with epidemic potential that may result in major mortality and economic slowdown. The GMS is located in Southeast Asia, which has major population hubs and intensive livestock husbandry, with associated environmental and biosafety problems, and intense connectivity. In recent years, the GMS has experienced several outbreaks of EID including severe acute respiratory syndrome (SARS) and avian influenza. The four project focus countries are particularly vulnerable due to low demand and shortcomings in health services arising from problems of access, quality and financing. Vulnerable groups, such as ethnic minorities and migrants who live in rural areas, and the poor and women in general, tend to use services less than the mainstream population. This constitutes both an individual and a public health risk. In general, government health services, constrained by a lack of capacity, funding and, in some cases, political will, are ill equipped to reach these priority groups.

3. The World Health Organization's (WHO) International Health Regulations (IHR), 2005,[93] mandates all countries to improve public health security. WHO Regional Office's Asia Pacific Strategy for Emerging Disease (APSED), 2010, identifies 10 strategic areas for compliance by not later than 2016.[94] At present, compliance has reached about 70-80% in the region, with specific gaps mainly relating to laboratory services, hospital infection control, and cooperation for outbreak prevention and control with communities, other sectors, and countries.[95] WHO has also requested countries to implement other regional strategies for the control of communicable diseases of regional importance including HIV, tuberculosis, malaria, dengue, and neglected tropical diseases (NTD), and related laboratory services.

4. While the burden of communicable diseases have declined overall in the GMS, their continuing control is a major challenge due to (i) high costs; (ii) changes in life style with better income and connectivity; (iii) urbanization, migrants and slum formation; and (iv) drug resistance and misuse of antibiotics. Investment in control measures for (re)-emerging diseases is needed. Dengue has become a major public health problem in the GMS and is spreading globally. There have been recent outbreaks of foot and mouth disease, cholera, and several dengue-related viral diseases. Common diarrheal diseases and respiratory infectious continue to be the major burden of diseases in children below five years of age. While countries have mostly achieved their Millennium Development Goals (MDG), they are facing new challenges that will require continued focus on disease prevention. Populations most notably affected by infectious

[92] ADB. 1998. *Policy on Gender and Development*. 2003. Manila
[93] World Health Organization. 2005. *International Health Regulations*. Geneva.
[94] World Health Organization. 2010. *Asia Pacific Strategy for Emerging Diseases*. Manila.
[95] WHO. 2014. *APSED Progress Report 2014, Securing Regional Health*, Manila.

diseases tend to be poor people – in particular migrants, young women and girls, and ethnic minorities – who live in isolated segments along GMS borders and economic corridors. These populations do not frequently access regular health services for prevention, reporting, and management of infections.

The Project

5. The project goal is strengthened GMS health security, with as indicators (i) no major outbreak of emerging or other epidemic disease in excess of 100 fatalities, (ii) outbreaks have less than 0.5% impact on GDP in any quarter of the year, and (iii) increased use of public health services in border areas by MEV. The project outcomes are (i) improved coverage of GMS public health security system and compliance with IHR/APSED and (ii) increased CDC coverage of MEV in border areas. The project outputs are: (i) improved GMS collaboration and MEV access to CDC in border areas; (ii) strengthened national surveillance and response system; and (iii) improved capacity to diagnose and manage infectious diseases. Outputs are summarized below.

6. MOH has made progress with regional information sharing and cross-border cooperation for communicable disease control. However, this needs to be mainstreamed and formalized. In addition, some groups of MEV that are more likely to get and spread infectious diseases are not using regular health services. Under the first output, the project (i) supports regional, cross-border, and intersectoral information sharing and coordination of outbreak control among GMS countries; (ii) develops regional disease control strategies and evidence-based CDC; and (iii) improves CDC for MEV along borders and economic corridors in targeted border provinces. Support is needed for joint planning and monitoring; and outreach and community mobilization to reach and engage MEV.

7. MOH has a functioning surveillance system for notifiable diseases in place, and surveillance of HIV, malaria and tuberculosis is strong. The system needs to be further computerized and extended to communities by employing syndromic reporting. Linkages or integration among surveillance systems will also be improved. MOH also needs to improve capacity for disease outbreak response. Under the second output, the project supports (i) syndromic reporting at community level; (ii) web-based reporting including information technology support; (iii) integration of surveillance systems; (iv) risk analysis, communication, and community preparedness; (v) improving capacity of outbreak response teams, and (vi) improving screening and quarantine capacity at border posts of entry and international quarantine centers. Support is needed for system design, computers, training, and vehicles and equipment for outbreak control.

8. District facilities are unable to comply with internationally acceptable levels of biosafety or to guarantee the accuracy of their laboratory testing. Underlying problems are substandard training of laboratory staff, lack of quality control, and insufficient facilities, equipment, and supplies. The quality assurance system is in a nascent stage, and there is no national laboratory audit system. Nosocomial infections are becoming a major public health problem. Under the third output, the project supports (i) improving quality assurance; (ii) in-service training; (iii) improving district laboratory services; and (iv) equipment and training for infection control and case management of dangerous diseases.

9. In Viet Nam, the project is estimated to cost $84.0 million including $80 million in loan from ADB; and will be implemented by MOH through the General Department of Preventive Medicine acting as the EA, in conjunction with four institutes of hygiene and epidemiology, and relevant

agencies in 36 provinces along the borders and corridors in northern, central and southern Viet Nam. The project will be implemented over a period of 5-year period beginning early 2017. The project completion date is 30 June 2022.

10. The project will benefit 22.8 million people in 250 focus districts in 36 selected provinces. About 9.3 million of these people are categorized as ethnic minority and 6.9 million are categorized as poor. Output 1 specifically targets migrants and mobile populations, ethnic minorities, and other vulnerable groups (MEV) in border areas and economic corridors.

Gender Analysis (Due Diligence)

11. The gender and social safeguards experts conducted consultations with officers of MOH, international agencies and NGOs, and field visits to Ha Giang and Tay Ninh provinces to meet with officials, health workers and potential beneficiaries. A questionnaire and semi-structured interviews were used to collect information. Findings are summarized in Appendix 2. The project has been ranked as Category II: effective gender mainstreaming (EGM) as it will directly improve women's opportunities and access to health services.

A. Gender Policy and Institutions

12. Gender equality is reflected in the Viet Nam Constitution and in multiple international commitments of the Government of Viet Nam. Strong commitment to gender equality and women's empowerment is reflected in the Viet Nam Law on Gender Equality, 2006, which guarantees equal rights to women and requires gender strategies at the ministerial level.[96] The Law on Gender Equality (2007)97 and the National Strategy on Gender Equality 2011-202098 oblige all sectors and ministries to mainstream gender in their work. Viet Nam also passed the Law on Domestic Violence Prevention in 2007 and subsequently launched a public awareness campaign targeting men. In 2011, the Government adopted the National Program on Gender Equality 2011-2015. Other important legislation adopted to protect women's rights includes the Law on Anti-Human Trafficking, 2011.99

13. Institutional arrangements have been put in place to move the Government's gender agenda forward. Instead of a Ministry of Women's Affairs, Viet Nam has opted for a cross-cutting National Commission for the Advancement of Women (NCFAW) for gender mainstreaming in development policies and programs.100 Its recommendations are implemented through five-year plans. Committees for the Advancement of Women (CAW) were set up in all ministries and provinces, and were made responsible for building capacity and issuing gender action plans to implement the Strategy on Gender Equality. The Gender Equality Department, in the Ministry of Labor, Invalids, and Social Affairs, was created to function as a center and secretariat of NCFAW work and help implement the Law on Gender Equality. MOH has central and provincial focal points for gender and development. National and provincial health CAW provide oversight for gender activities of national programs and projects and provincial services. Large hospitals are also expected to have a CAW.

14. The Viet Nam Women's Union (VWU) is mandated to represent women of all ethnic groups and to protect women's rights and interests. It is a quasi-governmental mass

[96] ADB. 2012. *CPS Gender Analysis*. Manila.
[97] https://www.wcwonline.org/pdf/lawcompilation/Viet NamGenderEqualityLaw.pdf
[98] http://www.chinhphu.vn/portal/page/portal/English/strategies/strategiesdetails?categoryId=30&articleId=10050924
[99] http://www.no-trafficking.org/resources_laws_vietnam.html
[100] JICA. 2011. *Country Gender Profile. Viet Nam Final Report*. Tokyo.

organization with representation in all villages and has substantial local powers. The VWU has substantial international funding and implements a wide array of programs including in health, education, training, water and sanitation, microcredit, and other areas, all of which support women's development. Relatively few national and international non-government organizations such as the Viet Nam Red Cross Society also contribute to gender advocacy, training and services for women.

15. The Government of Viet Nam (GVN) pays some attention to the welfare of ethnic minority groups. There is a ministerial-level government body, the Committee for Ethnic Minority and Mountainous Area Affairs (CEMA), which is in charge of management functions for ethnic minorities and mountainous areas. In geographically strategic areas or areas with an ethnic minority population of 5,000 or more, CEMA has its own representative agency down to the district-level. Programs that specially target ethnic minority groups are numerous and diverse.101

16. The Asian Development Bank (ADB) is committed to poverty reduction as its overarching goal and regional cooperation as one of the pillars of Strategy 2020.[102] As articulated in ADB's 1998 Policy for Gender and Development and Strategy 2020, ADB remains committed to gender equality in all its operations, and requires due diligence of all its projects. ADB's Viet Nam CPS 2012-2015[103] is aligned with the government's 9th Five-Year Socio-Economic Development Plan, 2011-2015,[104] and focuses on Viet Nam's transitional constraints to a modern economy. In the health sector, the Viet Nam CPS supports sector management, improving quality of services, and support for the disadvantaged. Under the GMS economic development program, ADB supports regional connectivity and development and addressing related health and gender issues. ADB has been supporting various projects for communicable diseases control.[105]

B. Gender Issues

17. The government has a strong party ideology of gender equality and substantial gender legislation is in place. Implementation of this legislation, however, needs strengthening. Vietnamese society remains strongly patriarchal, with important difference in perception of the value and role of men and women. Males tend to assume authority and control of resources, while women tend to assume the role of house manager and family caretaker. Women typically have many responsibilities both within and beyond the home and frequently work significantly longer hours than men. Young women are particularly vulnerable to male harassment both inside and outside the family setting. Gender-based violence, often linked to peer pressure and alcoholism, remains a major problem. Among ethnic groups, male-female relationships can be quite different from those in the mainstream population.

18. The patterns of mortality and infectious diseases are known to differ somewhat among women and men due to differences in exposure and response linked to differences in household activities, occupation, habits, workload, nutrition, reproduction and child care. As primary caregivers, women are usually responsible for the prevention, detection and care of infectious

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[101] http://www.undp.org/content/dam/vietnam/docs/Project%20Documents/27404
[102] ADB. 2008. *The Long-Term Strategic Framework of the Asian Development Bank 2008-2020*. Manila
[103] ADB. 2012. *Viet Nam Country Partnership Strategy 2012-2015*. Manila.
[104] Government of Viet Nam. 2010. *9th Socio-Economic Development Plan 2011-2015*. Hanoi.
[105] ADB. 2004. *GMS Regional Communicable Diseases Control Project.* Manila; ADB. 2009. *Second GMS Communicable Diseases Control Project.* Manila.

diseases amongst family members. Women's access to health services is also affected by cultural perceptions, permission granted or withheld by male family members, security, cost and distance of travel, and caregiving and workload.[106]

19. Viet Nam has made major progress in gender related health indicators. For example, the maternal mortality ratio reduced from 223 to 54 per 100,000 live births between 1990 and 2015.[107] However, progress has been uneven, with urban and Kinh people having better access to maternal health care than rural and ethnic minority people.[108]

20. A key gender issue relating to maternal care and family planning is an increasing imbalance in sex ratio at birth. With better access to ultrasound screening, the sex ratio at birth (SRB) has increased from 106 male births for every 100 female births in 1999, to 120 male births for every 100 female births in 2014. This is due in large part to the role of male children as ancestral caretakers and family landholders. Given that Viet Nam is already seeing a migration of would-be-bride to other countries, this will likely result in a shortage of women and a potential increase in trafficking of women and early marriage of girls. Driven in part by Viet Nam's strict two children policy, women often receive "menstrual regulation" (early abortion) as a form of family planning, instead of using alternative forms of contraception.[109]

21. With major public education campaigns for safe sex, the HIV epidemic has been contained at a prevalence of less than 0.3% among the general population. HIV infection is now concentrated groups who exhibit higher risk behaviors, including prisoners, sex workers, men who have sex with men, and injecting drug users. With an increase in sexual activity among youths and suspected increased drug use among new cohorts, including the newly wealthy, there is a real risk of resurgent HIV transmission.110

22. Improved communication, industrialization, and migrant labor increase economic opportunity for rural women and have had a largely positive impact on improving health - including increased nutrition and better maternal and child survival. There are, however, associated health risks; both direct, such as road injuries, malaria, dengue and avian influenza, and indirect, including increased rural-urban migration and the well-documented associated social and health impacts.

23. While the proportion of female staff working in the health sector is relatively high, women tend to be concentrated in the lower-levels of the system. In remote locations, there is an overall shortage of female staff due to security concerns. Health workers from ethnic minorities are also under-represented. Female staff are underrepresented in training activities due to family obligations.

24. MOH and the provinces have CAW and central focal points for gender. These are mostly preoccupied with gender advocacy and training, and may play an advisory role in project design. Gender is not perceived as a major issue in MOH. One major concern is the fragmentation of gender efforts in MOH in general and projects in particular. Each project has its own GAP with its own indicators, making implementation more difficult. There is no sector-wide

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[106] WHO. 2007. *Addressing Sex and Gender in Epidemic Prone Infections*. Geneva.

[107] MOH. 2009. *JAHR 2009*. Hanoi; see also http://data.worldbank.org/indicator/SH.STA.MMRT?page=5. As maternal mortality data are hospital-based, this ratio excludes non-hospitalized women with serious complications in pregnancy and child birth.

[108] http://www.who.int/bulletin/volumes/91/4/12-112425/en

[109] http://english.vietnamnet.vn/fms/society/112597/male-female-ratio-imbalance-may-reach-over-four-million.html

[110] http://www.unaids.org/sites/default/files/country/documents//file,94776,fr.pdf

gender strategy, GAP, and few gender disaggregated standard indicators[111]. Resource mobilization for GAPs is also weak.

25. At local level, information is recorded by sex, but this is not aggregated for higher levels except for certain disease control programs for HIV/AIDS and immunization that have their own data collection system. Other sex-disaggregate data comes from surveys and central administration. MOH has prepared a list of gender quality indicators which reflecs the availability of sources and the lack of a general gender-disaggregated health management information system[112].

26. Past ADB health projects have shown less satisfactory implementation of project GAPs,[113] but on the whole the performance of MOH in GAP implementation has shown steady improvement. Important issues are the GAP relevance and feasibility: if GAPs are well designed and resourced, these are more likely to be implemented.

C. Gender Strategy, Actions, and Monitoring

27. The project has been classified as "Category II: effective gender mainstreaming". Gender mainstreaming will improve project outcomes, benefit women equally or more, and address gender imbalances such as in training and in outreach services.

28. Following the lead of other countries, MOH is considering the development of one overall gender strategy and GAP for each subsector, including related projects, which may be fine-tuned according to specific project needs.

29. Accordingly, the project gender strategy aims to (i) promote gender dimensions in all project activities, (ii) target vulnerable groups such as poor women and ethnic minorities, (iii) enhance equal opportunity in the sector, and (iv) synchronize with the subsector gender strategy. As the GDPM is in the process of updating its gender strategy, the project GAP may need to be adjusted in the future to align with this strategy.

30. MOH will fully incorporate the project GAP in the government's project design documents, and state/region annual operational plans and budgets. MOH proposes to maximize benefits for poor and ethnic women and other vulnerable groups at increased risk of infectious diseases in border areas. MEV will benefit from the project by closer and more immediate contact with the disease surveillance system, and improved laboratory functioning will provide more effective diagnosis and treatment while reducing travel time and costs.

31. MOH is committed to provide the necessary inputs to fully implement the GAP. The project director will provide leadership and ensure that the GDPM and provinces implement the GAP in terms of gender mainstreaming in all project activities and prioritizing women's services and opportunities in general and among MEV in particular. Gender focal points will be activated in the GDPM and at provincial and district levels. These focal points will ensure gender training/orientation and GAP implementation of all staff involved in the project. At central level, central focal point will need to ensure that gender equality dimensions are included in all meetings and workshops.

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[111] MOH. 2012. *Indicators for Gender Equality Of The Health Sector.* Promulgated along with Decision No. 3318 / QD-BYT dated 12/9/2012 of the Minister of Health) *(Promulgated along with Decision No. 3318 / QD-BYT dated 12/9/2012 of Minister of health)*

[112] MOH. 2012. Decision 3318/QD-BYT of 12 September 2012.

[113] ADB. 2013. *PCR GMS Communicable Diseases Control Project*. Manila.

32. Within the Project Management Unit (PMU) of the project, gender and social safeguards specialists will be engaged to help plan, provide capacity building for, and monitor GAP implementation. Linkages will be established with VWU and other organizations as needed. Active engagement of women's associations is proposed to mobilize communities and reach MEV. Engagements of NGOs in areas where MOH has less capacity may also be considered by MOH. Gender disaggregated indicators will be used for project monitoring, based on what can be obtained through the regular health management information system, special programs and surveys.

33. In accordance with ADB's Policy on Gender and Development and Operations Manual for Bank Policies, gender dimensions have been incorporated in the project documentation including the scope and due diligence of the Report and Recommendation to the President (RRP), the Design and Monitoring Framework (DMF), Project Administration Manual (PAM), Project Performance Monitoring System (PPMS), and assurances and covenants. The project GAP has been agreed with MOH and is aligned with sector-wide gender equality commitments.

34. The summary project GAP presented below has been agreed with MOH and is aligned with the national context, policies and plans, MOH sector-wide commitments, and ADB policy. In summary, following actions have been agreed to:

(i) All regional, cross-border and intersectoral events will increase female participation, promote gender equality, identify and address gender issues, and monitor gender actions;
(ii) The project will proactively target MEV including youth and women;
(iii) Education materials and care procedures will be gender-sensitive;
(iv) Outbreak response and outreach services will ensure female participation;
(v) Equitable participation of female and male staff in scholarships and training programs;
(vi) Refurbishment of laboratories and isolation wards will be gender sensitive;
(vii) There will be active focal points in all implementing agencies;
(viii) Gender and social development experts will be engaged for capacity building;
(ix) Project annual operational plans (AOPs) will address gender dimensions;
(x) The project will collect, analyze and report gender-disaggregated data;
(xi) All project reports report on gender issues.

Table 13: Viet Nam Gender Action Plan

Actions	Targets/Indicators/Source	Responsible
Output 1: Improved Regional Cooperation and CDC in Border Areas		
Increase and enhance participation of women in regional, cross-border, and intersectoral events and outreach services.	Participation of women in these events and services reaches at least 35% from less than xx% to date, (RCU baseline and annual reports)	MOH, PMU, RCU, local health offices
Raise gender awareness and address gender issues in CDC workshops.	All workshops address gender issues in CDC workshops (event reports). Workshop materials clearly demonstrate mainstreaming of gender issues and promotion of gender-sensitive strategies.	MOH, PMU, RCU
Ensure full participation of female staff for outreach activities using gender-sensitive education and care procedures.	Participation of female staff in outreach activities at least 50%.	Local health offices, health facilities

Actions	Targets/Indicators/Source	Responsible
Ensure that outreach teams are competent in technical and social dimensions of disease control in poor communities, in particular also on gender	Each outbreak team has female and male staff trained in technical and social dimensions of disease control in poor communities, in particular on gender	PMU, local health offices, health facilities
Proactively target ethnic and migrant girls and women with outreach services and referral to health services in border areas.	At least 50% of outreach services targets remote ethnic groups and migrants including girls and women in border areas, from nil to date (facility reports).	Local health offices and health facilities
Output 2: Strengthened national surveillance and response		
Collect, analyze, and report gender-disaggregated surveillance data including studies	Gender disaggregated surveillance data are available at national level (report of national data collection centers).	National surveillance centers
Ensure participation of women in field epidemiology training. Social hurdles for female staff to attend this training will be addressed.	Selection of participants in field epidemiology training is merit-based. Approx. 40% of participants is expected to be female, from less than 20% at present (PMU report).	MOHs, PMUs
Increase participation of female staff in any surveillance and outbreak response teams.	Each surveillance and outbreak response team has at least one female staff member, from less than 50% at present (CDC report).	Local health offices and health facilities
Output 3: Improved diagnostics and management of infectious diseases		
Ensure equitable participation of female and male staff in laboratory management and quality assurance training programs.	Female and male participants in laboratory management and quality assurance training programs are merit-based and maintained at approx.. 50% (national laboratory annual report).	National laboratories
Ensure equitable participation of female and male doctors and nurses in scholarships for hospital infection prevention and control. Social hurdles for female staff to attend this training will be addressed.	Selection of participants in hospital infection prevention and control scholarship is merit-based. A majority of participants are expected to be female staff. No baseline. (PMU annual report).	MOH, Departments of Hospital Services
Improve hygiene and sanitation facilities for female patients in hospitals.	All female wards have proper hygiene and sanitation facilities for patients, from approx. 50% at present (to be based on baseline and end-of-project survey).	Hospitals
Project Management		
Improve capacity of PMU and provincial implementation units in addressing gender and social safeguard issues	All PMU staff are trained in addressing gender and social safeguards issues	Project Director
Ensure orientation of all health staff involved in the project on gender and social safeguards issues and requirements	All health staff involved in project activities at central and local level have received gender and social safeguards orientation as part of project orientation	PMUs, local health offices
Improve annual operational plans and budgets in project-supported provinces to adequately address gender dimensions.	All annual operational plans address gender dimensions adequately (PMU reports).	PMUs, local health offices
Fully engage gender focal points in implementing agencies.	All implementing agencies have a fully engaged gender focal point (PMU report, based on participation in events).	PMUs, local health offices
All quarterly and annual reports.	All quarterly reports adequately report on gender issues (PMU reports).	PMUs, local health offices
Advance participation of female consultants	Female consultants represent at least 30% of project consultants (PMU	PMUs

Actions	Targets/Indicators/Source	Responsible
	reports).	

CDC: communicable diseases control; MOH: ministry of health; PMU: project management unit
Source: Ministries of Health of Cambodia, Lao, Myanmar and Viet Nam

ASIAN DEVELOPMENT BANK

THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

FINANCIAL MANAGEMENT ASSESSMENT

of the Project Preparatory Technical Assistance

April 2015

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1. Financial Management

1. This Financial Management Assessment (FMA) has been prepared in accordance with ADB's Guidelines for the *Financial Management and Analysis of Projects*[1] and the publication *Financial Due Diligence A Methodology Note*.[2] The FMA includes a review of the accounting and reporting system, internal and external auditing arrangements, fund disbursement procedures, and information systems. The instrument to be used for the assessment is the Asian Development Bank's (ADB) financial management assessment questionnaire (FMAQ). This FMA incorporates the Financial Management Internal Control and Risk Management Assessment required by the Guidelines.

2. The FMAs were prepared during the scoping phase of the TA preparation from 19 September to 8 November, 2015. The FMA considers the Ministries of Health (MOH) as the executing agency (EA) in all four countries and the Provincial Departments of Health (PHDs) as the implementing agency (IA) for Vietnam, Cambodia and Lao PDR. For Myanmar the implementing agency are the State/ Regional Departments of Health.

3. Preparatory activities included reviewing documents, interviewing and discussing issues with counterparts from MOH, PHDs, States/ Regions, development partners and NGOs. Previous FMAs done for each country were used, whenever available, including the PPTA consultant's final report for the preparation of the CDC2 project in 2010. This FMA report also referred extensively to the Public Expenditure and Financial Accountability (PEFA) assessment. For Myanmar, there was no previous FMA done by ADB therefore, this report used the World Bank Essential Health Services Access Project 2014 as reference whenever applicable.

4. It is proposed that ADB help finance the GMS Health Security Project through a loan amounting to about US$ 124 million from the Asian Development Fund (ADF) equivalent to about 93 percent. Total government counterpart financing for the project is estimated to be about US$ 9.1 million or about 7 percent. Total project cost without contingencies and finance chargers is about US$ 133.1 million. The Program will be implemented over a 5-year period.

Country	ADB Loan ($ million)	Government ($ million)	Total Project Cost ($ million)
Vietnam	80.0	5.9	85.9
Lao PDR	12.0	0.6	12.6
Cambodia	20.0	2.0	22.0
Myanmar	12.0	0.6	12.6
Total	**124.0**	**9.1**	**133.1**
Percent	93.2%	6.8%	100.0%

[1] ADB. 2005. *Financial Management and Analysis of Projects*. Refer page 14 of Knowledge Management Addendum for more information on the Financial Management Assessment.

[2] ADB. 2009. *Financial Due Diligence A Methodology Note*. Refer page 3 for more information on the Financial Management Assessment.

5. **For Vietnam.** The Program will be executed by MOH through the General Department of Preventive Medicine (GDPM) and implemented by the PHDs in the different provinces. A total of about 275 districts in 38 provinces were proposed to be the beneficiaries of the project.

6. Country PFM arrangements were assessed in July 2013 using the Public Expenditure Financial Accountability (PEFA) PFM Performance Measurement Framework.[3] The results of the PEFA assessment highlighted the average performance of PFM in the country but weaknesses remain in the areas of budget credibility and internal controls. These performance areas are the challenges faced in PFM in Vietnam. The detailed assessment for Vietnam is in **Annex 1**.

7. **For Lao PDR.** The Program will be executed by MOH Department of Planning and International Cooperation (DPIC) and implemented by the Provincial Health Departments in the 12 provinces that were identified to be the beneficiaries of the project.

8. Country Public Financial Management (PFM) systems were most recently assessed by the World Bank in 2010 using the PEFA PFM Performance Measurement Framework. This was the first comprehensive diagnosis of PFM in Lao PDR that had been prepared with the objective of providing government with a concise, standardized and objective assessment of PFM and to highlight the issues against which future improvements in PFM can be gauged. The results of the PEFA assessment highlighted the poor performance of PFM in the country. The detailed assessment for Lao PDR is in **Annex 2**.

9. **For Cambodia.** The Program will be executed by MOH through the Communicable Disease Control Department (CDCD) and implemented by the Provincial Health Departments of the MOH in about 12 provinces. The latest IFAPER[4] assessment in 2011 using the PEFA framework showed that budget credibility was enhanced after completion of the first stage of the PFMRP[5] in 2008. The result was improved cash management resulting in greater predictability, reliability and availability of financial resources. Despite the significant improvements in cash management, PEFA noted that weaknesses in the PFM remain and a number of issues related to cash flow forecasting have serious implications for ensuring significant resources are on hand to meet the government's cash flow requirement.

10. The FMA for MOH was delayed due to the tedious government approval process to conduct the FMA. The detailed assessment for Cambodia is in **Annex 3**.

11. **For Myanmar.** The Program will be executed by MOH and implemented by the State/Regional Health Departments of the MOH. About 4 states/regions will be the beneficiaries of the project. Country Public Financial Management (PFM) systems were most recently assessed using the PEFA PFM Performance Measurement Framework in 2013. The results of the PEFA assessment above

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[3] Under the PEFA framework, performance is assessed in relation to seven dimensions of public financial management: credibility of the budget; comprehensiveness and transparency; degree to which the budget is prepared with due regard to government policy; predictability and control in budget execution; accounting, recording and reporting; external scrutiny and audit operations; appropriateness of development partner practices in country; and intergovernmental fiscal relationships.

[4] Integrated Fiduciary Assessment and Public Expenditure Review

[5] Public Financial Management Reform Program

highlighted the poor performance of PFM in the country with most categories receiving a “D” rating.

12. The FMA could not be undertaken for MOH due to the tedious government approval process to conduct the FMA. The full assessment will be included in the draft final report after receiving government approval. The detailed assessment for Myanmar is in **Annex 4**.

FMA Annex 1

Financial Management Assessment
Ministry of Health
Government of Viet Nam

(May 2016)

ABBREVIATIONS

ADB	–	Asian Development Bank
ADF	–	Asian Development Fund
COSO	–	Central Operations Services Office
CPS	–	Country Partnership Strategy
DOH	–	Department of Health
DP	–	Development partner
DPF	–	Department of Planning and Finance
EA	–	Executing agency
FGIA	–	First Generation Imprest Account
FMA	–	Financial Management Assessment
FMAQ	–	Financial management assessment questionnaire
FMICRA	–	Financial Management Internal Control and Risk Assessment
FY	–	Fiscal year
GDPM	–	General Department of Preventive Medicine
GMS	–	Greater Mekong Sub-region
IA	–	Implementing agency
IFRS	–	International financial reporting system
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MPI	–	Ministry of Planning and Investment
ODA	–	Official Development Assistance
PEFA	–	Public Expenditure Financial Accountability
PFM	–	Public financial management
DOH	–	Provincial Heath Department
TAMBIS	–	Treasury and Budget Management Information System
SAV	–	State Audit of Viet Nam

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EXECUTIVE SUMMARY

1. The financial management assessment was conducted for the Ministry of Health as the executing agency for the proposed GMS Health Security Project. The FMA was prepared in accordance with ADBs Technical Guidance Note 2015 and incorporates the Financial Management Internal Control and Risk Management Assessment (FMICRA) required by the Guidelines. The assessment also made extensive use of the Public Expenditure and Financial Accountability (PEFA) assessment for Viet Nam in 2013[1] as well as ADBs Country Partnership Strategy (CPS) for 2012- 2015.

2. The PEFA assessment noted weaknesses in the areas of Public Financial Management, master planning, auditing and procurement. PEFA findings showed that budget carry-over from previous years was around 30% of the original budget making it difficult to determine the actual annual budget deficit. There is also a lack of master-planning capacity in line ministries and sub-national governments resulting in fragmented and thinly spread public investments. With regards to audits, the State Audit Agency of Viet Nam (SAV) has limited resources and staff that SAV can cover only 60 percent of central government units and 50 percent of provinces. Furthermore, there are few government agencies that have a functioning internal audit unit including Ministry of Finance, State Bank of Viet Nam and the Ministry of Defense. On procurement, although substantial progress has been made in informing the public about procurement plans, tendering opportunities and contracts awarded through the Ministry of Planning and Investment (MPI) website and Procurement Gazette, not all provinces provide MPI with complete reports. Furthermore, while open tendering is the procurement norm, the law also permits a number of exceptions to the use of open competition. This has now become the preferred procurement method with about 70 percent of all contracts done through direct contracting.

3. The ADB Country Partnership Strategy 2012 – 2015 assessed the major governance-related risks to be in public finance management, procurement and corruption. PFM issues relate to the lack of performance based budgeting; budget comprehensiveness and lack of sufficient capacity of the State Audit Viet Nam. Procurement was assessed to be high risk with deliberate splitting of investments by implementing agencies into multiple packages resulting in reduced cost effectiveness and prevalence of procurement malpractice. Decentralization has also resulted in the widening gap between national procurement norms and international standards.

4. Using the Financial Management and Internal Control Risk Assessment (FMICRA) table, the overall inherent risk was assessed to be high and project risks were assessed to be moderate. The overall combined risk was also assessed to be moderate. A summary of the risks and mitigating measures are presented in Table 1 below.

5. The GMS Health Security Project when implemented will (i) to prevent or control emerging infectious diseases and other infectious diseases of regional importance in a timely manner, (ii) enable the Viet Nam diagnostic system to provide accurate results in a safe and timely manner, thereby improving the health of patients and providing value for money and (iii) reducing the risk of nosocomial infection and increasing drug resistance by improving biosafety.

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[1] http://www.pefa.org/en/assessment/files/1205/rpt/9497

Although several financial management risks were identified, the proposed mitigating measures are assessed to be sufficient for the satisfactory implementation of the project.

Table 1: Summary of Major Risks and Mitigating Measures

Risk Description	Risk Assessment	Mitigating Measure or Risk Management Plan
Staffing - lack of qualified staff to implement financial management responsibilities in the provinces and districts	High	Outsource the staff needed in each province to support the Project Implementation Team. All the staff need to be trained in ADB procedures including but not limited to financial management and procurement
Internal Control - No internal audit unit in the MOH and DOHs	High	MOH should establish an internal audit unit to upgrade the financial management system as part of government PFM reform. The audit unit should be established by the second year of project implementation. In the interim, MOH should engage an auditing firm to review internal control procedures including bank reconciliations. Reports of findings should be provided quarterly to ADB and MOH
Reporting and Monitoring – difficulty in coordination between MOH and the DOHs	High	CPMU should increase the number of staff to conduct regular coordination meetings and monitoring of project implementation in all 36 provinces to address problems efficiently. Annual planning workshop between MOH and DOH should be conducted to assess previous years' performance and to synchronize targets for next year.

Source: Consultant's Assessment

I. Introduction

1. This Financial Management Assessment (FMA) for the GMS Health Security Project (the Project) of the Ministry of Health (MOH), Viet Nam, was prepared in accordance with ADB's Technical Guidance Note for financial management[2]. The FMA includes a review of the accounting and reporting system, internal and external auditing arrangements, fund disbursement procedures, and information systems. The instrument used for the assessment was Asian Development Bank's (ADB) financial management assessment questionnaire (FMAQ). This FMA incorporates the Financial Management Internal Control and Risk Management Assessment required by the Guidelines. The completed FMAQ is in Appendix 1.

2. This assessment was prepared during the scoping phase of the TA preparation from October 3 to 18, 2015. Preparation activities included reviewing documents, interviewing and discussing issues with counterparts from MOH, DOHs and development partners. A previous FMA was done for the MOH for the CDC2 in 2010. This will also serve as a reference in this FMA. The FMA also made extensive use of the assessment report based on the Public Expenditure and Financial Accountability (PEFA) assessment developed by the World Bank in 2013 in collaboration with other development partners as well as the ADB Country Partnership Strategy for Viet Nam 2012-2015.

II. Project Description

3. It is proposed that ADB help finance the Project through a loan amounting to about US$ 80 million from the Asian Development Fund (ADF). The Project will be implemented over a 5-year period. The Government of Viet Nam will likewise contribute parallel financing of about $ 4 million equivalent to about 5% of the total project cost. The total Project cost is estimated to be about $ 84 million.

4. The MOH is the executing agency (EA) represented by the General Department of Preventive Medicine (GDPM). GDPM and MOH's institutions, the Department of Health Services, and the 36 Provincial Departments of Health (DOHs) are the implementing agency (IA) for the proposed Project. The Project will target beneficiaries in 36 provinces, 250 districts.[3] As the EA, MOH will oversee the implementation of the Project and support the outputs: (i) regional cooperation and CDC in border areas; (ii) national strengthening of surveillance and response; (iii) improving laboratory services and infection control and (iv) project management.

III. Country and Sector level Issues

A. Public Financial Management

5. Viet Nam has gradually developed a new legal system that meets the requirements of a market economy but still maintaining an appropriate degree of State regulation. Country PFM arrangements were assessed in July 2013 using the Public Expenditure Financial Accountability (PEFA) PFM Performance Measurement

[2] ADB. 2105. *Financial Management Assessment Technical Guidance Note.*

[3] Almost all the districts bordering China, Lao PDR and Cambodia.

Framework.[4] The purpose of the assessment is to provide information to all the stakeholders particularly the Government of Viet Nam about the actual performance of the public financial management system against a common and standardized assessment framework and thereby facilitate the identification of areas of reform. Under the PEFA framework, performance is assessed in relation to seven dimensions of public financial management using 28 indicators which are rated from A (best) to D (worse). A summary of the 2013 PFM assessment framework is presented in the Table 1 below.

Table 2: Viet Nam PFM Assessment Systems, Processes and Institutions

SUMMARY OF PERFORMANCE MEASUREMENT FRAMEWORK		Score
A. PFM outturns: Credibility of the budget		
PI-1	Aggregate expenditure out-turn compared to original approved budget	C
PI-2	Composition of expenditure out-turn to original approved budget	D+
PI-3	Aggregate revenue out-turn compared to original approved budget	D
PI-4	Stock and monitoring of expenditure payment arrears	NR
B. Key cross-cutting issues: Comprehensiveness and transparency		
PI-5	Classification of the budget	D
PI-6	Comprehensiveness of information included in budget documentation	B
PI-7	Extent of unreported government operations	C+
PI-8	Transparency of intergovernmental fiscal relations	B_
PI-9	Oversight of aggregate fiscal risk from other public sector entities	C+
PI-10	Public access to key fiscal information	B
C. Budget Cycle		
C. (i) Policy-based budgeting		Score
PI-11	Orderliness and participation in the annual budget process	B
PI-12	Multiyear perspective in fiscal planning, expenditure policy, and	C
C. (ii) Predictability and control in budget execution		
PI-13	Transparency of taxpayer obligations and liabilities	C+
PI-14	Effectiveness of measures for taxpayer registration and tax assessment	C+
PI-15	Effectiveness in collection of tax payments	C+
PI-16	Predictability in the availability of funds for commitment of expenditures	B+
PI-17	Recording and management of cash balances, debt, and guarantees	B
PI-18	Effectiveness of payroll controls	B
PI-19	Competition, value for money, and procurement controls	C+
PI-20	Effectiveness of internal controls for non-salary expenditure	D+
PI-21	Effectiveness of internal audit	D+
C. (iii) Accounting, recording, and reporting		Score
PI-22	Timeliness and regularity of accounts reconciliation	B+
PI-23	Availability of information on resources received by service delivery units	A
PI-24	Quality and timeliness of in-year budget reports	D+
PI-25	Quality and timeliness of annual financial statements	D+
C. (iv) External scrutiny and audit		Score

[4] Under the PEFA framework, performance is assessed in relation to seven dimensions of public financial management: credibility of the budget; comprehensiveness and transparency; degree to which the budget is prepared with due regard to government policy; predictability and control in budget execution; accounting, recording and reporting; external scrutiny and audit operations; appropriateness of development partner practices in country; and intergovernmental fiscal relationships.

PI-26	Scope, nature, and follow-up of external audit	C+
PI-27	Legislative scrutiny of the annual Budget Law	B+
PI-28	Legislative scrutiny of external audit reports	B+
D. Donor practices		Score
D-1	Predictability of Direct budget Support	D+
D-2	Donor information for budgeting and reporting on project/program aid	B
D-3	Proportion of aid managed by national procedures	C

Source: Viet Nam PEFA report 2013

6. The results of the PEFA assessment above highlighted the average performance of PFM in the country with almost equal performance ratings of B and C but weaknesses remain in the areas of budget credibility and internal controls. These performance areas are the challenges faced in PFM in Viet Nam. The report concluded that:

- Strengthening the PFM is an important element in the work of the Government of Viet Nam. In pursuit of this, a system of legislation has been enacted to provide the PFM legal framework.[5] The main problem identified in the PEFA assessment however concerns budget carry-overs between years. Budget credibility is demonstrated by the difference between the approved budget and the actual expenditures and revenues. The smaller the difference the higher the rating as this reflects discipline in compliance with the original approved budget. PEFA findings showed that budget carry-over from previous years was around 30% of the original budget. Carry-overs make it difficult to determine the actual annual budget deficit. Furthermore, the absence of a complete and detailed comparison between budget and out-turn has been identified as the most pressing problem.

- There is also a lack of master-planning capacity in line ministries and sub-national governments resulting in fragmented and thinly spread public investments. However, Viet Nam is undertaking public financial management reforms that are consistent with the country's financial strategy up to 2020. These reforms include; i) state budget expenditure management reform; ii) tax management; iii) public procurement; iv) public asset management reform and v) auditing and accounting reforms.

- Viet Nam uses national accounting standards but this is not consistent with International Public Sector Accounting Standards (IPSAS). Furthermore, the submission of the consolidated government financial statements to the National Assembly covering both revenue and expenditures is delayed by as much as 14 months after the end of the year. This is significantly longer than international best practice.

- External audit is the responsibility of the State Audit Agency of Viet Nam (SAV). However, the resources of SAV can cover only 60 percent of central government units and 50 percent of provinces. SAV estimates that it will require more than 3,000 staff to completely cover all central government and provinces.

- A functioning internal audit unit is a prerequisite to good financial management practice and international good practice. There are only few government agencies that have a functioning internal audit unit as mentioned above. To increase coverage, Article 39 in the Accounting

[5] PFM legislation consists of the following: State budget law, 2002; Law on Tax Administration, 2007; Value Added Tax Law, 1997; Procurement Law, 2005; Public Debt Management Law, 2009; Corporate Income Tax Law, 2003; Personal Income Tax law, 2007; Accounting Law, 2003

Law which is to be effective on 1 January 2017 states that the Government will provide detailed guidance on internal audit in ministries and state-owned enterprises.

- Substantial progress has been made in informing the public about procurement plans, tendering opportunities and contracts awarded through the Ministry of Planning and Investment (MPI) website and Procurement Gazette. Although all levels of government are required to publish procurement plans, tendering opportunities and contracts awarded information, not all provinces provide MPI with complete reports. Furthermore, while open tendering is the procurement norm, the law also permits a number of exceptions to the use of open competition. This has now become the preferred procurement method with about 70 percent of all contracts are done through direct contracting. An advisory panel was also created to deal with procurement complaints in accordance with Article 73 of Decree 85/2009, but because the advisory panel does not have the authority to suspend the contract awarding pending completion of the review process, the advisory panel is ineffective.

B. ADB Country Partnership Strategy[6]

7. **Risks.** The CPS assessed the major governance-related risks to be in public finance management, procurement and corruption. PFM issues include: lack of performance based budgeting; budget comprehensiveness and lack of sufficient capacity of the State Audit Viet Nam. It was noted that these could be mitigated and addressed by providing technical assistance to improve monitoring and evaluation systems; use of the joint development partner budget support program as a platform for policy dialogue with the government; and active participation in the PFM working group of development partners.

8. For procurement, the issues identified were the widening gap between national procurement norms and international standards as a result of decentralization; deliberate splitting of investments by implementing agencies into multiple packages resulting in reduced cost effectiveness; conflict of interest provisions are insufficiently detailed and prevalence of procurement malpractice. To mitigate against these risks, the CPS proposes to push for a broader definition of conflict of interest; stricter language regarding malpractice in the new Public Procurement Law; proper training for government agencies by OSFMD prior to project startup and review of all procurement plans by the resident mission early in the project design.

9. The CPS also identified corruption as a high risk in Viet Nam with the lack of monitoring and oversight particularly from the SAV including the lack of clarity on institutional mandates of agencies fighting corruption. These risks could be mitigated through engagement in policy dialogue through the anti-corruption dialogue and evaluation of support for the construction sector transparency initiative to support anti-corruption.

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[6] Viet Nam Country Partnership Strategy 2012-2015

IV. Project Financial Management System

A. Overview

10. The executing agency for the proposed GMSHSP will be the Ministry of Health through the General Department of Preventive Medicine (GDPM). The Department of Planning and Finance (DPF) of GDPM is well organized and has good experience in implementing ODA loan project including those funded by ADB[7]. The implementing agency for the project will be the provincial departments of health in 36 provinces. The focus of the project however will be at the district level. In all around 250 districts will be the beneficiaries of the project.

11. A central project management unit (CPMU) will be created within the GDPM to manage the project. To implement the projects in the 250 districts, a Project Implementation Team (PIT) will be created in each of the 36 provinces covered by the project. The CPMU and PITs will be supported by both international and national consultants. A total of 80 person months of international and 284 person months of national consultants will be hired. The consultants will be based mostly in the central level as most of the project's activities will be centralized at CPMU, but will conduct regular visits to the project's provinces and districts.

12. The consulting team will be headed by an international Chief Technical Adviser (24 person-months) and a national Deputy Chief Technical Adviser to be based in Hanoi over the five-year implementation period. There will be other consultants supporting the project including a national financial management (60 person-months). The overall financial management of the project will managed by the CPMU, and a clear responsibility mechanism between CPMU and PITs will be set up right from the early stage of project implementation.

B. Strengths

13. The current finance staff under GDPM have extensive experience in the accounting, disbursement procedures and procurement having implemented CDC1 and CDC2 project for the ADB. The skills and capacity at the central level that were developed will be relied upon in the implementation of the proposed GMSHSP.

C. Weaknesses

14. The major weaknesses identified in the project financial management are:

Staffing. Although the skills and capacity of the staff at the central level have been developed through involvement in previous ADB projects, the same cannot be said for the provinces and much less at the district level. Since the focus of the project is at the district level, the personnel that will be hired to implement the project will have to undergo intensive training on all ADB procedures after loan effectiveness. Tailor-made trainings will be sought for staff at central, provincial and district levels given their current various financial management capacity.

Internal Controls. Internal audit is an essential part of internal controls. The absence of an internal audit unit in MOH means that nobody in MOH is inspecting and evaluating the business

[7] CDC1 and CDC2

operations for material misstatements that can affect the reliability of the financial statements. The appointment of a regular staff of the MOH as chief accountant does not necessarily translate to effective internal control.

Reporting and Monitoring. The project is focused on the district level rather than the province. With 250 districts in 36 provinces, the coordination between the MOH at the central level with the provinces and districts will be difficult. The CPMU and provincial Project Implementation Teams should be well staffed with competent personnel to be able to monitor all the activities and ensure that the project is being implemented as designed.

D. Personnel, Accounting Policies and Procedures, Internal and External Audit

15. **Personnel.** The Department of Planning and Finance (DPF) in GDPM is well organized and has good experience in implementing ODA loan project including those funded by ADB. DPF staff consist of 50 government staffs and 40 contracted staffs with rich experience and expertise in various management areas including health policy development, health systems M&E, finance and accounting, external aid, procurement management. This experience would be helpful for DPF in the forthcoming GMSHS project.

16. It is government policy to allow for the outsourcing of the chief accountant position for ODA projects but MOH instead appointed a full time MOH accountant for the position of chief accountant in CDC2. This condition is expected to continue with the new project. However, as the accountant is a full time employee of the Ministry, it is expected that he/she will undertake the duties and responsibilities in MOH also on a full time basis. Although the appointed staff will receive 50 percent of the monthly salary as additional compensation, two issues arise; i) the difficulty of carrying out two full time accounting responsibilities; and ii) possibility of conflict of interest which can be an internal control risk. The effectiveness, efficiency and possible conflict of interest of this arrangement should be carefully studied by MOH and ADB.

17. At the provincial level, it is not yet known if the provinces were recipients of any donor assisted projects in the past as well as the condition of the finance units is each of the 36 provinces identified as beneficiaries of the project. The DOHs will also have to setup their respective Project Implementation Teams and will need to hire additional staff to implement the proposed GMS Health Security Project. If the DOHs will follow the lead of the MOH and hire a full time chief accountant from its ranks, then the question of effectiveness and efficiency will also have to be reviewed. Furthermore all the staff of the Project Implementation Teams will have to undergo training on ADB procedures.

18. **Internal Audit.** There is no internal audit unit within the MOH that can check on the veracity of the documents and conformity of the financial transactions in the CPMU with approved government accounting standards. The chief accountant in the CPMU checks all the transactions done by CPMU accounting staff and reports only to the Project Director. Although the external audit findings of the 2013 and 2014 audits found no adverse issues, the lack of an oversight function in MOH due to the absence of an internal audit unit, presents a high risk that project funds can be misused. Since the SAV has recommended that internal audit units should be established in all government ministries, MOH should immediately establish the audit unit prior to the implementation of the GMS Health Security Project. ADB has

recognized the significance of internal audits that in the last review mission ADB has required the CPMU to instruct the PCPMUs to conduct audits of all documents and transactions from 2011 – 2015. For the proposed GMS Health Security Project, this situation should be best corrected with the establishment of an internal audit unit in MOH.

19. **External Audit.** As a line ministry, MOH will be audited by the SAV. However, due to the limited staff of SAV, audits are not performed annually as required. For the project, it is mandatory for ADB funded projects to have the annual financial statements audited by independent auditors acceptable to ADB and MOH and audit reports submitted to ADB within six months from the end of the fiscal year. The TOR for the external auditors for the GMS Health Security Project will be done by the CPMU and the selection of the external auditors will be done through open tendering.

E. Financial Reporting Systems

20. As a government line Ministry, MOH is required to comply with government accounting and financial reporting standards issued by the MOF under Decision 19/2006. The project director also has full authority to execute all transactions under the project. This condition is expected to continue with the implementation of the proposed GMS Health Security Project.

21. Projects in MOH use a computerized accounting software to record all transactions and produce the required financial reports. Furthermore, all the reports and supporting documents are retained. The current CDC2 project uses the accounting software MISA, a locally developed accounting software. Although not officially endorsed by the MOF, it is widely used even in the provinces. It is to the project's advantage to use the same software. However, the ability to interface with TAMBIS, the approved government financial management information system (FMIS) is not known.

F. Disbursement Arrangements and Funds Flow

22. The loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook*[8] (2015, as amended from time to time) Direct payment procedures will generally be used for contracts for the supply of goods and equipment and for consulting services contracts. An imprest account will be used for payment of eligible expenditures rather than reimbursement.

23. Funding for the GMSHSP will be similar to CDC2. A total of three accounts will be opened for the project at the central level. The first account is a US$ denominated account (Imprest account - IA)[9] in a commercial bank that is acceptable to SBV. This account will receive ADB loans funds for the project. The second account is also an IA but denominated in the local currency to receive converted US$ funds to VND when needed. The third account is another IA account will be opened by the CPMU with the State Treasury at central level. This account will be opened to

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[8] There are four types of disbursement procedures under the Loan Disbursement Handbook. These are a) Direct payment procedure; b) Commitment procedure; c) Reimbursement procedure; and d) Imprest fund procedure

[9] First generation imprest account

distinguish ADB loan funds from government contribution. The amount limits for the IA will be the same as in CDC2. The proposed GMSHSP funds flow is shown in Appendix 1.

24. The Project Implementation Team of each DOH will likewise open an account to receive and disburse ADB loan funds from the IA. This will be sub account (SA)[10]. The sub-account will be opened at a commercial bank of the same bank system with CPMU's IA bank. The limits and replenishment policy and procedures for the sub-accounts will be the same as in CDC2.

V. Risk Description and Rating

Table 2: Identified Risks and Mitigating Measures

Risk Description	Impact	Likelihood	Risk Assessment	Mitigation Measure
Inherent Risk				
1. Country Specific -				
1.1. High budget carryover from year to year makes it difficult to determine actual budget deficit	High	Likely	High	MOF and Treasury should review practice of budget carryover and establish a timeframe to phase out the practice
1.2. Viet Nam uses national accounting standards but is not consistent with IPSAS	Moderate	Likely	Moderate	Government should move towards compliance with IPSAS standards
1.3. Delays in reporting of consolidated government financial statements due to manual recording system used in lower government levels. Delays take as much as 14 months.	High	Likely	High	MOF should implement the full operation of the Treasury and Budget Management Information System (TAMBIS) to automate the recording and consolidation of financial statements at the district level
1.4. Low external audit coverage by the State Audit Agency	High	Likely	High	Expedite the hiring of additional staff for SAV to cover all government functions. For the project, continue hiring external auditors
1.5. Extensive use of direct contracting in procurement	High	Likely	High	Government should impose more stringent rules on the use of direct contracting to make the procurement process more transparent
1.6. Viet Nam external debt is expected to rise to about 64.9% of GDP in 2016. The current set limit is 65%. This could affect the timely availability of counterpart funding for the project	High	Likely	High	The Minister of MPI has recommended the review the public debt law and increase current debt limit.
2. Entity Specific - the management and monitoring of project implementation in the 250 districts from 36 provinces will be difficult even with the establishment of 46 Project Implementation Team.	Moderate	Likely	Moderate	MOH and DOHs will need to hire more staff than the current CDC2 to conduct more frequent monitoring of project implementation. Staff particularly from the DOHs will need to be trained in ADB procedures
Overall Inherent Risk			**High**	
Project Risk				

[10] SA are exclusive for provinces to distinguish from IAs that are exclusive to MOH.

1. Implementing Entity - Chief accountant of the CPMU is also a regular MOH staff working full time with the Ministry. Working on two responsibilities affects efficiency as well as the possibility of conflict of interest	Moderate	Likely	Moderate	The chief accountant of the CPMU is supported by 2 accountants hired on contract for the project. Being involved in CDC2, both will be knowledgeable in all ADB financial management requirements. Since government policy allows for outsourcing, one of the accountants can take over the chief accountant position.
2. Funds Flow - Counterpart funds at central and provincial levels will not be adequate and available on a timely basis	Moderate	Likely	Moderate	Improve on master planning activities in the provincial and district level to ascertain that funds will be available for the project
3. Accounting Policies and Procedures – the accounting system and chart of accounts is not adequate for the efficient and effective management of the project	Moderate	Likely	Moderate	DOHs and district staff need to be trained on ADB procedures and upgrade to international accounting standards.
4. Staffing - Lack of qualified personnel in the province and district level to implement the project	High	Likely	High	Outsource the staff needed in each province to support the Project Implementation team. All the staff need to be trained in ADB procedures including but not limited to financial management and procurement
5. Internal Audit - No internal audit unit in MOH and in the DOHs	High	Likely	High	Establish an internal audit unit to upgrade the financial management system as part of government reform. The unit should be established by the second year of project implementation. In the interim, MOH should engage an auditing firm to review internal control procedures including bank reconciliations. Reports of findings should be provided quarterly to ADB and MOH
6. External Audit - Lack of timely audits by SAV	Low	Likely	Low	Annual audits of the project will be outsourced to private accounting and auditing firms. The recruitment of the auditing firm will funded from the loan proceeds. External audit reports will be required to be submitted within six months after the end of the fiscal year
7. Reporting and Monitoring – Lack of coordination between MOH and DOHs and the slow approval of the annual implementation plan. This has caused delays in contract awards in many projects in MOH in the past	High	Likely	High	CPMU should have sufficient number of staff to conduct regular coordination meetings and monitoring of project implementation in all 300 districts to address problems efficiently. Conduct annual planning workshop between MOH and DOH to assess previous years performance and to synchronize targets for next year. MOH should improve its annual planning activities to ensure that projects are identified and provided with sufficient funding when needed.
8. Information Systems – Project FMIS is not used in the provinces and districts.	Low	Likely	Moderate	The CPMU will continue to use the MISA software until MOF is able to fully implement the TAMBIS in all government ministries, provinces and districts. MISA will be required in all the DOHs and districts to ensure easy monitoring. However, there should be regular reporting from the provinces to the CPMU on the receipts and uses of funds as part of project internal control measures.

Overall Project Risk	**Moderate**
Overall (Combined) Risk	**Moderate**

Source: Consultant's Assessment

VI. Proposed Time-Bound Action Plans

25. The following initial Financial Management Action Plan has been prepared based on the basic principles of sound financial management practices in the areas of (i) internal control, (ii) funds flow, (iii) accounting and financial reporting, (iv) and independent audits. This plan will be updated annually based on discussions with the government as well as based on the results of the annual fiduciary reviews conducted.

Table 3: Action Plan

Weakness	Mitigating Action	Responsibility	Timeframe
Financial management and staff capacity in the Provinces and Districts are low	Intensive training on ADB procedures to include but not limited to financial management and procurement	ADB	Within six months of loan effectiveness
	Outsource the staff requirement in the provinces and districts to support the Project Implementation Team. All the staff need to be trained in ADB procedures	MOH and DOHs	Staff recruitment within three months of loan effectiveness. In the first year, the staff will be guided by the implementation consultants. During the second year, the staff take over but with supervision from consultants. From the third year onwards by the staff.
Internal control - No internal audit function in the MOH	Establish and internal audit unit with MOH	MOH	Establish internal audit unit in MOH as recommended by SAV as part of the PFM reform program. During the first year of implementation, MOH will outsource the internal audit function to a reputable auditing firm with quarterly reporting to MOH and ADB. On the second year, MOH should operationalize the audit unit within the Ministry.
Reporting and Monitoring – implementation of the project in the 300 districts will be difficult	MOH together with the DOHs should undertake multi-year planning to ensure that all activities are synchronized and funds made available on time to prevent any delays in project implementation. DOHs will also provide regular monthly reports to CPMU on the activities undertaken during the month including	MOH and DOHs	Multi-year planning should be conducted annually as part of annual budget preparation. Furthermore, coordination meetings between the CPMU and Project Implementation Teams should be held monthly to monitor accomplishments against

	problems/issues encountered and measures adopted by the Project Implementation Team and the district to address the problem/issues.		targets.

Source: Consultant's Assessment

VII. Suggested Financial Management Covenants

26. The following are the suggested to be included as part of the financial management covenants:

a) MOH through the CPMU will engage the services of an auditing firm to conduct annual external audit of the project and to submit the report within six months after the end of the fiscal year.
b) MOH and DOHs to conduct yearly planning activities every year as part of the MOH budget preparation process. CPMU will submit to MOH and ADB a report on the results of the planning exercise. At the end of the year, CPMU will conduct an assessment of the accomplishments made against targets, identify problems encountered and corrective actions made.

c) MOH and DOH will ensure that highly experience and qualified personnel are recruited under the project. Furthermore, MOH will ensure that all personnel will undergo training on ADB procedures.

VIII. Conclusion

27. The results of the Financial Management and Internal Control Risk Assessment identified several financial management risks in staffing, internal controls and reporting and monitoring systems. A summary of the risks and mitigating measures are presented in Table 1 below. The overall inherent risk was assessed to be high and project risks were assessed to be moderate. The overall combined risk was also assessed to be moderate. Although several major financial management risks were identified, the proposed mitigating measures are sufficient for the satisfactory implementation of the project.

Weakness	Risk Rating	Mitigating Measure
Staffing - lack of qualified staff to implement financial management responsibilities in the provinces and districts	High	Outsource the staff needed in each province to support the Project Implementation Team. All the staff need to be trained in ADB procedures including but not limited to financial management and procurement
Internal Control - No internal audit unit in the MOH and PHDs	High	MOH should establish an internal audit unit to upgrade the financial management system as part of government PFM reform. The audit unit should be established by the second year of project implementation. In the interim, MOH should engage an auditing firm to review internal control procedures including bank reconciliations. Reports of findings should be provided quarterly to ADB and MOH

Reporting and Monitoring – difficulty in coordination between MOH and the PHDs	High	CPMU should increase the number of staff to conduct regular coordination meetings and monitoring of project implementation in all 36 provinces to address problems efficiently. Annual planning workshop between MOH and PHD should be conducted to assess previous years performance and to synchronize targets for next year.

Appendix 1

Table 1: Financial Management Assessment Questionnaire[11]

Topic	Response	Remarks
1. Implementing Agency		
1.1 What is the entity's legal status / registration?	General Department of Preventive Medicine (GDPM) is the Implementing Agency. The CPMU is Project Management Unit of GDPM.	
1.2 How much equity (shareholding) is owned by the Government	Not Applicable	
1.3 Obtain the list of beneficial owners of major blocks of shares (non-government portion), if any	Not Applicable	
1.4 Has the entity implemented an externally-financed project in the past (if so, please provide details)?	Yes, GDPM's CPMU has implemented CDC1 and CDC2 project. The same staff is expected to implement this Health Security Project (CDC3).	
1.5 Briefly describe the statutory reporting requirements for the entity?	GDPM belongs to the MOH, which assists the Minister of Health in implementing state management functions and organizing the implementation of legal regulations in the field of preventive medicine nationwide. GDPM has its own legal entity and account.	
1.6 Describe the regulatory or supervisory agency of the entity		
1.7 What is the governing body for the project? Is the governing body for the project independent?	GDPM has its own legal entity but is not "dependent" from MOH	
1.8 Obtain organizational structure and describe key management personnel. Is the organizational structure and governance appropriate for the needs of the project?	The expected organization structure is appropriate for the project needs	
1.9 Describe the code of ethics in place?		
1.10 Describe (if any) any historical issues reports of ethics violations involving entity and management. How were they addressed?		

[11] The responses to this questionnaire were based on interviews conducted by the domestic consultant with concerned official of the finance department of GDPM

Topic		Response	Remarks
2.	**Funds Flow Arrangements**		
2.1	Describe (proposed) project funds flow arrangements in detail, including a flow of funds diagram and explanation of the flow of funds from ADB, government and other financiers to the government, EA, IA, suppliers, contractors, ultimate beneficiaries	See Annex 1 for the chart.	
2.2	Are the (proposed) arrangements to transfer the proceeds of the loan (from the government / Finance Ministry) to the entity satisfactory?	Yes	
2.3	Are the disbursement methods appropriate	Yes	
2.4	What have been the major problems in the past in receipt of funds by the entity?	None	
2.5	In which bank will the imprest account be opened?	To be announced by SBV	
2.6	Is the bank in which the imprest account is established capable of – • Executing foreign and local currency transactions • Issuing and administering letters of credit • Handling large volume of transactions • Issuing detailed monthly bank statements promptly	Yes	
2.7	Is the ceiling for disbursements from the imprest account and SOE appropriate/ required?	Yes, as estimated 6-month expenditures	
2.8	Does the (proposed) project implementing unit (PIU) have experience in the management of disbursements from ADB?	Yes, CDC 1 and CDC2	
2.9	Does the PIU have adequate administrative and accounting capacity to manage the imprest fund and statement of expenditure (SOE) procedures in accordance with ADBs loan disbursement handbook. Identify any concern or uncertainty about the PIUs administrative and accounting capability which would support the establishment of a ceiling on the use of the SOE procedure.	Only for PIUs that have implemented ADB projects	
2.10	Is the entity exposed to foreign exchange risks? If yes describe the entity's policy and arrangements for managing foreign exchange risk	Yes, CPMU will closely monitor the net loan amount to ensure no cost overrun on case of SDR depreciation against USD.	
2.11	How are the counterpart funds accessed?	Via national treasury at both Provincial and Central level	
2.12	How are payments made from the counterpart funds?	Payment made based on annual plan pre-approved by State Treasury	
2.13	If part of the project is implemented by communities or NGOs, does the PIU have the necessary reporting and monitoring features built into its systems to track the use of project proceeds by such agencies?	None part of the project is implemented by other parties	

Topic		Response	Remarks
2.14	Are the beneficiaries required to contribute to project costs? If beneficiaries have an option to contribute in kind (in the form of labor), are proper guidelines formulated to record and value the labor contribution?	NA	
3.	**Staffing**		
3.1	What is the (proposed) organizational structure of the accounting department? Attach an organization chart.	6 persons in accounting department	
3.2	Will existing staff be assigned to the project or will new staff be recruited	Existing staff will be assigned	
3.3	Describe the (proposed) accounts staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions and CVs of key accounting staff.	2 national consultants under contract 3: officials under contract 1: senior officer (usually assigned from accounting department of GDMP)	
3.4	Is the project finance and accounting function staffed adequately?	Yes CDC 1: 2006, 2011: CDC 2 : 2011 - 2017	The experience and lessons learned from CDC projects will be invaluable to the implementation of GMSHSP
3.5	Are the finance and accounts staff adequately qualified and experienced?	Yes	
3.6	Are the project accounts and finance staff trained in ADB procedures?	Yes	
3.7	What is the duration of the contract with the finance and accounts staff?	For financial consultant, the contract is 3 years. For accountants, contract is 1 year	
3.8	Identify key positions not contracted yet, and the estimated date of appointment.	The CDC2 CPMU has all key positions contracted.	Most key staff will be retained for the GMSHSP
3.9	For new staff, describe the proposed project finance and accounting staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions	NA	
3.10	Does the project have written position descriptions that clearly define duties, responsibilities, lines of supervision, and limits of authority for all of the officers, managers, and staff?	CDC2 CPMU has manual and will be the same CPMU for GMS-HS	
3.11	What is the turnover rate for finance and accounting staff?		
3.12	What is training policy for the finance and accounting staff?	MOF has a training course for accounting staff. ADB also provide training course for accountants, 1 course per year.	

Topic	Response	Remarks
3.13 Describe the list of training programs attended by finance and accounting staff in the last 3 years		
4. Accounting Policies and Procedures		
4.1 Does the entity have an accounting system that allows for the proper recording of project financial transactions, including the allocation of expenditures in accordance with the respective components, disbursement categories, and sources of funds? Will the project use the entity accounting system?	Decision 19/ MOF	The system is adequate for regular update of the financial status of the project. The accounting system of CCPMU will be the same as CDC2 project.
4.2 Are controls in place concerning the preparation and approval of transactions, ensuring that all transactions are correctly made and adequately explained?	Yes The preparation and approval of transaction are under control	There is cross checking between chief accountant/ accountant to make sure no mistake
4.3 Is the chart of accounts adequate to properly account for and report on project activities and disbursement categories?	Yes Adequate	
4.4 Are cost allocations to the various funding sources made accurately and in accordance with established agreements?	Yes Accurate	
4.5 Are the General Ledger and subsidiary ledgers reconciled and in balance?	Yes Unified and balanced	
4.6 Describe the EAs policy for retention of accounting records including supporting documents (e.g. ADBs policy requires that all documents should be retained at least 1 year after ADB receives the audited project financial statements for the final accounting period of implementation, or 2 years after the loan closing date whichever is later). Are all accounting and supporting documents retained in a defined system that allows authorized users' access?	Yes	
4.7 Describe any previous audit findings that have not been addressed	NA	
Segregation of Duties		
4.8 Are the following functional responsibilities performed by different units or persons: (i) authorization to execute a transaction; (ii) recording of the transaction; and (iii) custody of assets involved in the transaction?	Yes they are performed by different persons. There is no delegation of duties to other party	Maintain conformity in directive command
4.9 Are the functions of ordering, receiving, accounting for, and paying for goods and services appropriately segregated?	Yes Accountant responsible directly for payment when	
Budgeting System		
4.10 Do budgets include physical and financial targets?	Yes, the budgeting system include both physical and financial targets	Budget adequately reflect the actual physical condition together with financial target

	Topic	Response	Remarks
4.11	Are budgets prepared for all significant activities in sufficient detail to provide a meaningful tool with which to monitor subsequent performance?	Yes	
4.12	Are actual expenditures compared to the budget with reasonable frequency, and explanations required for significant variations from the budget?	Yes	
4.13	Are approvals for variations from the budget required in advance or after the fact?	Yes, being compared	
4.14	Is there a ceiling, up to which variations from the budget may be incurred without obtaining prior approval		
4.15	Who is responsible for preparation and approval of budgets?	The CPMU's financial department prepare and submit budget for project director for approval	MOET will provide details guidance on this
4.16	Describe the budget process. Are procedures in place to plan project activities, collect information from the units in charge of the different components, and prepare the budgets?	Yes	Yes, performed by financial consultants
4.17	Are the project plans and budgets of project activities realistic, based on valid assumptions, and developed by knowledgeable individuals? Is there evidence of significant mid-year revisions, inadequate fund releases against allocations, or inability of the EA to absorb/spend released funds? Is there evidence that government counterpart funding is not made available adequately or on a timely basis in prior projects? What is the extent of over-or-under budgeting of major heads over the last 3 years? Is there a consistent trend either way?	Yes, based on legal assumptions being advised by consultants	
	Payments		
4.18	Do invoice-processing procedures provide for: (i) Copies of purchase orders and receiving reports to be obtained directly from issuing departments? (ii) Comparison of invoice quantities, prices and terms, with those indicated on the purchase order and with records of goods actually received? (iii) Comparison of invoice quantities with those indicated on the receiving reports? (iv) Checking the accuracy of calculations?	Invoice processing are obtained directly from issuers, with cross checking for quantity, price and actual invoice. Calculation is checked and there are no mistakes.	Invoice is adequate and kept to make sure taxes are paid to state budget
4.19	Are all invoices stamped PAID, dated, reviewed and approved, and clearly marked for account code assignment?	Yes. All invoices need to stamped PAID, with accordance account code	Adequately perform according to State regulation

Topic	Response	Remarks
4.20 Do controls exist for the preparation of the payroll and are changes to the payroll properly authorized?	Yes, there is cross check system for salary, in accordance to current regulation	Adequately perform according to State regulation
Policies And Procedures		
4.21 What is the basis of accounting (e.g., cash, accrual)?	Accounting use accrual basis	According to Viet Nam regulation
4.22 What accounting standards are followed (International Financial Reporting Standards, International Public Sector Accounting Standards – cash or accrual or national accounting standards or other?	Vietnamese Accounting Standard ADB guidelines	According to regulation
4.23 Does the project have an adequate policies and procedures manual to guide activities and ensure staff accountability?	Yes	According to regulation
4.24 Is the accounting policy and procedure manual updated for the project activities?	Yes	Manual updated on a regular basis
4.25 Do procedures exist to ensure that only authorized persons can alter or establish a new accounting principle, policy or procedure to be used by the entity?	Yes	According to regulation
4.26 Are there written policies and procedures covering all routine financial management and related administrative activities?	Yes	According to regulation
4.27 Do policies and procedures clearly define conflict of interest and related party transactions (real and apparent) and provide safeguards to protect the organization from them?	Yes	
4.28 Are manuals distributed to appropriate personnel?	Yes	Manual is distributed to appropriate personnel and is recorded at relevant departments
4.29 Describe how compliance with policies and procedures are verified and monitored	NA	
Cash and Bank		
4.30 Indicate names and positions of authorized signatories in the bank accounts.	To be determined for next project	
4.31 Does the organization maintain an adequate, up-to-date cashbook, recording receipts and payments?	Yes	
4.32 Describe the collection process and cash handling procedures. Do controls exist for the collection, timely deposit and recording of receipts at each collection location?	NA	
4.33 Are bank and cash reconciled on a monthly basis or more often? Is cash on hand physically verified and reconciled with the cash books? With what frequency is this done?	Yes	

Topic	Response	Remarks
4.34 Are all reconciling items approved and recorded?	Yes	Monthly reconciliation to maintain conformity of numbers
4.35 Are all unusual items on the bank reconciliation reviewed and approved by a responsible official?	Yes	
4.36 Are there any persistent/ non-moving reconciling items?	NA	
4.37 Are there appropriate controls in safekeeping of unused checks, USB keys and passwords, official receipts and invoices?	NA	
4.38 Are any large cash balances maintained at the head office or field offices? If so, for what purpose?	NA	
4.39 For online transactions, how many persons possess USB keys (or equivalent) and passwords? Describe the security rules on passwords and access controls	NA	
Safeguard over Assets:		
4.40 What policies and procedures are in place to adequately safeguard or protect assets from fraud, waste and abuse?	MOF's regulation (Circular 98/2013TT-BTC) regulating on asset management	
4.41 Does the entity maintain a fixed asset registry? Is the register updated monthly? Does the register record ownership of assets, any assets under lien or encumbered or have been pledged	NA	
4.42 Are subsidiary records of fixed assets, inventories and stocks kept up to date and reconciled with control accounts?	NA	
4.43 Are there periodic physical inventories of fixed assets and stocks?	Annual assessment	
4.44 Are there periodic physical inventories of fixed assess, inventories and stocks reconciled with the respective fixed assets and stock registers and discrepancies analyzed and resolved?	Yearly inventory	
4.45 Describe the policies and procedures in disposal of assets. Is the disposal of each asset appropriately approved and recorded? Are steps immediately taken to locate lost or repair broken assets?	NA	
4.46 Are the assets sufficiently covered by insurance policies?	No	
4.47 Describe the policies and procedures in identifying and maintaining fully depreciated assets from active assets	NA	
Other Offices and Implementing Entities		
4.48 Describe any other regional offices or executing entities participating in implementation	Yes, there will be PPMU (the structure is to be determined)	
4.49 Describe staff, their roles and responsibilities in performing accounting and financial management functions of such offices as they relate to the project	NA	

Topic	Response	Remarks
4.50 Has the project established segregation of duties, controls and procedures for flow of funds and financial information, accountability and reporting and audits in relation to the other offices or entities?	NA	
4.51 Does information among the different offices/ implementing agencies flow in an accurate and timely fashion? In particular, do the offices other than the head office use the same accounting and reporting system?	Yes	
4.52 Are periodic reconciliations performed among the different offices/ implementing agencies? Describe the project reporting and auditing arrangements between these offices and the main executing/ implementing agencies	NA	
4.53 If any sub-accounts (under imprest account) will be maintained, describe the results of the assessment of the financial management capacity of the administrator of such sub-accounts	NA	
Contract Management and Accounting		
4,54 Does the agency maintain contract wide accounting records to indicate gross value of the contract and any amendments, variations and escalations, payments made, and undisbursed balances? Are the records consistent with physical outputs/ deliverables of the contract	NA	
4.55 If contract records are maintained, does the agency reconcile them regularly with the contractor?	NA	
Other		
4.56 Describe project arrangements for reporting fraud, corruption, waste and misuse of project resources. Has the project advised employees, beneficiaries and other recipients to whom to report if they suspect fraud, waste or misuse of project resources or property?	NA	
5. Internal Audit		
5.1 Is there an internal audit department in the entity?	None	
5.2 What are the qualifications and experience of audit department staff?	Same, cross checking. Coordinator (Mrs. Van)	
5.3 To whom does the internal auditor report?	NA	
5.4 Will the internal audit department include the project in its work program?	NA	
5.5 Are actions taken on the internal audit findings?	NA	
5.6 What is the scope of the internal audit program?	NA	
5.7 Is the IA department independent?	NA	
5.8 Do they perform pre-audit of transactions	NA	
5.9 Who approves the internal audit program	NA	
5.10 What standards guide the internal audit program?	NA	
5.11 How are audit deficiencies tracked?	NA	

Topic	Response	Remarks
5.12 How long have the internal audit staff members been with the organization?	NA	
5.13 Does any of the internal audit staff have an IT background?	NA	
5.14 How frequent does the internal auditor meet with the audit committee without the presence of management	NA	
5.15 Has the internal auditor identified/ reported any issue with reference to availability and completeness of records	NA	
5.16 Does the auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6. External Audit		
6.1 Is the entity financial statement audited regularly by an independent auditor? Who is the auditor?	Yes, AASC.[12] (Vietnamese consulting firm)	
6.2 Are there any delays in audit of the entity? When are the audit reports issued?	No. Normally 6 months.	
6.3 Is the audit of the entity conducted according to the International Standards on Auditing?	Yes, since the financial statement submit to ADB follow ADB's format and requirements, the audit entity conducted under IFRS[13]	
6.4 Were there any major accountability issues brought out in the audit report of the past three years?	None	
6.5 Does the external auditor meet with the audit committee without the presence of management?	NA	
6.6 Has the entity engaged the external audit firm for any non-audit engagements (e.g. consulting)? If yes, what is the total value of non-audit engagements, relative to the value of the audit services?	No	
6.7 Has the external auditor expressed any issues on the availability of complete records and supporting documents?	NA	
6.8 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures?	NA	
6.9 Are there any material issues noted during the review of the audited entity financial statements that were not reported in the external audit report?	NA	
External Audit – Project Level		
6.10 Will the entity auditor audit the project accounts or will another auditor be appointed to audit the project financial statements	NA	

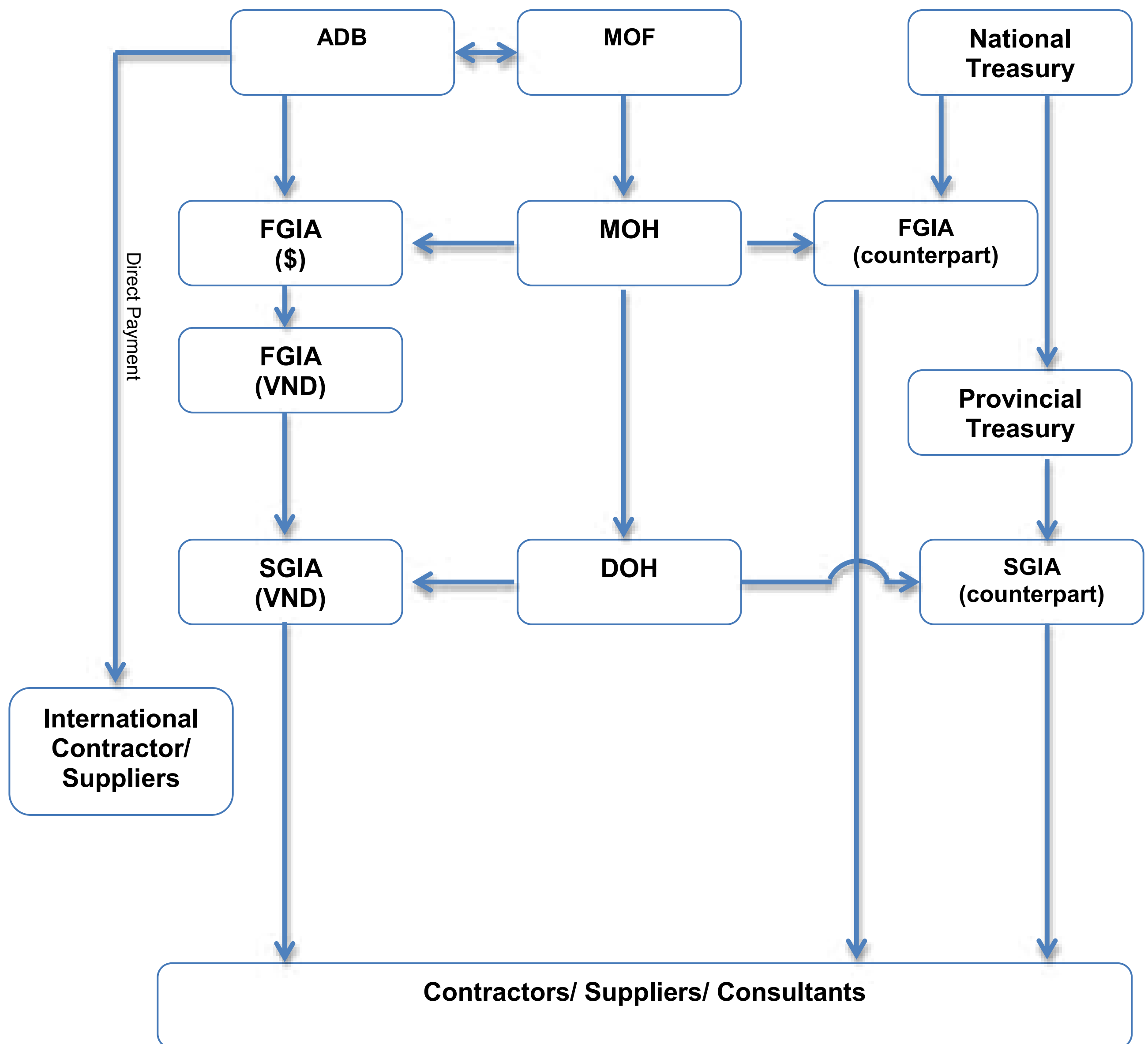
[12] Auditing and Accounting Financial Consultancy Services.
[13] International Financial Reporting System

Topic	Response	Remarks
6.11 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	NA	
6.12 Is the project subject to any kind audit from an independent government entity (e.g. Supreme audit institution) in addition to the external audit?	Yes	
6.13 Has the project prepared acceptable terms of reference for an annual project audit? Have these been agreed and discussed with the EA and the auditor?	Yes, project will follow ADB VRM's TOR for recruiting audit firms	
6.14 Has the project auditor identified any issues with the availability and completeness of records and supporting documents?	NA	
6.15 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6.16 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	NA	
6.17 (for second and subsequent projects) Were past audit reports complete and did they fully address the obligations under the loan agreements? Were there any material issues noted during the review of the audited project financial statements and related audit report that have remained unaddressed?	NA	
7. Reporting and Monitoring		
7.1 Are financial statements prepared for the entity? In accordance with which accounting standards?	Yes	
7.2 Are financial statements prepared for the implementing unit?	Yes	
7.3 What is the frequency of preparation of financial statements? Are the reports prepared in a timely fashion so as to useful to management for decision making?	Annual	
7.4 Does the reporting system need to be adapted to report on the project components?	Yes, depends on project components design	
7.5 Does the project have established financial management reporting responsibilities that specify what reports are to be prepared, what they are to contain, and how they are to be used?	Yes. There is guidelines for government expenditure and also ADB guideline for financial management reporting.	
7.6 Are financial management reports used by management?	Yes	
7.7 Do the financial reports compare actual expenditures with budgeted and programmed allocations?	Yes. There are separate lines for actual expenditure and budgeted allocations	

Topic	Response	Remarks
7.8 How are financial reports prepared? Are financial reports prepared directly by the automated accounting system or are they prepared by spreadsheets or some other means	Yes, CCPMU and most CPMU use automate account system: MISA	
7.9 Does the financial system have the capacity to link the financial information with the projects physical progress? If separate systems are used to gather and compile physical data, what controls are in place to reduce the risk that the physical data may not synchronize with the financial data?	Yes	
7.10 Does the entity have experience in implementing projects of any other donors, co-financiers or development partners	Yes	
8. Information Systems		
8.1 Is the financial management system computerized?	Yes, MISA program	
8.2 If computerized, is the software off the shelf or customized?	Off the shelf	
8.3 Is the computerized software standalone or integrated and used by all departments in the headquarters and field units using modules	standalone	
8.4 How are the project financial data integrated with the entity financial data? Is it done through a module in the enterprise financial system with automatic data transfer or does it entail manual entry?	NA	
8.5 Is the computerized software used for directly generating periodic financial statements or does it require manual intervention and use of Excel or similar spreadsheet software?	Yes	
8.6 Can the system automatically produce the necessary project financial reports	Yes	
8.7 Is the staff adequately trained to maintain computerized system	Yes	
8.8 Does the management organization and processing system safeguard the confidentiality, integrity and availability of the data?	Yes	
8.9 Are there back-up procedures in place?	NA	
8.10 Describe back up procedures – online storage, offsite storage, offshore storage, fire, earthquake and calamity protection for backups?	NA	

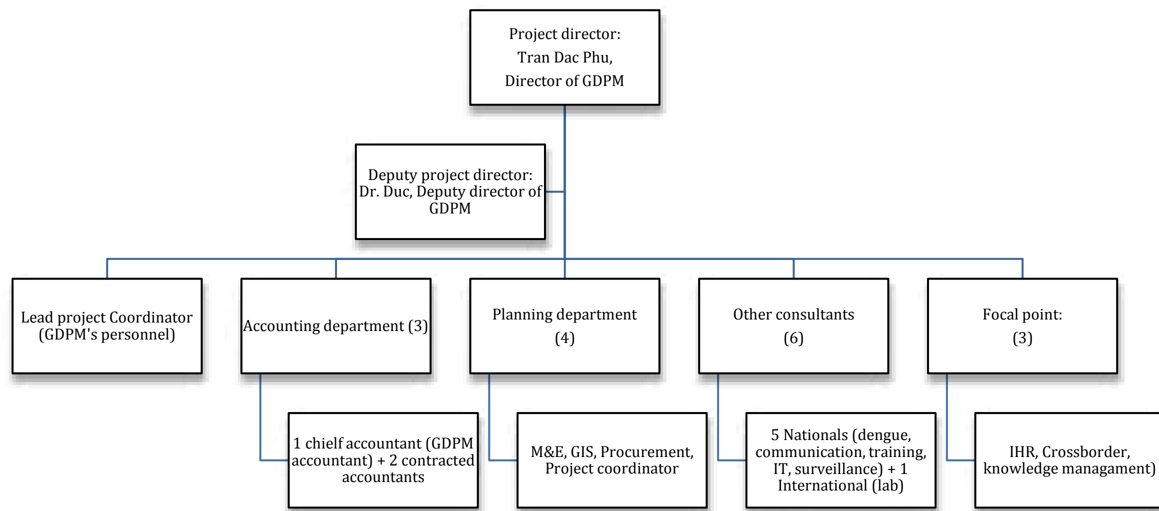
Appendix 2

Proposed Flow of Funds



Appendix 3

Organizational Chart of CPMU



FMA Annex 1

Financial Management Assessment for the Ministry of Health, Lao PDR

March 2016

ABBREVIATIONS

ADB	–	Asian Development Bank
ADF	–	Asian Development Fund
CPS	–	Country Partnership Strategy
DOH	–	Department of Health
DP	–	Development partner
DPIC	–	Department of Planning and International Cooperation
EA	–	Executing agency
FMA	–	Financial Management Assessment
FMAQ	–	Financial management assessment questionnaire
FY	–	Fiscal year
IA	–	Implementing agency
MOF	–	Ministry of Finance
MOH	–	Ministry of Health
MPI	–	Ministry of Public Investment
PEFA	–	Public Expenditure Financial Accountability
PFM	–	Public financial management
PHD	–	Provincial Heath Department
SCO	–	State Control Organization

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EXECUTIVE SUMMARY

1. The financial management assessment was conducted for the Ministry of Health as the executing agency for the proposed GMS Health Security Project. The FMA was prepared in accordance with ADBs Technical Guidance Note 2015 and incorporates the Financial Management Internal Control and Risk Management Assessment (FMICRA) required by the Guidelines. The assessment also made extensive use of the Public Expenditure and Financial Accountability (PEFA) assessment for Lao PDR in 2013 as well as ADBs Country Partnership Strategy (CPS) for 2012-2015.

2. The PEFA assessment in 2010 highlighted the weakness in PFM but also acknowledged that the country was taking steps to improve PFM. The assessment identified PFM weakness in budget planning; comprehensiveness and transparency in budget formulation arising from unreported government operations and lack of oversight of fiscal risk; the ineffectiveness of internal audit and the poor accounting, recording and reporting system resulting in the poor quality and delays in the annual financial statements.

3. The ADB Country Partnership Strategy 2012 – 2016 assessed the major governance-related risks to be in public finance management, procurement and corruption. PFM issues relate to weakness in institutional arrangements and capacity; comprehensiveness and transparency in budget formulation and weak execution of the budget. Lao PDRs budget has become more credible through government's medium term fiscal framework utilizing multiyear projections of government revenue, expenditure and financing accounts; treasury reform through improved chart of accounts. The government's continuing implementation of an electronic financial information system for the past 10 years have also contributed to the improving credibility. Despite these improvements however, the coordination between MPI and MOF remains weak. Furthermore, budget execution remains weak as a result of the deficient accounting and reporting arrangements. For procurement, the issues identified were the weak procurement framework and lack of appropriate regulations, documentation and other tools for implementation including insufficient institutional capacity. Furthermore, there is insufficient competition in public biddings reflecting the low confidence of the private sector in the legal and regulatory framework.

4. Using the Financial Management and Internal Control Risk Assessment (FMICRA) table, the overall inherent was assessed to be substantial and the overall control risk was assessed to be moderate. The overall combined risk was also assessed to be moderate. A summary of the risks and mitigating measures are presented in Table 1 below.

5. The GMS Health Security Project when implemented will (i) to prevent or control emerging infectious diseases and other infectious diseases of regional importance in a timely manner, (ii) enable the Viet Nam diagnostic system to provide accurate results in a safe and timely manner, thereby improving the health of patients and providing value for money and (iii) reducing the risk of nosocomial infection and increasing drug resistance by improving biosafety. Although several financial management risks were identified, the proposed mitigating measures are assessed to be sufficient for the satisfactory implementation of the project.

Table 1: Summary of Risks and Mitigating Measures

Weakness	Risk Rating	Mitigating Measure
Staffing - lack of qualified staff to implement financial management responsibilities in the provinces	High	Outsource the staff needed in each province to support the PPPIU. All the staff need to undergo intensive training in ADB procedures including but not limited to financial management and procurement
Internal Control – internal and external audit issues and recommendations have not been acted upon	High	Rigorous monitoring by MOH and MOF of any current internal and external audit observations and issues should be resolved quickly.
Information System – manual accounting system and the use of MS excel in the generation of financial reports is prone to errors and fraud	Substantial	MEF should hasten the implementation of the FMIS to include all ministries and their provincial departments.

Source: Consultant’s Assessment

I. Introduction

1. This Financial Management Assessment (FMA) for the GMS Health Security Project (the Project) of the Ministry of Health (MOH), Lao PDR, was prepared in accordance with ADB's Technical Guidance Note for financial management[1]. The FMA includes a review of the accounting and reporting system, internal and external auditing arrangements, fund disbursement procedures, and information systems. The instrument used for the assessment was Asian Development Bank's (ADB) financial management assessment questionnaire (FMAQ). This FMA incorporates the Financial Management Internal Control and Risk Management Assessment required by the Guidelines. The completed FMAQ is in Appendix 1.

2. This assessment was prepared during the scoping phase of the TA preparation from October 17 to 28, 2015. Preparation activities included reviewing documents, interviewing and discussing issues with counterparts from MOH, PHDs and development partners. A Financial Management Assessment was conducted in November 2014 for the MOH as part of Lao Health Sector Governance Program (HSGP). Since the FMA for HSGP is very recent, the HSGP FMA was also used for the GMSHSP FMA report. The GMSHSP FMA also made extensive use of the assessment report based on the Public Expenditure and Financial Accountability (PEFA) assessment developed by the World Bank in collaboration with other development partners as well as the ADB Country Partnership Strategy for Lao PDR.

II. Project Description

3. It is proposed that ADB help finance the Project through a loan amounting to about US$ 4 million from the Asian Development Fund (ADF) and an additional ADB grant amounting to US$ 8 million. The Project will be implemented over a 5-year period. The Government of Lao will likewise contribute parallel financing of about $ 0.6 million equivalent to about 5% of the total project cost. The total Project cost is estimated to be about $ 12.6 million.

4. The MOH is the executing agency (EA) represented by the Department of Planning and International Cooperation (DPIC) and the Provincial Health Departments (PHDs) as the implementing agencies for the proposed GMS Health Security Project (the Project). About 12 provinces were identified to be the beneficiaries of the project. As the EA, MOH will oversee the implementation of the Project and support the outputs covering; (i) regional cooperation and CDC in border areas; (ii) national strengthening of surveillance and response; (iii) improving laboratory services and infection control.

III. Country and Sector level Issues

A. Public Financial Management

5. The World Bank (WB) using the Public Expenditure Financial Accountability (PEFA) PFM Performance Measurement Framework in 2010 last assessed country public

[1] ADB. 2105. *Financial Management Assessment Technical Guidance Note.*

financial management (PFM) arrangements in Lao PDR.[2] This was the first comprehensive diagnosis of PFM in Lao PDR that had been prepared with the objective of providing government with a concise, standardized and objective assessment of PFM and to highlight the issues against which future improvements in PFM can be gauged. Under the PEFA framework, performance is assessed in relation to seven dimensions of public financial management using 28 indicators which are scored from A (best) to D (worse).[3] A summary of the 2010 PFM assessment framework is presented in the Table 1 below.

Table 1: Lao PDR PFM Assessment Systems, Processes and Institutions

SUMMARY OF PERFORMANCE MEASUREMENT FRAMEWORK		Score
A. PFM outturns: Credibility of the budget		
PI-1	Aggregate expenditure out-turn compared to original approved budget	B
PI-2	Composition of expenditure out-turn to original approved budget	NR
PI-3	Aggregate revenue out-turn compared to original approved budget	A
PI-4	Stock and monitoring of expenditure payment arrears	C+
B. Key cross-cutting issues: Comprehensiveness and transparency		
PI-5	Classification of the budget	C
PI-6	Comprehensiveness of information included in budget documentation	B
PI-7	Extent of unreported government operations	D+
PI-8	Transparency of intergovernmental fiscal relations	D
PI-9	Oversight of aggregate fiscal risk from other public sector entities	D+
PI-10	Public access to key fiscal information	C
C. Budget execution		
C. (i) Policy-based budgeting		
PI-11	Orderliness and participation in the annual budget process	C+
PI-12	Multiyear perspective in fiscal planning, expenditure policy, and budgeting	D+
C. (ii) Predictability and control in budget execution		
PI-13	Transparency of taxpayer obligations and liabilities	D+
PI-14	Effectiveness of measures for taxpayer registration and tax assessment	C
PI-15	Effectiveness in collection of tax payments	NR
PI-16	Predictability in the availability of funds for commitment of expenditures	B+
PI-17	Recording and management of cash balances, debt, and guarantees	D+
PI-18	Effectiveness of payroll controls	C+
PI-19	Competition, value for money, and procurement controls	D+
PI-20	Effectiveness of internal controls for non-salary expenditure	D+
PI-21	Effectiveness of internal audit	D
C. (iii) Accounting, recording, and reporting		
PI-22	Timeliness and regularity of accounts reconciliation	C
PI-23	Availability of information on resources received by service delivery units	D
PI-24	Quality and timeliness of in-year budget reports	C+
PI-25	Quality and timeliness of annual financial statements	D+
C. (iv) External scrutiny and audit		
PI-26	Scope, nature, and follow-up of external audit	D+

[2] The Lao PDR Public Expenditure and Financial Accountability (PEFA) Public Financial Management Assessment, World Bank, June 2010, with the support of the World Bank. Australian Government Aid Program, EU, Swiss Agency for Development and Cooperation, and SIDA.

[3] Credibility of the budget; comprehensiveness and transparency; degree to which the budget is prepared with due regard to: government policy; predictability and control in budget execution; accounting, recording and reporting; external scrutiny and audit operations; appropriateness of development partner practices in country; and intergovernmental fiscal relationships

PI-27	Legislative scrutiny of the annual Budget Law	C+
PI-28	Legislative scrutiny of external audit reports	C+
D. Donor practices		
D-1	Predictability of Direct budget Support	D+
D-2	Donor information for budgeting and reporting on project/program aid	C+
D-3	Proportion of aid managed by national procedures	D

Source: Lao PDR PEFA report 2010

6. The results of the PEFA assessment above highlighted the poor performance of PFM in the country with only one category receiving an "A" (revenue matches to the approved budget) and most scores are at the lower end of the range with mostly Ds and Cs. This highlights the challenges faced in PFM in Lao. The report concluded that[4]:

- In recent years the PFM system had been reasonably effective in maintaining macro fiscal discipline, allowing an improvement in the external debt position and the need for cash rationing (which may not have persisted in the tightening fiscal situation in 2013-14).

- Excessive decentralization of authority to the province is being corrected, but it was noted that significant expenditure is financed by users' fees and charges in the provinces (especially in the health sector) that remain outside of the budget and that domestically financed investment projects are undertaken without any effective central control.

- The PFM system is not well adapted to secure the optimum allocation of resources to contribute to economic growth and improvement in public services, although it is acknowledged that the government is taking steps to remedy this issue.

- The separate planning of recurrent and capital expenditures, the absence of articulated programs for the development of most public services taking account of current and capital resources, and detailing of specific outputs to be achieved, shows the need for better strategies for the allocation of resources. The fact that SOEs do not publish audited accounts is also noted.

- Service delivery is constrained by a lack of resources, weak policy based budgeting, uncompetitive procurement practices, and a lack of information and scrutiny of the results achieved.

7. However, it should be acknowledged that the Government is embarking on plans to improve PFM through the Public Financial Management Strengthening Program (PFMSP) to address the various problems with the support of the WB and other development partners. These include the introduction of VAT, widening the tax base, output budgeting and other PFM functions. Support has been provided to building capacity in the health sector PFM through additional technical assistance, such as the ADB-funded CDTA 7446.[5]

[4] Proposed Policy Based Loan, Lao PDR, Health Sector Governance Program, Financial Management Assessment, November 2014

[5] CDTA 7446-LAO: Building Capacity for the Health Sector Program Approach, 2010 - 2011

B. ADB Country Partnership Strategy[6]

8. **Risks.** The CPS assessed the major governance-related risks to be in public finance management, procurement and corruption. PFM issues include weakness in institutional arrangements and capacity; comprehensiveness and transparency in budget formulation and weak execution of the budget. It was noted that institutional arrangements and capacity could be mitigated and addressed by supporting reforms and capacity building in public expenditure management; focus on strengthening central and provincial government capacity to strengthen budget planning, formulation and execution. With regards to the budget, Lao PDRs budget has become more credible through government's medium term fiscal framework utilizing multiyear projections of government revenue, expenditure and financing accounts; treasury reform through improved chart of accounts. The government's continuing implementation of an electronic financial information system for the past 10 years have also contributed to the improving credibility. Despite these improvements however, the coordination between MPI and MOF remains weak. Furthermore, budget execution remains weak as a result of the deficient accounting and reporting arrangements.

9. For procurement, the issues identified were the weak procurement framework and lack of appropriate regulations, documentation and other tools for implementation including insufficient institutional capacity. Furthermore, there is insufficient competition in public biddings reflecting the low confidence of the private sector in the legal and regulatory framework. To mitigate against these risks, the government of Lao created the new Procurement Management Office that has oversight over all procurement in the country. The Office also issued a national procurement manual and standard bidding documents as well as a procurement capacity building program. Further improvements on procurement were the creating of a website designed to inform the public of planned procurements and results of completed procurements. All this is designed to provide greater assurance of effective competition.

10. The CSP also identified corruption as a high risk in Lao particularly on the legislative framework and the integrity and capacity of institutions. In 2010, Transparency International ranked Lao PDR 154 out of 178 countries in its corruption perception index. In 2011 Lao PDR ranked 171 out of 183 countries in ease of doing business. All these were due to the highly bureaucratic and underperforming civil service, weak judicial system, poor legislative oversight and the lack of empowerment of civil society. The decision making process and structures lack transparency and accountability. Several mitigating measures were adopted (i.e. the anticorruption decree in 1999, several other anticorruption laws in 2005; the UN convention against corruption in 2009, the new State Audit Law), however despite these measures, corruption risk remains high. Overall, the ADB CSP assessed the risks to be high in all areas. The PFM weaknesses will take a long time to be fully addressed given the capacity constraints, weak audit oversight and institutions, thus improvements in PFM will have to be made in the future.

[6] Lao PDR Country Partnership Strategy 2012-2016

IV. Project Financial Management System

A. Overview

11. The executing agency for the proposed GMSHSP will be the Ministry of Health through the Department of Planning and International Cooperation (DPIC). The Department of Planning and Finance (DPF) of DPIC is well organized and has good experience in implementing ODA loan project including those funded by ADB[7]. The implementing agency for the project will be the provincial departments of health in 12 provinces.

12. A central project management unit (CPMU) will be created within the DPIC to manage the project. The current CPMU in the CDC2 project may be maintained to continue the implementation of the proposed GMS Health Security project. To implement the projects in the provinces, a PPIU will be created in each of the 12 provinces covered by the project. Both international and national consultants will support the CPMU and PPIUs. A total of 43 person months of international and 100 person months of national consultants will be hired. The consultants will be based mostly in the central level but will conduct regular visits to the provinces.

13. The consulting team will be headed by a Chief Technical Adviser to be based in Vientiane over the five-year implementation period. The other team members will be composed of laboratory, gender and procurement specialists. The financial management of the project will be managed by the Department of Planning and Finance of DPIC and oversee the financial management arrangements in the PPIUs.

B. Strengths

14. The current PMU finance staff under DPIC has extensive experience in the accounting, disbursement procedures and procurement having implemented CDC1 and CDC2 project for the ADB. The skills and capacity at the central level that were developed will be relied upon in the implementation of the proposed GMSHSP.

C. Weaknesses

15. The major weaknesses identified in the project financial management are:

Staffing. Although the skills and capacity of the staff at the central level have been developed through involvement in previous ADB projects, the same cannot be said for the provinces. Since the provinces will be the beneficiaries of the project, the personnel that will be hired to implement the project will have to undergo intensive training on all ADB procedures after loan effectiveness.

Internal Controls. Internal and external audits are an essential part of internal controls and audit observations should be immediately acted upon. Frequent monitoring of internal and external audit issues by MOF should be conducted to ensure that all audit findings are acted upon.

[7] CDC1 and CDC2

Information Systems. The manual accounting system and using MS Excel to generate financial reports is inefficient and prone to errors making the financial statements unreliable. The implementation of the electronic financial management system as part of the PFMSP has been slow. In 2015, MOF approved the use of customized accounting software for MOH but the use is limited to the central level. The software will integrate all accounting and financial reporting requirements for the ministry including in the provincial and district levels. To date only four provinces have undergone training on the software.

D. Personnel, Accounting Policies and Procedures, Internal and External Audit

Personnel. The Department of Planning and Finance (DPF) staff at MOH have experience in implementing two ADB projects[8] but although familiar with ADB guidelines, the competency level remains low in areas of accounting and budgeting. The FMA also indicated that the accounting and finance functions in the PHDs have limited capable staff with accounting knowledge. Therefore if PHDs will receive increased funds from the project, the risk is high that financial management of the project will not meet ADB requirements. PHD finance staff have limited experience in the accounting and disbursement procedures. This is because the staff do not possess the formal education in accounting and English language proficiency to understand international accounting and financial reporting standards. It is proposed that MOH as the EA should enable staff of the PHD to be have intensive training on all ADB procedures including but not limited to financial management and disbursement. Furthermore, once the new MOH FMIS becomes fully operational, MOH DPF should conduct intensive training on the use of the software. Additional staff should also be hired on contractual basis for the duration of the project since PHD cannot provide the manpower to fill up all staff positions in the PPPIU.

16. For the proposed GMS Health Security Project, the DPF is again expected to manage all financial management issues but as noted above, the staff competency in the central and provincial levels should be improved through more rigorous training in financial management, English language proficiency and increasing the number of staff, including outsourcing, to meet the expected increased responsibilities.

17. **Internal Audit.** There is an internal audit division within MOH and in each PHD. However, the internal audit staff has limited knowledge and skills in accounting and finance[9]. The country partnership strategy highlighted that one of the mitigating measures to the governance related risks was to enhance financial controls, particularly internal and external controls and reinforcing capacity[10].

18. **External Audit.** External audits of government entities including line ministries and provinces is undertaken by the SCO. Previous audit reports from 2010-2013 on MOH including the PHDs concluded that there were issues related to internal control and financial control, preparation of financial statements, delays in budget approval, clearing of cash advances, replenishment of imprest account, lack of supporting documentation for procurement and management of fixed asset register.

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[8] CDC1 and CDC2.

[9] Proposed Policy Based Loan, Lao PDR, Health Sector Governance Program, Financial Management Assessment, November 2014

[10] Proposed Policy Based Loan, Lao PDR, Health Sector Governance Program, Financial Management Assessment, November 2014

E. Financial Reporting Systems

19. MOH shifted to using accrual accounting method and more recently in 2015 started testing a customized accounting software that was specifically designed for MOH and approved by the MOF. DPF staff worked closely with MOF in the development of this software. The accounting software will integrate all accounting and financial reporting requirements for the ministry including in the provincial and district levels. To date about four provinces including at the district level are undergone training on the software and more are scheduled in the coming months. It is anticipated that the software will be fully operational throughout MOH, provinces and districts by 2016.

F. Disbursement Arrangements and Funds Flow

20. The loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2012, as amended from time to time). Direct payment procedures will generally be used for contracts for the supply of goods and equipment and for consulting services contracts. An imprest account will be used for payment of eligible expenditures rather than reimbursement.

21. Funding for the GMSHSP will be similar to CDC2. Two US dollar denominated imprest accounts will be opened for the project with the Bank of Lao PDR (BOL) to distinguish between loan funds from grant funds and for ease in monitoring and audit. The first of the US$ denominated account (FGIA)[11] will receive ADB loans funds for the project. The second account is also an FGIA will receive ADB grant funds. Subsequently, two more accounts but denominated in the local currency will be opened with the BOL to receive converted US$ loan and grant funds when needed. A counterpart FGIA account will be opened by the MOF through the national treasury to distinguish ADB funds from government counterpart contribution for the project. The counterpart FGIA funds will be managed by the MOF. The amount limits for the FGIA will be the same as in CDC2. The proposed GMSHSP funds flow is shown in Appendix 1.

22. The PPPIU of each PHD will likewise open an account, a second generation imprest account (SGIA)[12], to receive and disburse funds coming from the two FGIAs. The account will be opened in a commercial bank that is acceptable to PMU. The limits and fund replenishment policy and procedures for the SGIA will be the same as in CDC2. The PHDs will likewise open another account for counterpart funds coming from the provincial budget.

V. Risk Description and Rating

Risk Description	Impact	Likelihood	Risk Assessment	Mitigation Measure
Inherent Risk				
1. Country Specific -				

[11] First generation imprest account

[12] Second generation imprest accounts are exclusive for provinces to distinguish from FGIA accounts that are exclusive to MOH.

1.1. Weak Public Financial Management, lack of transparency, accountability, weak governance at all levels and fragmented linkages with central government.	Substantial	Likely	Substantial	Implement reforms supported by HSGP to address the core issues of PFM.
1.2. Weak planning and budgeting, low level of government budget allocation will undermine the sustainability of project investments.	Moderate	Likely	Moderate	Support to "bottom up" provincial planning and budgeting processes to ensure that funds are adequate and provided on a timely basis. Conduct multi-year planning and budgeting to allow strategic allocation of resources.
1.3. Transparency and accountability risks with limited reporting and monitoring of the funds received and disbursed by the project	Substantial	Likely	Substantial	Good governance developed through a comprehensive TA support to the reform program and development of financial accounting reporting and verification of the source and application of funds.
2. Entity Specific – Management and skills capacity in financial management is low	Substantial	Likely	Substantial	Targeted training and capacity building to the PHDs to address low levels of skills and competency in financial management
Overall Inherent Risk			**Substantial**	
Control Risk				
1. Implementing Entity – Financial management policies are inadequate for the project and the lack of control at the central level over investments made in the provinces	Moderate	Likely	Moderate	• Regular monthly coordination meetings between MOH and PHDs to thresh out problems early to avoid delays in project implementation • Regular training by MOF and ADB on financial management policies and procedures to upgrade staff capacity
2. Funds Flow - Counterpart funds in provinces will not be adequate and available on a timely basis	Low	Likely	Low	PMU should guide provinces in conducting multi-year planning and budgeting
3. Accounting Policies and Procedures – the accounting system and chart of accounts is not adequate for the efficient and effective management of the project	Low	Likely	Low	Hasten implementation of the new FMIS supported by training and follow up support. Insurance should not be limited to vehicles. It should include all laboratory equipment that will be procured by the project.
4. Staffing - Lack of qualified personnel in the province and district level to implement the project	High	Likely	High	A comprehensive training package will be provided to provincial and district staff in accounting, financial reporting and procurement
5. Internal Audit – Internal audit issues and recommendations have not been acted upon	High	Likely	High	Rigorous monitoring by MOH of any current internal audit observations and issues should be resolved quickly.
6. External Audit - The PHDs and project activities are subject to annual audit by the SCO as part of government's governance process, and audit report are shared with ADB, but issues of PFM are not being seriously addressed. Furthermore, SCO is a relatively new organization and lacks resources.	High	Likely	High	Audit reports and findings should be monitored and to immediately address issues identified.

7. Reporting and Monitoring – Manual recording and reporting of transactions is slow and affects the preparation of timely financial reports	Moderate	Likely	Moderate	PMU should use computerized accounting system for more accuracy and increased efficiency
8. Information Systems – the use of MS excel in the generation of financial reports is prone to errors and fraud	Substantial	Likely	Substantial	MEF should hasten the implementation of the FMIS to include all ministries and their provincial departments.
Overall Control Risk			**Moderate**	
Overall (Combined) Risk			**Moderate**	

Source: Consultant's Assessment

VI. Proposed Time-Bound Action Plans

23. The following initial Financial Management Action Plan has been prepared based on the basic principles of sound financial management practices in the areas of (i) internal control, (ii) funds flow, (iii) accounting and financial reporting, (iv) and independent audits. This plan will be updated annually based on discussions with the government as well as based on the results of the annual fiduciary reviews conducted.

Weakness	Mitigating Action	Responsibility	Timeframe
Financial management and staff capacity is low	Intensive training on ADB procedures to include but not limited to financial management and procurement	ADB	• Within six months of loan effectiveness • Staff recruitment within three months of loan effectiveness. In the first year, the staff will be guided by the implementation consultants. During the second year, the staff take over but with supervision from consultants. From the third year onwards by the staff.
Internal control - Internal and external audit issues and recommendations are not immediately acted upon	Rigorous monitoring by MOH of any current internal audit observations and issues should be resolved quickly.	MOH	Quarterly during the first year of project implementation and semi-annual until the end of the project

Source: Consultant's Assessment

VII. Suggested Financial Management Covenants

24. The following are the suggested to be included as part of the financial management covenants:

a) MOH through the CPMU will engage the services of an auditing firm to conduct annual external audit of the project and to submit the report within six months after the end of the fiscal year.
b) MOH and PHDs to conduct multi- year planning activities every year as part of the MOH budget preparation process. CPMU will submit to MOH and ADB a report on

the results of the multiyear planning exercise. At the end of the year CPMU will conduct an assessment of the accomplishments made against targets, identify problems encountered and the corrective actions made.

VIII. Conclusion

25. The GMS Health Security Project when implemented will (i) to prevent or control emerging infectious diseases and other infectious diseases of regional importance in a timely manner, (ii) enable the Viet Nam diagnostic system to provide accurate results in a safe and timely manner, thereby improving the health of patients and providing value for money and (iii) reducing the risk of nosocomial infection and increasing drug resistance by improving biosafety. Although several financial management risks were identified, the proposed mitigating measures are sufficient for the satisfactory implementation of the project.

Appendix 1

Table 2: Financial Management Assessment Questionnaire[13]

Topic	Response	Remarks
1. Implementing Agency		
1.1 What is the entity's legal status / registration?	Legal status of Department of Finance is operated accordingly with the role and function stipulated in the Health Ministerial Decree No o76 dated 10 January 2013	
1.2 How much equity (shareholding) is owned by the Government	Not Applicable	
1.3 Obtain the list of beneficial owners of major blocks of shares (non-government portion), if any	Not Applicable	
1.4 Has the entity implemented an externally-financed project in the past (if so, please provide details)?	Yes CDC1 and CDC2	
1.5 Briefly describe the statutory reporting requirements for the entity?	the statutory reporting requirements for the entity are: Monthly, quarterly, semester, annually reporting	
1.6 Describe the regulatory or supervisory agency of the entity	NA	
1.7 What is the governing body for the project? Is the governing body for the project independent?	Not independent	
1.8 Obtain organizational structure and describe key management personnel. Is the organizational structure and governance appropriate for the needs of the project?	See appendix 3	
1.9 Describe the code of ethics in place?	NA	
1.10 Describe (if any) any historical issues reports of ethics violations involving entity and management. How were they addressed?	NA	
2. Funds Flow Arrangements		
2.1 Describe (proposed) project funds flow arrangements in detail, including a flow of funds diagram and explanation of the flow of funds from ADB, government and other financiers to the government, EA, IA, suppliers, contractors, ultimate beneficiaries	See Appendix 2 for the chart. Impress account in BOL managed by Ministry of Finance and transfer to subaccount of project in BCEL and paid directly to project activities	
2.2 Are the (proposed) arrangements to transfer the proceeds of the loan (from the government / Finance Ministry) to the entity satisfactory?	Yes satisfactory	
2.3 Are the disbursement methods appropriate	Yes	

[13] The responses to this questionnaire describe the existing situation in the Ministry of Finance and Treasury (MOFT) under its present legal status, structure and staffing.

Topic		Response	Remarks
2.4	What have been the major problems in the past in receipt of funds by the entity?	T No major problems in the past in receipt of funds by the entity	
2.5	In which bank will the Imprest Account be opened?	Bank of Lao (BOL); Subaccounts in BCEL	
2.6	Is the bank in which the imprest account is established capable of – • Executing foreign and local currency transactions • Issuing and administering letters of credit • Handling large volume of transactions • Issuing detailed monthly bank statements promptly	NA	
2.7	Is the ceiling for disbursements from the imprest account and SOE appropriate/ required?	NA	
2.8	Does the (proposed) project implementing unit (PPIU) have experience in the management of disbursements from ADB?	NA	
2.9	Does the PPIU have adequate administrative and accounting capacity to manage the imprest fund and statement of expenditure (SOE) procedures in accordance with ADBs loan disbursement handbook. Identify any concern or uncertainty about the PPIUs administrative and accounting capability which would support the establishment of a ceiling on the use of the SOE procedure.	Yes the project implementing unit (PPIU) has experience in the management of disbursements from ADB	
2.10	Is the entity exposed to foreign exchange risks? If yes describe the entity's policy and arrangements for managing foreign exchange risk	No capacity to manage foreign exchange risk	
2.11	How are the counterpart funds accessed?	In kind not in cash	
2.12	How are payments made from the counterpart funds?	The counterpart fund is paid in form of in kind e.g. tax exception, labor, venue location	
2.13	If part of the project is implemented by communities or NGOs, does the PPIU have the necessary reporting and monitoring features built into its systems to track the use of project proceeds by such agencies?	The PPIU have not the necessary reporting and monitoring features built into its systems to track the use of project proceeds by such agencies	
2.14	Are the beneficiaries required to contribute to project costs? If beneficiaries have an option to contribute in kind (in the form of labor), are proper guidelines formulated to record and value the labor contribution?	It will be very good in case of this feasible in order to mobilize the community participation in the project activity implementation. After that the community labor participation should be financially evaluated accordingly with the labor law.	

Topic		Response	Remarks
3.	**Staffing**		
3.1	What is the (proposed) organizational structure of the accounting department? Attach an organization chart.	Mr. Anoulat Phengsomphan, Head of accounting Finance for CDC2 Mr. Somphone Chanthavong CDC2 Assistant Ms. Laylai vongsoulack Accounting finance staff See appendix 3	
3.2	Will existing staff be assigned to the project or will new staff be recruited	Yes	
3.3	Describe the (proposed) accounts staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions and CVs of key accounting staff.	See appendix 3 For job description	
3.4	Is the project finance and accounting function staffed adequately?	Yes the project finance and accounting function staffed adequately	
3.5	Are the finance and accounts staff adequately qualified and experienced?	Yes the finance and accounts staff adequately qualified and experienced	
3.6	Are the project accounts and finance staff trained in ADB procedures?	Yes the project accounts and finance staff trained in ADB procedures	
3.7	What is the duration of the contract with the finance and accounts staff?	The duration of the contract with the finance and accounts staff is 1 year contract and renewable	
3.8	Identify key positions not contracted yet, and the estimated date of appointment.	All key positions are subject to contract.	
3.9	For new staff, describe the proposed project finance and accounting staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions	NA	
3.10	Does the project have written position descriptions that clearly define duties, responsibilities, lines of supervision, and limits of authority for all of the officers, managers, and staff?	Yes the project have written position descriptions that clearly define duties, responsibilities, lines of supervision, and limits of authority for all of the officers, managers, and staff	
3.11	What is the turnover rate for finance and accounting staff?	No transfer of personnel transfer until the end of project	
3.12	What is training policy for the finance and accounting staff?	Allocation of per-diem and some material facilities.	
3.13	Describe the list of training programs attended by finance and accounting staff in the last 3 years	NA	

	Topic	Response	Remarks
4.	**Accounting Policies and Procedures**		
4.1	Does the entity have an accounting system that allows for the proper recording of project financial transactions, including the allocation of expenditures in accordance with the respective components, disbursement categories, and sources of funds? Will the project use the entity accounting system?	DPF follows the state accounting system. Using government chart of accounts. For the project, it use entity accounting system to be in line with MOH	
4.2	Are controls in place concerning the preparation and approval of transactions, ensuring that all transactions are correctly made and adequately explained?	Yes there are controls in place concerning the preparation and approval of transactions, ensuring that all transactions are correctly made and adequately explained	
4.3	Is the chart of accounts adequate to properly account for and report on project activities and disbursement categories?	Yes the chart of accounts adequate to properly account for and report on project activities and disbursement categories if not it will rejected by parties concerned	
4.4	Are cost allocations to the various funding sources made accurately and in accordance with established agreements?	Yes the allocations to the various funding sources made accurately and in accordance with established agreements	
4.5	Are the General Ledger and subsidiary ledgers reconciled and in balance?	Yes the General Ledger and subsidiary ledgers reconciled and in balance. It also reconciled with Bank Statement and with ADB on monthly period	
4.6	Describe the EAs policy for retention of accounting records including supporting documents (e.g. ADBs policy requires that all documents should be retained at least 1 year after ADB receives the audited project financial statements for the final accounting period of implementation, or 2 years after the loan closing date whichever is later). Are all accounting and supporting documents retained in a defined system that allows authorized users' access?	Yes all accounting and supporting documents retained on a permanent basis in a defined system that allows authorized users easy access and has to keep all documents related to finance at least 10 years	
4.7	Describe any previous audit findings that have not been addressed	NA	

Topic	Response	Remarks
Segregation of Duties		
4.8 Are the following functional responsibilities performed by different units or persons: (i) authorization to execute a transaction; (ii) recording of the transaction; and (iii) custody of assets involved in the transaction?	Yes : (i) authorization to execute a transaction; (ii) recording of the transaction; and (iii) custody of assets involved in the transaction are performed by different units or persons	
4.9 Are the functions of ordering, receiving, accounting for, and paying for goods and services appropriately segregated?	Yes there is segregation of functions of ordering, receiving, accounting for, and paying for goods and services appropriately.. • Accounting division proceeds to enter the account • Administration Division manages the merchandises in the stock and the services in the department	
Budgeting System		
4.10 Do budgets include physical and financial targets?	Yes the budgets include physical and financial targets	
4.11 Are budgets prepared for all significant activities in sufficient detail to provide a meaningful tool with which to monitor subsequent performance?	Yes budgets are prepared for all significant activities in sufficient detail in order to monitor subsequent performance	
4.12 Are actual expenditures compared to the budget with reasonable frequency, and explanations required for significant variations from the budget?	Yes the actual expenditures compared to the budget with reasonable frequency, and explanations required for significant variations from the budget By using the form F4.	
4.13 Are approvals for variations from the budget required in advance or after the fact?	Yes approvals for variations from the budget required in advance. Most of them are concerned with small activities.	
4.14 Is there a ceiling, up to which variations from the budget may be incurred without obtaining prior approval	NA	
4.15 Who is responsible for preparation and approval of budgets?	For small activities is the person who is responsible on these activities to prepare budget and submit to project manager. For annual budget is the planning unit to prepare and submit to the approval of project managers	

Topic	Response	Remarks
4.16 Describe the budget process. Are procedures in place to plan project activities, collect information from the units in charge of the different components, and prepare the budgets?	Yes	
4.17 Are the project plans and budgets of project activities realistic, based on valid assumptions, and developed by knowledgeable individuals? Is there evidence of significant mid-year revisions, inadequate fund releases against allocations, or inability of the EA to absorb/spend released funds? Is there evidence that government counterpart funding is not made available adequately or on a timely basis in prior projects? What is the extent of over-or-under budgeting of major heads over the last 3 years? Is there a consistent trend either way?	Yes the project plans and budgets of project activities realistic, based on valid assumptions, and developed by knowledgeable individuals	
Payments		
4.18 Do invoice-processing procedures provide for: (i) Copies of purchase orders and receiving reports to be obtained directly from issuing departments? (ii) Comparison of invoice quantities, prices and terms, with those indicated on the purchase order and with records of goods actually received? (iii) Comparison of invoice quantities with those indicated on the receiving reports? (iv) Checking the accuracy of calculations?	Yes Copies of purchase orders and receiving reports to be obtained directly from issuing departments there is comparison of invoice quantities, prices and terms, with those indicated on the purchase order and with records of goods actually received and comparison of invoice quantities with those indicated on the receiving reports and finally we have also checking the accuracy of calculations.	
4.19 Are all invoices stamped PAID, dated, reviewed and approved, and clearly marked for account code assignment?	Yes all invoices stamped PAID, dated, reviewed and approved, and clearly marked for account code assignment	
4.20 Do controls exist for the preparation of the payroll and are changes to the payroll properly authorized?	Yes the controls exist for the preparation of the payroll and the payroll properly authorized	
Policies And Procedures		
4.21 What is the basis of accounting (e.g., cash, accrual)?	Accounting use accrual basis	
4.22 What accounting standards are followed (International Financial Reporting Standards, International Public Sector Accounting Standards – cash or accrual or national accounting standards or other?	.We base on MOF and ADB or related government rules and procedures	

Topic		Response	Remarks
4.23	Does the project have an adequate policies and procedures manual to guide activities and ensure staff accountability?	Yes the project has an adequate policies and procedures manual to guide activities and ensure staff accountability	
4.24	Is the accounting policy and procedure manual updated for the project activities?	Yes the accounting policy and procedure manual updated for the project activities the last one was made in 15/09/2015	
4.25	Do procedures exist to ensure that only authorized persons can alter or establish a new accounting principle, policy or procedure to be used by the entity?	Yes	
4.26	Are there written policies and procedures covering all routine financial management and related administrative activities?	Yes	
4.27	Do policies and procedures clearly define conflict of interest and related party transactions (real and apparent) and provide safeguards to protect the organization from them?	We base on MOF and ADB or related government rules and procedures	
4.28	Are manuals distributed to appropriate personnel?	Yes manuals distributed to appropriate personnel	
4.29	Describe how compliance with policies and procedures are verified and monitored	NA	
	Cash and Bank		
4.30	Indicate names and positions of authorized signatories in the bank accounts.	Dr. Prasongsith Boupha DG of DPIC and Director of project CDC2, Dr Founkham, Rattanavong DDG of DPIC and Dr. Somphone Phamanixai DDG of Finance.	
4.31	Does the organization maintain an adequate, up-to-date cashbook, recording receipts and payments?	Yes the organization maintain an adequate, up-to-date cashbook, recording receipts and payments	
4.32	Describe the collection process and cash handling procedures. Do controls exist for the collection, timely deposit and recording of receipts at each collection location?	Yes there are controls for the collection, timely deposit and recording of receipts at each collection location	
4.33	Are bank and cash reconciled on a monthly basis or more often? Is cash on hand physically verified and reconciled with the cash books? With what frequency is this done?	Yes	
4.34	Are all reconciling items approved and recorded?	Yes	
4.35	Are all unusual items on the bank reconcilitation reviewed and approved by a responsible official?	Yes	

Topic	Response	Remarks
4.36 Are there any persistent/ non-moving reconciling items?	NA	
4.37 Are there appropriate controls in safekeeping of unused cheques, USB keys and passwords, official receipts and invoices?	NA	
4.38 Are any large cash balances maintained at the head office or field offices? If so, for what purpose?	NA	
4.39 For online transactions, how many persons possess USB keys (or equivalent) and passwords? Describe the security rules on passwords and access controls	NA	
Safeguard over Assets:		
4.40 What policies and procedures are in place to adequately safeguard or protect assets from fraud, waste and abuse?	Yes based on the state property management law updated in 2012. The assets to be registered are: 1) Land and building 2) Vehicle 3) Assets of loan projects 4) Assets (Electrical device) 5) Assets (Furniture)	
4.41 Does the entity maintain a fixed asset registry? Is the register updated monthly? Does the register record ownership of assets, any assets under lien or encumbered or have been pledged	Yes	
4.42 Are subsidiary records of fixed assets, inventories and stocks kept up to date and reconciled with control accounts?	Yes but records are not computerized. For stocks, the records do not include remaining value.	
4.43 Are there periodic physical inventories of fixed assets and stocks?	Yes	
4.44 Are there periodic physical inventories of fixed assets, inventories and stocks reconciled with the respective fixed assets and stock registers and discrepancies analyzed and resolved?	NA	
4.45 Describe the policies and procedures in disposal of assets. Is the disposal of each asset appropriately approved and recorded? Are steps immediately taken to locate lost or repair broken assets?	NA	
4.46 Are the assets sufficiently covered by insurance policies?	Only for vehicles	
4.47 Describe the policies and procedures in identifying and maintaining fully depreciated assets from active assets	NA	
Other Offices and Implementing Entities		
4.48 Describe any other regional offices or executing entities participating in implementation	No	
4.49 Describe staff, their roles and responsibilities in performing accounting and financial management functions of such offices as they relate to the project	NA	

Topic	Response	Remarks
4.50 Has the project established segregation of duties, controls and procedures for flow of funds and financial information, accountability and reporting and audits in relation to the other offices or entities?	Yes	
4.51 Does information among the different offices/ implementing agencies flow in an accurate and timely fashion? In particular, do the offices other than the head office use the same accounting and reporting system?	Yes	
4.52 Are periodic reconciliations performed among the different offices/ implementing agencies? Describe the project reporting and auditing arrangements between these offices and the main executing/ implementing agencies	Yes monthly, quarterly and yearly	
4.53 If any sub-accounts (under imprest account) will be maintained, describe the results of the assessment of the financial management capacity of the administrator of such sub-accounts	NA	
Contract Management and Accounting		
4,54 Does the agency maintain contract wide accounting records to indicate gross value of the contract and any amendments, variations and escalations, payments made, and undisbursed balances? Are the records consistent with physical outputs/ deliverables of the contract	NA	
4.55 If contract records are maintained, does the agency reconcile them regularly with the contractor?	NA	
Other		
4.56 Describe project arrangements for reporting fraud, corruption, waste and misuse of project resources. Has the project advised employees, beneficiaries and other recipients to whom to report if they suspect fraud, waste or misuse of project resources or property?	NA	
5. Internal Audit		
5.1 Is there an internal audit department in the entity?	Yes internal audit division	
5.2 What are the qualifications and experience of audit department staff?	The staff of the audit division have been trained by the State Control Organization and financial management procedures issued by the Ministry of Finance from time to time	
5.3 To whom does the internal auditor report?	The internal auditor reports to DG of DPIC	
5.4 Will the internal audit department include the project in its work program?	Yes	

Topic	Response	Remarks
5.5 Are actions taken on the internal audit findings?	No action have been taken in the past of internal audit but only to provide recommendations and suggestions	
5.6 What is the scope of the internal audit program?	NA	
5.7 Is the IA department independent?	NA	
5.8 Do they perform pre-audit of transactions	NA	
5.9 Who approves the internal audit program	NA	
5.10 What standards guide the internal audit program?	NA	
5.11 How are audit deficiencies tracked?	NA	
5.12 How long have the internal audit staff members been with the organization?	NA	
5.13 Does any of the internal audit staff have an IT background?	NA	
5.14 How frequent does the internal auditor meet with the audit committee without the presence of management	NA	
5.15 Has the internal auditor identified/ reported any issue with reference to availability and completeness of records	NA	
5.16 Does the auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6. External Audit		
6.1 Is the entity financial statement audited regularly by an independent auditor? Who is the auditor?	State control organization	
6.2 Are there any delays in audit of the entity? When are the audit reports issued?	Mostly there not delays and audit reports issued around a week later	
6.3 Is the audit of the entity conducted according to the International Standards on Auditing?	The audit of the entity conducted according to the donor purpose	
6.4 Were there any major accountability issues brought out in the audit report of the past three years?	No	
6.5 Does the external auditor meet with the audit committee without the presence of management?	NA	
6.6 Has the entity engaged the external audit firm for any non-audit engagements (e.g. consulting)? If yes, what is the total value of non-audit engagements, relative to the value of the audit services?	No	
6.7 Has the external auditor expressed any issues on the availability of complete records and supporting documents?	NA	

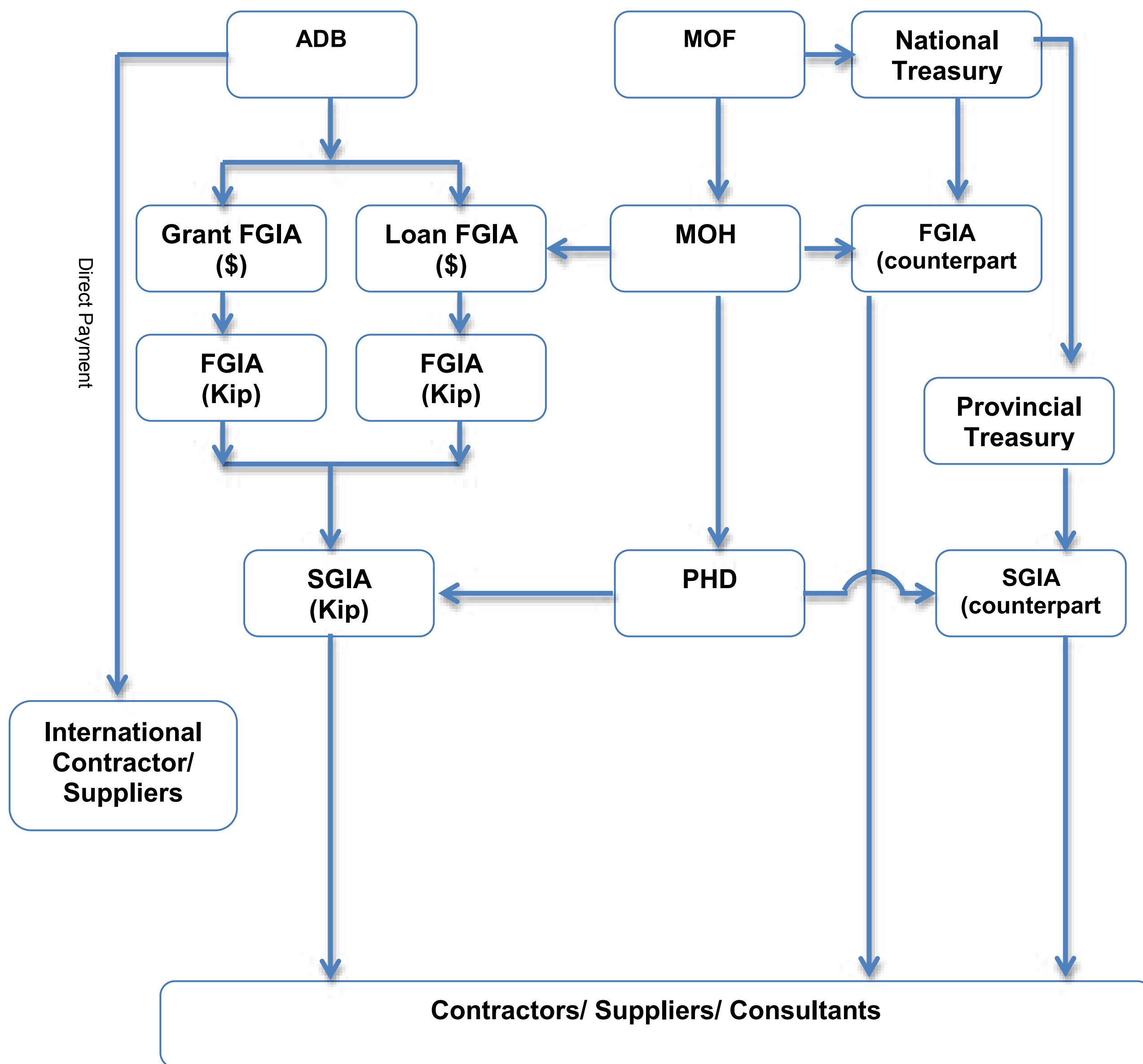
Topic	Response	Remarks
6.8 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures?	NA	
6.9 Are there any material issues noted during the review of the audited entity financial statements that were not reported in the external audit report?	NA	
External Audit – Project Level		
6.10 Will the entity auditor audit the project accounts or will another auditor be appointed to audit the project financial statements	External auditors hired by the project	
6.11 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	Mostly of recommendations have been implemented as required	
6.12 Is the project subject to any kind audit from an independent government entity (e.g. Supreme audit institution) in addition to the external audit?	Only State Control Organization to perform the audit of the whole budget of MOH both project and regular budget.	
6.13 Has the project prepared acceptable terms of reference for an annual project audit? Have these been agreed and discussed with the EA and the auditor?	Yes	
6.14 Has the project auditor identified any issues with the availability and completeness of records and supporting documents?	NA	
6.15 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6.16 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	NA	
6.17 (for second and subsequent projects) Were past audit reports complete and did they fully address the obligations under the loan agreements? Were there any material issues noted during the review of the audited project financial statements and related audit report that have remained unaddressed?	NA	
7. Reporting and Monitoring		
7.1 Are financial statements prepared for the entity? In accordance with which accounting standards?	Yes, and in accordance with ADB project accounting standards.	
7.2 Are financial statements prepared for the implementing unit?	Yes	
7.3 What is the frequency of preparation of financial statements? Are the reports prepared in a timely fashion so as to useful to management for decision making?	The frequency of preparation of financial statements is weekly	

Topic	Response	Remarks
7.4 Does the reporting system need to be adapted to report on the project components?	Yes the reporting system need to be adapted to report on the project components	
7.5 Does the project have established financial management reporting responsibilities that specify what reports are to be prepared, what they are to contain, and how they are to be used?	Yes the project have established financial management reporting responsibilities that specify what reports are to be prepared, what they are to contain, and how they are to be used	
7.6 Are financial management reports used by management?	Yes financial management reports used by management every week	
7.7 Do the financial reports compare actual expenditures with budgeted and programmed allocations?	Yes the financial reports compare actual expenditures with budgeted and programmed allocations	
7.8 How are financial reports prepared? Are financial reports prepared directly by the automated accounting system or are they prepared by spreadsheets or some other means	Financial reports are prepared by spreadsheets	
7.9 Does the financial system have the capacity to link the financial information with the projects physical progress? If separate systems are used to gather and compile physical data, what controls are in place to reduce the risk that the physical data may not synchronize with the financial data?	NA	
7.10 Does the entity have experience in implementing projects of any other donors, co-financiers or development partners	NA	
8. Information Systems		
8.1 Is the financial management system computerized?	Financial management system is made by computer but not yet created computer network as LAN.	
8.2 If computerized, is the software off the shelf or customized?	NA	
8.3 Is the computerized software standalone or integrated and used by all departments in the headquarters and field units using modules	standalone	
8.4 How are the project financial data integrated with the entity financial data? Is it done through a module in the enterprise financial system with automatic data transfer or does it entail manual entry?	NA	
8.5 Is the computerized software used for directly generating periodic financial statements or does it require manual intervention and use of Excel or similar spreadsheet software?	Excel	
8.6 Can the system automatically produce the necessary project financial reports	Yes	

Topic	Response	Remarks
8.7 Is the staff adequately trained to maintain computerized system	Yes	
8.8 Does the management organization and processing system safeguard the confidentiality, integrity and availability of the data?	Yes	
8.9 Are there back-up procedures in place?	NA	
8.10 Describe back up procedures – online storage, offsite storage, offshore storage, fire, earthquake and calamity protection for backups?	NA	

Appendix 2

Proposed Flow of Funds



Appendix 3

Composition of CPMU

	Name	Position
	Dr. Prasongsith Boupha	DG of DPIC
	Dr. Founkham Rattanavong	DDG DPIC
	Dr. Somphone Phangmanixai	DDG DPIC
	Dr. Soutthanou Nanthamontry	Deputy Director of projects
	Dr. Chansaly Phommavong	Deputy Director of projects
International Consultants		
	Dr. Alain Noel	Planning Management Expert
	Mr. Michael O'ROURKE	Consultant of CDCII
Local consultant for CDCII		
	Dr. Phonsavan Phanthaly	Administrator of CDCII project
	Dr. Khampiane Philavong	Training Specialist of CDCII
	Dr. Bounpone Sidavong	Dengue Specialist
	Dr. Ms. Kongxai Luangphengsouk	Outbreak Specialist
	Dr. khamphou Phanakhone	Administrator Assistant of CDCII
Finance Unit of CDCII		
Mr. Anoulat Phengsomphane		Head of Accounting and Finance of CDCII project
Mr. Amphone Khamvixai		Accounting and Finance CDCII
Ms. Lelai Vongsoulack		Accounting and Finance staff CDCII

Appendix 4

Job Descriptions for Financial staffs of Project Management Unit (PMU) of CDCII
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A. POSITION: Senior Accounting Supervisor Part time. Mr. Vannavong

Responsibility:
To supervise the accounting staff in the Second Greater Mekong Subregion Communicable Diseases Control Project
Tasks

1. Develop Project Financial Management procedure
2. Assure that all staff fulfills their responsibilities in accordance with their scope of work
3. Guarantee accuracy and timeliness of finance and accounting data and timely submission of monthly financial report to the project director.
4. Monitor Contract awards and disbursements in accordance with the budget in the grant agreement.
5. Assure that all audit recommendations are incorporated into the accounting system and implemented.

Qualifications:

- Requires a degree in accounting and at least 10 years senior-level accounting experience
- Require knowledge of generally accepted accounting principles and practical knowledge of financial systems, internal financial controls and procedures
- Must be a good problem solver, analytical, creative and innovative
- English language ability is a requirement.

B. POSITION: Chief Accountant – Full time Mr Anoutalth Phengsomphane

Responsibility: Managing the financial accounts of the Second Greater Mekong subregion Communicable Diseases Control Project
Tasks:

1. Monitor and record all financial transactions made by:
    - ADB via Direct Payment
    - MOF via imprest Account
    - Project Management Executing Agency via EA sub-account
    - Province via Provincial advances
2. Supervise accountant that manage provincial advances for 12 provinces,
3. Provide training and supervision for accountants in 12 provinces,
4. Prepare documentation required to replenish the EA subaccount
5. Prepare withdrawal applications required to replenish the EA sub-account
6. Prepare requests for payment for signature by appropriate signatories
7. Prepare consolidated financial statement on a monthly basis
8. Prepare weekly financial reports required by the project
9. Prepare documentation for project external audit.

10. Attend and participate in the staff meetings and other corporate functions

Qualifications

- Certified public accountant
- 7 year experience as an accountant
- Previous experience working with foreign assistance preferred
- Good problem solver, analytical, creative and innovative
- Good ability to organize, delegate, and monitor completion of work
- Ability to speak write and read English
- Good knowledge on computer, accounting software, spreadsheets, word processing program
- Ability to travel to provinces for accounting training of project accountant

C. POSITION: Project Accountant- Full time Mr Bounchoy Vannavong report to chief accountant

Responsibility: provide verification, control, analysis, processing and recording of project financial transaction and generating the required financial reports, managing the financial account of provincial advances. Assistant the chief accountant

Tasks

1. Monitor and record all financial transactions in the provincial advances
2. Monitor and support provincial accountant to make monthly financial reports
3. Examine and verify financial statements for the provincial advances submitted by the accountant
4. Encode and enter data from provincial advances into computerized Manila software
5. Prepare documentation required to replenish the provincial advances
6. Assist Chief accountant in accordance with requirements of the project
7. Attend and participate in the staffs meeting and other corporate functions

Qualifications:

- A credential in accounting that demonstrates strong foundation in accounting
- 3 year work experience
- Experience in computer programs: Microsoft Office
- Ability to work in cross cultural situation
- Ability to read write and speak English preferred
- Willingness to assist chief accountant
- Willingness to learn computer accounting system
- Familiarity and working knowledge of spreadsheet computer program (Excel) and word processing program
- Ability to travel to provinces for accounting training of project accountant.

Project Director   Manager ASA

Signed   Signed

FMA Annex 1

Financial Management Assessment
Ministry of Health
Royal Government of Cambodia

March 2016

ABBREVIATIONS

ADB	–	Asian Development Bank
ADF	–	Asian Development Fund
CPS	–	Country Partnership Strategy
DP	–	Development partner
EA	–	Executing agency
FMA	–	Financial Management Assessment
FMAQ	–	Financial management assessment questionnaire
FY	–	Fiscal year
IA	–	Implementing agency
IFAPER	–	Integrated Fiduciary Assessment and Public Expenditure Review
MEF	–	Ministry of Economy and Finance
MOH	–	Ministry of Health
NAA	–	National Audit Agency
PEFA	–	Public Expenditure Financial Accountability
PFM	–	Public Financial management
PFMRP	–	Public Financial Management Report Program
PHD	–	Provincial Heath Department
SNA	–	Sub-National Authorities

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EXECUTIVE SUMMARY

1. The financial management assessment was conducted for the Ministry of Health as the executing agency for the proposed GMS Health Security Project. The FMA was prepared in accordance with ADBs Technical Guidance Note 2015 and incorporates the Financial Management Internal Control and Risk Management Assessment (FMICRA) required by the Guidelines. The assessment also made extensive use of the Integrated Fiduciary Assessment and Public Expenditure Review (IFAPER) for Cambodia in 2011 as well as ADBs Country Partnership Strategy (CPS) for 2014- 2018.

2. In the 2003 IFAPER report, the World Bank concluded that; (i) the PFM system is weak creating unacceptably high levels of fiduciary risk to public funds; and (ii) deficiencies in budget formulation and execution undermine efficiency and effectiveness resulting in the misallocation of resources across sectors and regions over time. To address these issues, the Royal Government of Cambodia (RGC) developed a long-term phased strategy in 2004, the Public Financial Management Reform Program (PFMRP): "Strengthening Governance through Enhanced Public Financial Management". Under the strategy, Cambodia will pursue the long term comprehensive PFMRP through a four-stage strategy spanning a 20 year period. Each stage was designed to change the performance of the PFM system and provide the platform on which further stages could be undertaken. Significant progress has been accomplished in stage 1 and 2 but challenges remain.

3. The latest IFAPER assessment in 2011 using the PEFA framework showed that budget credibility was enhanced after completion of the first stage of the PFMRP in 2008. The result was improved cash management resulting in greater predictability, reliability and availability of financial resources. Despite the significant improvements in cash management, PEFA noted that weaknesses in the PFM remain and a number of issues related to cash flow forecasting have serious implications for ensuring significant resources are on hand to meet the government's cash flow requirement. The report concluded that, (i) The financial management information system (FMIS) should be implemented in key ministries to control spending and prioritize expenditures across programs, projects and policies; (ii) As with many developing member countries, RGC has a shortage of technical skills. Despite on-going capacity building efforts, management skills capacity remains weak and impacts the progress on the PFMR; (iii) The public procurement system is fragmented mainly due to separate legal and regulatory framework for procurement using government funds and external donors; (iv) Internal controls remain weak. MEF has developed templates for audit reports but these are not uniformly used in line ministries and the improvements are largely due to donor reporting requirements rather than those of the government.

4. The ADB Country Partnership Strategy assessed the major governance-related risks to be in public finance management, procurement and corruption. Although gradually improving, the PFM systems remain weak due to low transparency and accountability resulting from (i) the continuation of a centralized budget management with the MEF; (ii) the delay in the transfer of functions and resources to SNAs is also holding back the build up of capacity in the SNAs thus increasing the risks for management of donor projects that have been assigned to the SNAs; (iii) internal audit and internal controls remain weak leading to less effective and transparent business processes icluding procurement; (iv) external audit remains weak due to the inadequacy of the NAAs to provide effective oversight of public expenditures. For procurement, the issues identified were the lack of better systems such as e-procurement, lack of an effective

complaint and grievance mechanism and lack to staff capacity. The CSP also indentified corruption as a high risk in Cambodia. The Anti-Corruption Unit (ACU) has been ineffective in implementing anti-corruption laws. Futhermore, the related legal and law enforcement instituions (i.e. police, prosecutors and judges) remain weak and vulnerable to poor governance practices due to low pay levels in the public sector that creates a disincentive to good governance practices, patronage and personnel management.

5. Using the Financial Management and Internal Control Risk Assessment (FMICRA) table, the overall inherent and control risks were assessed to also be substantial. The overall combined risk was also assessed to be substantial. A summary of the risks and mitigating measures are presented in Table 1 below.

6. The GMS Health Security Project when implemented will (i) to prevent or control emerging infectious diseases and other infectious diseases of regional importance in a timely manner, (ii) enable the Viet Nam diagnostic system to provide accurate results in a safe and timely manner, thereby improving the health of patients and providing value for money and (iii) reducing the risk of nosocomial infection and increasing drug resistance by improving biosafety. Although several financial management risks were identified, the proposed mitigating measures are assessed to be sufficient for the satisfactory implementation of the project.

Table 1: Summary of Risks and Mitigating Measures

Weakness	Risk Rating	Mitigating Measure
Staffing - lack of qualified staff to implement financial management responsibilities in the provinces	Substantial	Outsource the staff needed in each province to support the PPIU. All the staff need to be trained in ADB procedures including but not limited to financial management and procurement
Internal Control - internal audit unit in MOH is not performing audits of the project on a regular basis	Substantial	Internal audit unit in MOH should conduct regular audits of the project accounts to ensure the all transactions conform to ADB and government financial management policies and procedures.
Funds Flow - delays in liquidation of SOEs in the past will continue and replenishment of the imprest accounts and sub-accounts will be delayed resulting in the project activities not implemented on time	Substantial	Ensure that project related expenditures are liquidated more frequently to ensure that imprest account and sub-accounts will be replenished on time.
External Audit – audit recommendations are not acted upon. Liquidation of advances taking much longer than required	Substantial	Rigorous monitoring by MOH and MEF of any current external audit observations and audit issues should be resolved quickly.

Reporting and Monitoring – PHDs using manual accounting system is slow and affects the preparation of timely financial reports	Substantial	Upgrade accounting system to use computerized accounting software used by the PMU to hasten production of financial reports
Information Systems – use of MS Excel is prone to errors and fraud and cannot be relied upon	Substantial	MEF should hasten the implementation of the FMIS to include all ministries and their provincial departments.

Source: Consultant's Assessment

I. Introduction

1. This Financial Management Assessment (FMA) for the GMS Health Security Project (the Project) of the Ministry of Health (MOH), Cambodia, was prepared in accordance with ADB's Technical Guidance Note for financial management[1]. The FMA includes a review of the accounting and reporting system, internal and external auditing arrangements, fund disbursement procedures, and information systems. The instrument used for the assessment was Asian Development Bank's (ADB) financial management assessment questionnaire (FMAQ). This FMA incorporates the Financial Management Internal Control and Risk Management Assessment required by the Guidelines. The completed FMAQ is in Appendix 1.

2. This assessment was prepared during the scoping phase of the TA preparation from October 28 to November 7, 2015. Preparation activities included reviewing documents, interviewing and discussing issues with counterparts from MOH, PHDs and development partners. A previous FMA was done for the MOH for the CDC2 in 2010. This will also serve as a reference in this FMA. The FMA also made extensive use of the assessment report based on the Integrated Fiduciary Assessment and Public Expenditure Review (IFAPER) assessment developed by the World Bank in collaboration with other development partners as well as the ADB Country Partnership Strategy for Cambodia.

II. Project Description

3. It is proposed that ADB help finance the Project through a loan amounting to about US$ 21 million from the Asian Development Fund (ADF). The Project will be implemented over a 5-year period. The Government of Cambodia will likewise contribute parallel financing of about $ 2 million equivalent or about 9% of the total project cost. The total Project cost is estimated to be about $ 22.8 million.

4. The Ministry of Health (MOH) is the executing agency (EA), represented by the Health Sector Support Program. The Department of Communicable Diseases Control, the Department of Medical Services and 12 Provincial Departments of Health (PHDs) are the implementing agency (IA) for the proposed Project. The Project will target beneficiaries in 12 provinces and about 30 districts. As the EA, MOH will oversee the implementation of the Project and support the outputs covering; (i) regional cooperation and CDC in border areas; (ii) national strengthening of surveillance and response; (iii) improving laboratory services and infection control and (iv) project management.

III. Country and Sector level Issues

A. Public Financial Management

5. In the 2003 IFAPER report, the World Bank concluded that; (i) the PFM system is weak creating unacceptably high levels of fiduciary risk to public funds; and (ii) deficiencies in budget formulation and execution undermine efficiency and effectiveness resulting in the misallocation of resources across sectors and regions over time. To address these issues, the Royal Government of Cambodia (RGC) developed a long-term phased strategy in 2004, the Public Financial Management Reform Program (PFMRP): "Strengthening Governance through

[1] ADB. 2105. *Financial Management Assessment Technical Guidance Note.*

Enhanced Public Financial Management". Under the strategy, Cambodia will pursue the long term comprehensive PFMRP through a four-stage strategy spanning a 20 year period.

6. Each stage was designed to change the performance of the PFM system and provide the platform on which further stages could be undertaken. Significant progress has been accomplished in stage 1 and 2 but challenges remain. The IFAPER assessment further concluded that budget credibility requires additional strengthening in the areas of revenue policy, cash management, debt management and procurement.

7. The first stage of the reform strategy to build budget credibility was launched in 2004 and was completed in 2008. Stage 2 aimed at improving financial accountability, was launched in 2009, and will be completed by end of 2015. The third strategy that will improve budget-policy linkages will commence in 2016 and implemented up to 2020. Finally, the last phase of the PFM reform that will target the performance accountability will be launched soon after completion of phase 3, and by 2025, all the objectives of the PFM reform will be fully completed.

8. The latest IFAPER assessment in 2011 using the PEFA framework[2] showed that budget credibility was enhanced after completion of the first stage of the PFMRP in 2008. The result was improved cash management resulting in greater predictability, reliability and availability of financial resources. Despite the significant improvements in cash management, PEFA noted that weaknesses in the PFM remain and a number of issues related to cash flow forecasting have serious implications for ensuring significant resources are on hand to meet the government's cash flow requirement. A summary of the 2011 IFAPER report based on PEFA framework is presented in the Table 1 below. Under the PEFA framework, performance is assessed in relation to seven dimensions of public financial management using 28 indicators which are rated from A (best) to D (worse).

Table 1: Cambodia PFM Assessment Systems, Processes and Institutions

SUMMARY OF PERFORMANCE MEASUREMENT FRAMEWORK		Score
A. PFM outturns: Credibility of the budget		
PI-1	Aggregate expenditure out-turn compared to original approved budget	B
PI-2	Composition of expenditure out-turn to original approved budget	D
PI-3	Aggregate revenue out-turn compared to original approved budget	A
PI-4	Stock and monitoring of expenditure payment arrears	C+
B. Key cross-cutting issues: Comprehensiveness and transparency		
PI-5	Classification of the budget	C
PI-6	Comprehensiveness of information included in budget documentation	B
PI-7	Extent of unreported government operations	C
PI-8	Transparency of intergovernmental fiscal relations	C+
PI-9	Oversight of aggregate fiscal risk from other public sector entities	C+
PI-10	Public Access to key fiscal information	C
C. Budget execution		
C. (i) Policy-based budgeting		
PI-11	Orderliness and participation in the annual budget process	A
PI-12	Multiyear perspective in fiscal planning, expenditure policy, and budgeting	B

[2] Credibility of the budget; comprehensiveness and transparency; degree to which the budget is prepared with due regard to: government policy; predictability and control in budget execution; accounting, recording and reporting; external scrutiny and audit operations; appropriateness of development partner practices in country; and intergovernmental fiscal relationships

C. (ii) Predictability and control in budget execution		
PI-13	Transparency of taxpayer obligations and liabilities	B
PI-14	Effectiveness of measures for taxpayer registration and tax assessment	C
PI-15	Effectiveness in collection of tax payments	D+
PI-16	Predictability in the availability of funds for commitment of expenditures	C+
PI-17	Recording and management of cash balances, debt, and guarantees	C+
PI-18	Effectiveness of payroll controls	D+
PI-19	Competition, value for money, and procurement controls	C
PI-20	Effectiveness of internal controls for non-salary expenditure	C
		D+
C. (iii) Accounting, recording, and reporting		
PI-22	Timeliness and regularity of accounts reconciliation	C
PI-23	Availability of information on resources received by service delivery units	C
PI-24	Quality and timeliness of in-year budget reports	C+
		D+
C. (iv) External scrutiny and audit		
		D+
PI-27	Legislative scrutiny of the annual Budget Law	NU
PI-28	Legislative scrutiny of external audit reports	NU
D. Donor practices		
D-1	Predictability of direct budget support	C
D-2	Donor information for budgeting and reporting on project/program aid	D
D-3	Proportion of aid managed by national procedures	D

Source: Cambodia IFAPER report 2011

9. The results of the PEFA assessment above highlighted the below average performance of PFM in the country with mostly C performance ratings. Weaknesses remain in the areas of internal controls and financial reporting. These performance areas are the challenges faced in PFM in Cambodia. The report concluded that:

- The financial management information system (FMIS) should be implemented in key ministries to control spending and prioritize expenditures across programs, projects and policies. The Ministry of Economy and Finance has planned the FMIS to be implemented in two phases. The FMIS implementation will help to improve budget execution processes by having audit trails for each transaction, allowing for quicker and more secure payments, and preparing timely and consistent budget execution reports. However, while the MEF has considered the adoption of the FMIS across all ministries, this is not actively being pursued.

- As with many developing member countries, RGC has a shortage of technical skills. Despite on-going capacity building efforts, management skills capacity remains weak and impacts the progress on the PFMRP. The World Bank experience in developing with treasury and financial management information systems emphasized the need to develop the human resource capacity to fully implement the system. Thus, there remains an urgent need for continuous training particularly on financial management, accounting, budgeting, audit and basic management but this should be supplemented by capacity development efforts from within the line ministries.

- The public procurement system is fragmented mainly due to separate legal and regulatory framework for procurement using government funds and external donors. Each is governed by separate implementing rules under the oversight of two different

departments in the MEF. Local market of suppliers is limited and there is no legal framework against those involved in fraud and corruption in the procurement process. Furthermore, the capacity of line ministries to carry out procurement remains weak, thus public financial management risks are high.

- Although internal audit has been ongoing since 2006, PEFA assessed that internal controls remain weak. MEF has developed templates for audit reports but these are not uniformly used in line ministries. Internal audit of donor assisted project has significantly improved in key line ministries including Ministry of Health, Ministry of Agriculture, Forestry and Fisheries and Ministry of Rural Development. However, these improvements are largely due to donor reporting requirements rather than those of the government. As the government moves more financial management and accountability to the line ministries and sub-national agencies, audits will need to incorporate a risk based approach to be guided by the Internal Audit Department of the MEF.

B. ADB Country Partnership Strategy[3]

10. **Risks.** The CPS assessed the major governance-related risks to be in public finance management, procurement and corruption. Although gradually improving, the PFM systems remain weak due to low transparency and accountability resulting from (i) the continuation of a centralized budget management with the MEF; (ii) the delay in the transfer of functions and resources to SNAs is also holding back the build up of capacity in the SNAs thus increasing the risks for management of donor projects that have been assigned to the SNAs; (iii) internal audit and internal controls remain weak leading to less effective and transparent business processes icluding procurement; (iv) external audit remains weak due to the inadequacy of the NAAs to provide effective oversight of public expenditures. ADB has planned to mitigate these PFM risks through continued support of decentralization, expansion of the technical assistance to include other ministries. ADB will also provide additional support to the NAA for auditing of externally financed projects and engaging the National Assembly to discuss audit findings and to followup actions on the audit recommendations.

11. For procurement, the issues identified were the lack of better systems such as e-procurement, lack of an effective complaint and grievance mechanism and lack to staff capacity. To mitigate against these risks, the CSP proposes to strengthen procurement capacity in additional ministries and SNAs through training on ADB's gudelines and procurement procedures. At the project level, ADB will continue to identify procurement risks and implement mitigating measures.

12. The CSP also indetified corruption as a high risk in Cambodia. The Anti-Corruption Unit (ACU) has been ineffective in implementing anti-corruption laws. Futhermore, the related legal and law enforcement instituions (i.e. police, prosecutors and judges) remain weak and vulnerable to poor governance practices. This is due to low pay levels in the public sector that creates a disincentive to good governance practices, patronage and personnel management. ADB for its part will continue to support the ACU fuflfill its mandate through the implementation of the Anti-Corruption Action Plan which is being supported by the ADB-Organization for Economic Co-operation and Development Anti-Corruption Initiative. Civil service salary reform is also regarded as a priority by both government and development partners and is working on new salary compensation packages. ADB will also continue to strengthen the capacity of selective line ministries in regulatory impact assessments.

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[3] Cambodia Country Partnership Strategy 2014-2018

IV. Project Financial Management System

G. Overview

13. The proposed Project will be administratively managed by the Health Sector Support Program (HSSP) headed by the Secretary of State, and technically managed by the Director, Department of Communicable Disease Control (DCDC) of the MOH. The HSSP and DCDC have a long experience in managing donor funded projects including ADB financed projects.[4] With the breadth of experience in managing donor assisted projects, it is expected that this condition will at least remain and further improve for the Project.

14. As with CDC2, a central project management unit (CPMU) will be created within the Department of Communicable Disease Control (DCDC) of the MOH to manage the project. The current CPMU in the CDC2 project may be maintained to continue the implementation of the proposed GMS Health Security project. To implement the project, a PPIU will be created in each of the 12 provinces covered by the project. The CPMU and PIUs will be supported by both international and national consultants. A total of 64 person months of international and 378 person months of national consultants will be hired. The consultants will be based mostly in the central level but will conduct regular visits to the districts.

15. The consulting team will be headed by a Chief Technical Adviser to be based in Hanoi over the five-year implementation period. The other team members will be composed of laboratory, IPC, gender and procurement specialists. The financial management of the project will continue to be managed by the CPMU. The CPMU will oversee the financial management arrangements in the PIUs.

H. Strengths

16. The HSSP and PMU staff have extensive experience in project accounting, disbursement procedures and procurement having implemented CDC1 and CDC2 project for the ADB. The skills and capacity at the central level that were developed in the implementation of the two projects will be relied upon in the implementation of the proposed GMSHSP. For the MOH, the HSSP and the DCDC likewise have experience in the management of many donor funded projects.

I. Weaknesses

17. The major weaknesses identified in the project financial management are:

Accounting Policy and Procedures. Both donor funded projects and government use accrual method of accounting but donor funded projects use the computerized accounting software Quickbooks. The staff are proficient in the use of the software from the implementation of CDC1 and CDC2. For MOH and PHDs however, accounting is still manual recording with MS Excel as the primary tool to generate financial statements. Both government and donor funded projects should use the same accounting system, otherwise government will not be able to ensure reliable financial reporting if they revert back to manual recording after the project.

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[4] World Bank Health Sector Support Program Phase 1 and 2 and the ADB Communicable Disease Control Project Phase 1 and 2. HSSP2 and CDC2 are still on-going but expected to be completed in 2016.

Internal Controls. Although the MOH has its own internal audit unit that should check on the veracity of the documents and compliance of the PMU with approved government accounting standards, the internal audit unit only performs an audit if requested. The HSSP accountant instead performs the regular checks of all transactions and reports to the Project Coordinator. Corrective actions on external audit recommendations have also been slow.

Reporting and Monitoring. The centralized decision making in MEF delays critical actions from being implemented at the project level.

J. Personnel, Accounting Policies and Procedures, Internal and External Audit

18. **Personnel.** The proposed Project will be administratively managed by the Health Sector Support Program (HSSP) headed by the Secretary of State, and technically managed by the Director, Department of Communicable Disease Control (DCDC) of the MOH. The HSSP and DCDC have a long experience in managing donor funded projects including ADB financed projects.[5] With the breadth of experience in managing donor assisted projects, it is expected that this condition will at least remain and further improve for the Project.

19. The DCDC had a complement of 64 staff at the start of CDC2 project. However, since CDC is a technical department, it does not have its own finance unit. Instead, it relies on the finance department of HSSP within the MOH for all financial related reports. On-going and past projects administered by the DCDC hired their respective national finance consultant to manage financial matter on a day-to-day basis. However, it has been difficult to get competent mid-career consultants with accounting/finance education and experience as the market offers higher salaries than the allowed government ceiling for salaries of national consultants. At the provincial level, project accounting is done by the regular PHD staff assigned to the project. To assist the accountant, the province hires an assistant accountant on contractual basis.

20. **Internal Audit.** There is an internal audit unit within the MOH that can check on the veracity of the documents and conformity of the financial transactions in the PMU with approved government accounting standards. However, the department conducts an audit only if requested. The chief accountant in HSSP instead checks all the transactions done by PMU accounting staff and reports to the Project Coordinator. The internal audit unit should be mandated to conduct audits every month without the need of a request.

21. **External Audit.** It is mandatory for ADB funded projects to have the annual financial statements audited by independent auditors acceptable to ADB and MOH and audit reports submitted to ADB within six months from the end of the fiscal year. The TOR for the external auditors for the GMS Health Security Project will be done by the CPMU and the selection of the external auditors will be done through open tendering.

22. **Accounting Policy and Procedures.** As a donor funded project, the GMSHSP will use the same computerized accounting software used by the CDC2 and will follow the financial procedures the HSSP operations manual.

[5] World Bank Health Sector Support Program Phase 1 and 2 and the ADB Communicable Disease Control Project Phase 1 and 2. HSSP2 and CDC2 are still on-going but expected to be completed in 2016.

K. Financial Reporting Systems

23. As one of the line ministries in the RGC, all accounting, recording and financial reporting systems comply with the accounting system issued by the MEF. The MOH implements RGCs accounting policies and procedures to ensure that funds are properly recorded according to the new chart of accounts developed as part of the PFMRP.

24. Donor assisted MOH projects use computerized accounting software to record all transactions and produce the required financial reports. However, PHDs still use a manual accounting system using MS Excel for recording all financial transactions and production of all financial reports. All the reports and supporting documents are retained.

25. The project financial specialist reports to the HSSP accountant, the project manager and the project coordinator. The HSSP director in MOH in turn reports the project financial performance to the Ministry of Economic and Finance (MEF). Key decisions cannot be taken unless there is clearance from MEF. This highly centralized system was re-enforced after the 2003 IFAPAR report, and makes decision making slow and cumbersome.

L. Disbursement Arrangements and Funds Flow

26. The loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2012, as amended from time to time). Direct payment procedures will generally be used for contracts for the supply of goods and equipment and for consulting services contracts. An imprest account will be used for payment of eligible expenditures rather than reimbursement.

27. Funding for the GMSHSP will be similar to CDC2. A total of three accounts will be opened for the project. The first account is a US$ denominated account (FGIA)[6] with the National Bank of Cambodia. This account will receive ADB loans funds for the project. The second account is also an FGIA but denominated in the local currency to receive converted US$ funds to Riel when needed. The third account is also an FGIA but denominated in the local currency will be deposited in the ACLADA bank, a commercial bank where all government operational funds are deposited. The account with ACLADA will receive government counterpart funds for the project. The amount limits for the FGIA will be the same as in CDC2. The proposed project funds flow for Cambodia is shown in Appendix 1.

28. Each PHD will likewise open two sub-accounts to receive and disburse ADB loan funds and government counterpart funds from the FGIAs. The government sub-account will also be in the ACLADA bank. The replenishment policy and procedures for the sub-accounts will be the same as in CDC2.

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[6] First generation imprest account

V. Risk Description and Rating

Risk Description	Impact	Likelihood	Risk Assessment	Mitigation Measure
Inherent Risk				
1. Country Specific – weak public financial management system due to the delayed implementation of the new FMIS	Moderate	Likely	Substantial	MEF should hasten the implementation of the FMIS to include all ministries and their provincial departments. This will ensure that the whole government financial system will be in the same level thereby simplifying the monitoring of all government financial transactions by the MEF.
2. Entity Specific - manual accounting and financial reporting using MS Excel can be prone to errors or fraud making the generation of the financial statements slow and unreliable	High	Likely	Substantial	PHDs should be allowed by MEF to upgrade to a computerized accounting and financial reporting system while the FMIS is not yet being implemented outside the MEF.
Overall Inherent Risk			**Substantial**	
Control Risk				
1. Implementing Entity – Financial management policies are inadequate for the project	Moderate	Likely	Moderate	• MEF and ADB should conduct rigorous training on financial management to PHD staff • ADB should conduct training on ADB procedures including but not limited to financial management and procurement
2. Funds Flow – delays in liquidation of SOEs in the past will continue and replenishment of the imprest accounts and sub-accounts will be delayed resulting in the project activities not implemented on time	High	Likely	Substantial	Ensure that project related expenditures are liquidated more frequently to ensure that imprest account and sub-accounts will be replenished on time.
3. Accounting Policies and Procedures – the accounting policies and procedures are inadequate	Moderate	Likely	Low	PMU to distribute to the PHDs the financial operations manual of HSSP and conduct workshop on the manual
4. Staffing - Lack of qualified personnel in the province to implement the project	High	Likely	Substantial	PHD to outsource the accounting staff needed in each province to support the PPIU. All the staff need to be trained in ADB procedures including but not limited to financial management and procurement
5. Internal Audit – internal audit unit in MOH is not performing audits of the project on a regular basis	Moderate	Likely	Substantial	Internal audit unit in MOH should conduct regular audits of the project accounts to ensure the all transactions conform to ADB and government financial management policies and procedures.
6. External Audit – audit recommendations are not acted upon. Liquidation of advances taking much longer than required	High	Likely	Substantial	Rigorous monitoring by MOH and MEF of any current external audit observations and audit issues should be resolved quickly.

7. Reporting and Monitoring – PHDs using manual accounting system is slow and affects the preparation of timely financial reports	Moderate	Likely	Substantial	Upgrade accounting system to use computerized accounting software used by the PMU to hasten production of financial reports
8. Information Systems – use of MS Excel is prone to errors and fraud and cannot be relied upon	Moderate	Likely	Substantial	MEF should hasten the implementation of the FMIS to include all ministries and their provincial departments.
Overall Control Risk			**Substantial**	
Overall (Combined) Risk			**Substantial**	

Source: Consultant's Assessment

VI. Proposed Time-Bound Action Plans

29. The following initial Financial Management Action Plan has been prepared based on the basic principles of sound financial management practices in the areas of (i) internal control, (ii) funds flow, (iii) accounting and financial reporting, (iv) and independent audits. This plan will be updated annually based on discussions with the government as well as based on the results of the annual fiduciary reviews conducted.

Weakness	Mitigating Action	Responsibility	Timeframe
Staff capacity is low	Intensive training on ADB procedures to include but not limited to financial management and procurement	ADB	Within six months of loan effectiveness
	Outsource the staff requirement in the provinces and districts to support the PPIU. All the staff need to be trained in ADB procedures	MOH and PHDs	Staff recruitment within three months of loan effectiveness. In the first year, the staff will be guided by the implementation consultants. During the second year, the staff take over but with supervision from consultants. From the third year onwards by the staff.
Delays in the liquidation of SOEs will affect the replenishment of the imprest account that can affect the timely implementation of the project	Ensure that project related expenditures are liquidated more frequently to ensure that imprest account and sub-accounts will be replenished on time. The monthly audit by the internal audit unit of the MOH will highlight any delays in the liquidation	MOH	Monthly monitoring
Lack of regular internal audits of project accounts	Mandate the internal audit unit of the MOH to conduct monthly audits of the project to ensure that all financial transactions comply with established policies and procedures	MOH	• At loan effectiveness, MOH will mandate the internal audit unit to include the project in its annual audit plan and to conduct regular monthly audits. This will be included as part

			of the loan covenants. • MOH to ensure that the internal audit unit will have sufficient and capable staff in the internal audit unit to perform the increased tasks. New internal auditors to be hired at loan effectiveness
External Audit observations are not being acted upon	Rigorous monitoring by MOH and MEF of any current external audit observations and audit issues should be resolved quickly.	MOH	Annual Monitoring
Manual recording and use of Excel to generate financial statements is time consuming and prone to errors or fraud	Upgrade accounting system to use computerized accounting software used by the PMU to hasten production of financial reports	MOH and PHDs	Upgrade accounting system to use computerized accounting software used by the PMU to hasten production of financial reports. MEF should hasten implementation of the FMIS

Source: Consultant's Assessment

VII. Suggested Financial Management Covenants

30. The following are the suggested to be included as part of the financial management covenants:

a) MOH to mandate the internal audit unit to include the project in its annual audit plan and to conduct regular monthly audits of project accounts.
b) MOH to ensure that the internal audit unit will have sufficient and qualified internal auditors to perform the increased task.
c) MOH to ensure that PHD will have sufficient and qualified staff to implement the project
d) MEF should provide ADB with a timeframe for implementation of the new FMIS in MOH

VIII. Conclusion

31. The GMS Health Security Project when implemented will (i) to prevent or control emerging infectious diseases and other infectious diseases of regional importance in a timely manner, (ii) enable the Viet Nam diagnostic system to provide accurate results in a safe and timely manner, thereby improving the health of patients and providing value for money and (iii) reducing the risk of nosocomial infection and increasing drug resistance by improving biosafety. Although several financial management risks were identified, the proposed mitigating measures are sufficient for the satisfactory implementation of the project.

Appendix 1

Table 2: Financial Management Assessment Questionnaire[7]

Topic		Response	Remarks
1.	**Implementing Agency**		
1.1	What is the entity's legal status / registration?	Part of Government system.	
1.2	How much equity (shareholding) is owned by the Government	Not Applicable	
1.3	Obtain the list of beneficial owners of major blocks of shares (non-government portion), if any	Not Applicable	
1.4	Has the entity implemented an externally-financed project in the past (if so, please provide details)?	Yes, PMU has implemented CDC1 and CDC2 project. The same staff is expected to implement this Health Security Project (CDC3).	
1.5	Briefly describe the statutory reporting requirements for the entity?	All reporting requirements follow MOEF prakas. Financial reports are made monthly and quarterly.	
1.6	Describe the regulatory or supervisory agency of the entity	Same as 1.5 above	
1.7	What is the governing body for the project? Is the governing body for the project independent?	PMU reports to DCDC, MOH	
1.8	Obtain organizational structure and describe key management personnel. Is the organizational structure and governance appropriate for the needs of the project?	The expected organization structure is appropriate for the project needs	
1.9	Describe the code of ethics in place?	NA	
1.10	Describe (if any) any historical issues reports of ethics violations involving entity and management. How were they addressed?	NA	
2.	**Funds Flow Arrangements**		
2.1	Describe (proposed) project funds flow arrangements in detail, including a flow of funds diagram and explanation of the flow of funds from ADB, government and other financiers to the government, EA, IA, suppliers, contractors, ultimate beneficiaries	The funds flow from ADB flow into imprest account at National Bank of Cambodia for the MOH and sub accounts are provincial PHDs (ACLEDA Bank).See Appendix 2 for the chart.	
2.2	Are the (proposed) arrangements to transfer the proceeds of the loan (from the government / Finance Ministry) to the entity satisfactory?	Yes	
2.3	Are the disbursement methods appropriate	Yes	

[7] The responses to this questionnaire describe the existing situation in the Ministry of Health (MOH) under its present legal status, structure and staffing.

Topic	Response	Remarks
2.4 What have been the major problems in the past in receipt of funds by the entity?	None	
2.5 In which bank will the Imprest Account be opened?	National Bank of Cambodia for ADB and ACLADA bank for counterpart funds	
2.6 Is the bank in which the imprest account is established capable of – • Executing foreign and local currency transactions • Issuing and administering letters of credit • Handling large volume of transactions • Issuing detailed monthly bank statements promptly	Yes	
2.7 Is the ceiling for disbursements from the imprest account and SOE appropriate/ required?	NA	
2.8 Does the (proposed) project implementing unit (PIU) have experience in the management of disbursements from ADB?	Yes, the staffs are more experiences for the projects.	
2.9 Does the PIU have adequate administrative and accounting capacity to manage the imprest fund and statement of expenditure (SOE) procedures in accordance with ADBs loan disbursement handbook. Identify any concern or uncertainty about the PIUs administrative and accounting capability which would support the establishment of a ceiling on the use of the SOE procedure.	Only for PIUs that have implemented ADB projects in the past	
2.10 Is the entity exposed to foreign exchange risks? If yes describe the entity's policy and arrangements for managing foreign exchange risk	Yes	
2.11 How are the counterpart funds accessed?	Counterpart funds are in the form of staffs salaries and Taxes	
2.12 How are payments made from the counterpart funds?	10% payment from Government imprest account at NBC	
2.13 If part of the project is implemented by communities or NGOs, does the PIU have the necessary reporting and monitoring features built into its systems to track the use of project proceeds by such agencies?	Yes, at PMU level there is a system to keep track all those expenses, ex. NGOs, consulting company etc.	
2.14 Are the beneficiaries required to contribute to project costs? If beneficiaries have an option to contribute in kind (in the form of labor), are proper guidelines formulated to record and value the labor contribution?	Depends on the project design or feasibility study (beginning of implementation) before the activity implementation.	
3. Staffing		
3.1 What is the (proposed) organizational structure of the accounting department? Attach an organization chart.	2 person in PMU, supported by HSSP. Organizational chart is in Appendix 3	
3.2 Will existing staff be assigned to the project or will new staff be recruited	Existing staff will be assigned	

Topic		Response	Remarks
3.3	Describe the (proposed) accounts staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions and CVs of key accounting staff.	2 national consultant under contract 1 accountant under HSSP supported by the Project	
3.4	Is the project finance and accounting function staffed adequately?	Yes CDC 1: 2006 - 2011: CDC 2 : 2011 - 2017	
3.5	Are the finance and accounts staff adequately qualified and experienced?	Staff have higher education but no accounting degree	
3.6	Are the project accounts and finance staff trained in ADB procedures?	Yes	
3.7	What is the duration of the contract with the finance and accounts staff?	Contracts are extended annually.	
3.8	Identify key positions not contracted yet, and the estimated date of appointment.	The CDC2 CPMU has all key positions contracted.	
3.9	For new staff, describe the proposed project finance and accounting staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions	NA	
3.10	Does the project have written position descriptions that clearly define duties, responsibilities, lines of supervision, and limits of authority for all of the officers, managers, and staff?	CDC2 PMU follows HSSP manual	
3.11	What is the turnover rate for finance and accounting staff?	NA	
3.12	What is training policy for the finance and accounting staff?	MEF has a training course for accounting staff. ADB also provide training course for accountants, 1 course per year.	
3.13	Describe the list of training programs attended by finance and accounting staff in the last 3 years	NA	
4.	**Accounting Policies and Procedures**		
4.1	Does the entity have an accounting system that allows for the proper recording of project financial transactions, including the allocation of expenditures in accordance with the respective components, disbursement categories, and sources of funds? Will the project use the entity accounting system?	Yes. The accounting system will be the same as CDC2 project.	
4.2	Are controls in place concerning the preparation and approval of transactions, ensuring that all transactions are correctly made and adequately explained?	Yes. There are controls on the preparation and approval of transactions.	
4.3	Is the chart of accounts adequate to properly account for and report on project activities and disbursement categories?	Yes Adequate	
4.4	Are cost allocations to the various funding sources made accurately and in accordance with established agreements?	Yes	

Topic		Response	Remarks
4.5	Are the General Ledger and subsidiary ledgers reconciled and in balance?	Yes	
4.6	Describe the EAs policy for retention of accounting records including supporting documents (e.g. ADBs policy requires that all documents should be retained at least 1 year after ADB receives the audited project financial statements for the final accounting period of implementation, or 2 years after the loan closing date whichever is later). Are all accounting and supporting documents retained in a defined system that allows authorized users access?	NA	
4.7	Describe any previous audit findings that have not been addressed	NA	
Segregation of Duties			
4.8	Are the following functional responsibilities performed by different units or persons: (i) authorization to execute a transaction; (ii) recording of the transaction; and (iii) custody of assets involved in the transaction?	Yes done by different persons	
4.9	Are the functions of ordering, receiving, accounting for, and paying for goods and services appropriately segregated?	Yes	
Budgeting System			
4.10	Do budgets include physical and financial targets?	Yes, the budgeting system include both physical and financial targets	Budget adequately reflect the actual physical condition together with financial target
4.11	Are budgets prepared for all significant activities in sufficient detail to provide a meaningful tool with which to monitor subsequent performance?	Yes	
4.12	Are actual expenditures compared to the budget with reasonable frequency, and explanations required for significant variations from the budget?	Yes	
4.13	Are approvals for variations from the budget required in advance or after the fact?	Yes	
4.14	Is there a ceiling, up to which variations from the budget may be incurred without obtaining prior approval		
4.15	Who is responsible for preparation and approval of budgets?	Project Director, Chief of Finance, Management officer	
4.16	Describe the budget process. Are procedures in place to plan project activities, collect information from the units in charge of the different components, and prepare the budgets?	Yes	

Topic	Response	Remarks
4.17 Are the project plans and budgets of project activities realistic, based on valid assumptions, and developed by knowledgeable individuals? Is there evidence of significant mid-year revisions, inadequate fund releases against allocations, or inability of the EA to absorb/spend released funds? Is there evidence that government counterpart funding is not made available adequately or on a timely basis in prior projects? What is the extent of over-or-under budgeting of major heads over the last 3 years? Is there a consistent trend either way?	Yes	
Payments		
4.18 Do invoice-processing procedures provide for: (i) Copies of purchase orders and receiving reports to be obtained directly from issuing departments? (ii) Comparison of invoice quantities, prices and terms, with those indicated on the purchase order and with records of goods actually received? (iii) Comparison of invoice quantities with those indicated on the receiving reports? (iv) Checking the accuracy of calculations?	Yes	I
4.19 Are all invoices stamped PAID, dated, reviewed and approved, and clearly marked for account code assignment?	Yes	
4.20 Do controls exist for the preparation of the payroll and are changes to the payroll properly authorized?	Yes	
Policies And Procedures		
4.21 What is the basis of accounting (e.g., cash, accrual)?	Accrual for both donor and government but using excel only for government. For donor funded use quickbooks	
4.22 What accounting standards are followed (International Financial Reporting Standards, International Public Sector Accounting Standards – cash or accrual or national accounting standards or other?	According to ADB standard	
4.23 Does the project have an adequate policies and procedures manual to guide activities and ensure staff accountability?	Yes	
4.24 Is the accounting policy and procedure manual updated for the project activities?	Yes	

Topic	Response	Remarks
4.25 Do procedures exist to ensure that only authorized persons can alter or establish a new accounting principle, policy or procedure to be used by the entity?	Yes	
4.26 Are there written policies and procedures covering all routine financial management and related administrative activities?	NA	
4.27 Do policies and procedures clearly define conflict of interest and related party transactions (real and apparent) and provide safeguards to protect the organization from them?	Yes	
4.28 Are manuals distributed to appropriate personnel?	Yes	
4.29 Describe how compliance with policies and procedures are verified and monitored	NA	
Cash and Bank		
4.30 Indicate names and positions of authorized signatories in the bank accounts.	Eung Hout, Project Director,	
4.31 Does the organization maintain an adequate, up-to-date cashbook, recording receipts and payments?	Yes	
4.32 Describe the collection process and cash handling procedures. Do controls exist for the collection, timely deposit and recording of receipts at each collection location?	Yes	
4.33 Are bank and cash reconciled on a monthly basis or more often? Is cash on hand physically verified and reconciled with the cash books? With what frequency is this done?	Yes	
4.34 Are all reconciling items approved and recorded?	Yes	Monthly reconciliation to maintain conformity of numbers
4.35 Are all unusual items on the bank reconciliation reviewed and approved by a responsible official?	Yes	
4.36 Are there any persistent/ non-moving reconciling items?	NA	
4.37 Are there appropriate controls in safekeeping of unused cheques, USB keys and passwords, official receipts and invoices?	NA	
4.38 Are any large cash balances maintained at the head office or field offices? If so, for what purpose?	NA	
4.39 For online transactions, how many persons possess USB keys (or equivalent) and passwords? Describe the security rules on passwords and access controls	NA	
Safeguard over Assets:		
4.40 What policies and procedures are in place to adequately safeguard or protect assets from fraud, waste and abuse?	Yes	

Topic	Response	Remarks
4.41 Does the entity maintain a fixed asset registry? Is the register updated monthly? Does the register record ownership of assets, any assets under lien or encumbered or have been pledged	NA	
4.42 Are subsidiary records of fixed assets, inventories and stocks kept up to date and reconciled with control accounts?	Yes	
4.43 Are there periodic physical inventories of fixed assets and stocks?	Yes	
4.44 Are there periodic physical inventories of fixed asses, inventories and stocks reconciled with the respective fixed assets and stock registers and discrepancies analyzed and resolved?	NA	
4.45 Describe the policies and procedures in disposal of assets. Is the disposal of each asset appropriately approved and recorded? Are steps immediately taken to locate lost or repair broken assets?	NA	
4.46 Are the assets sufficiently covered by insurance policies?	No insurance	
4.47 Describe the policies and procedures in identifying and maintaining fully depreciated assets from active assets	NA	
Other Offices and Implementing Entities		
4.48 Describe any other regional offices or executing entities participating in implementation	Yes	
4.49 Describe staff, their roles and responsibilities in performing accounting and financial management functions of such offices as they relate to the project	NA	
4.50 Has the project established segregation of duties, controls and procedures for flow of funds and financial information, accountability and reporting and audits in relation to the other offices or entities?	NA	
4.51 Does information among the different offices/ implementing agencies flow in an accurate and timely fashion? In particular, do the offices other than the head office use the same accounting and reporting system?	Yes	
4.52 Are periodic reconciliations performed among the different offices/ implementing agencies? Describe the project reporting and auditing arrangements between these offices and the main executing/ implementing agencies	NA	
4.53 If any sub-accounts (under imprest account) will be maintained, describe the results of the assessment of the financial management capacity of the administrator of such sub-accounts	NA	
Contract Management and Accounting		

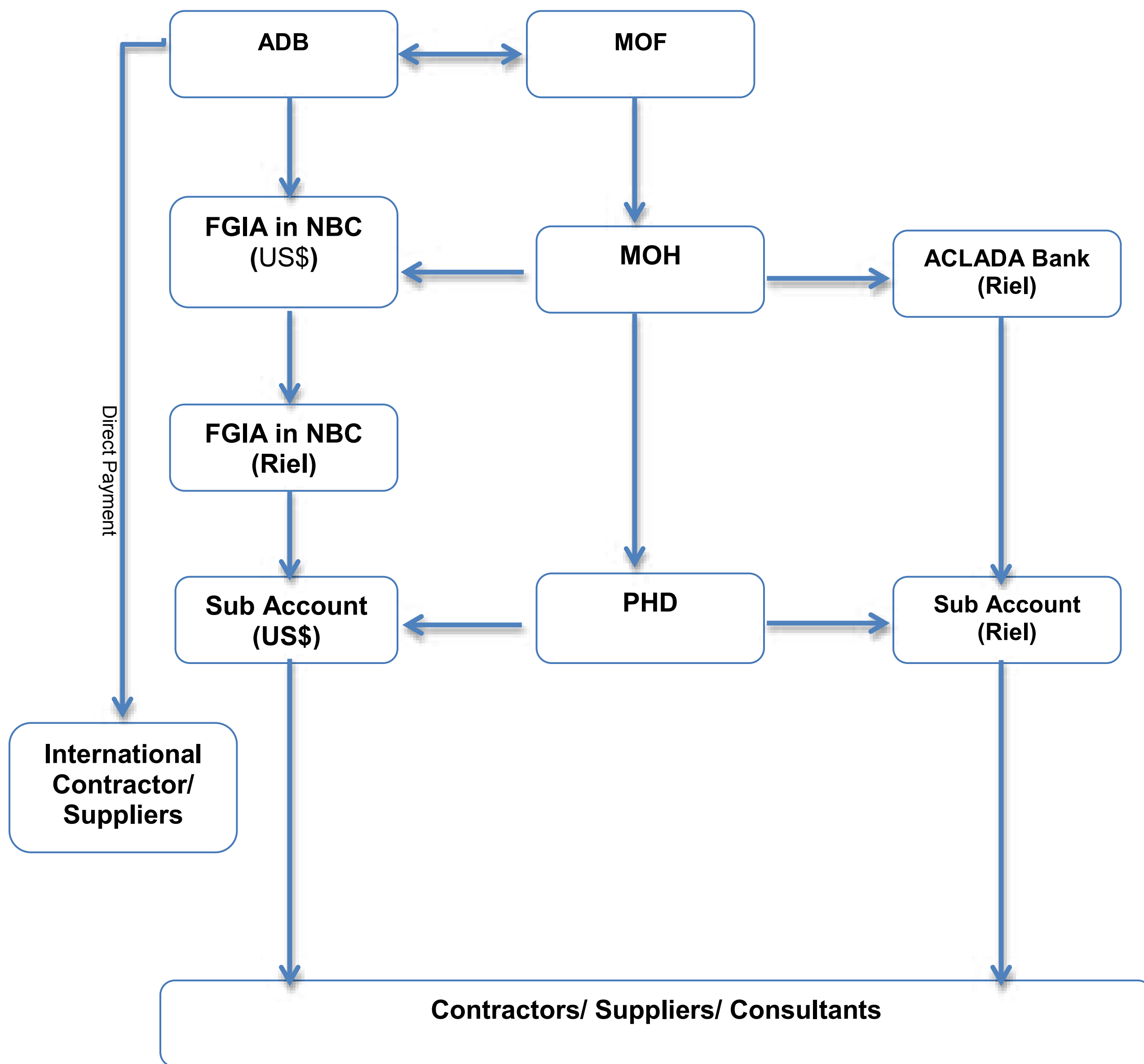
Topic	Response	Remarks
4,54 Does the agency maintain contract wide accounting records to indicate gross value of the contract and any amendments, variations and escalations, payments made, and undisbursed balances? Are the records consistent with physical outputs/ deliverables of the contract	NA	
4.55 If contract records are maintained, does the agency reconcile them regularly with the contractor?	NA	
Other		
4.56 Describe project arrangements for reporting fraud, corruption, waste and misuse of project resources. Has the project advised employees, beneficiaries and other recipients to whom to report if they suspect fraud, waste or misuse of project resources or property?	NA	
5. Internal Audit		
5.1 Is there an internal audit department in the entity?	Yes	
5.2 What are the qualifications and experience of audit department staff?	Training from ADB and MEF	
5.3 To whom does the internal auditor report?	MOH and MEF	
5.4 Will the internal audit department include the project in its work program?	yes	
5.5 Are actions taken on the internal audit findings?	yes	
5.6 What is the scope of the internal audit program?	NA	
5.7 Is the IA department independent?	NA	
5.8 Do they perform pre-audit of transactions	NA	
5.9 Who approves the internal audit program	NA	
5.10 What standards guide the internal audit program?	NA	
5.11 How are audit deficiencies tracked?	NA	
5.12 How long have the internal audit staff members been with the organization?	NA	
5.13 Does any of the internal audit staff have an IT background?	NA	
5.14 How frequent does the internal auditor meet with the audit committee without the presence of management	NA	
5.15 Has the internal auditor identified/ reported any issue with reference to availability and completeness of records	NA	
5.16 Does the auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6. External Audit		
6.1 Is the entity financial statement audited regularly by an independent auditor? Who is the auditor?	Yes KPMG	
6.2 Are there any delays in audit of the entity? When are the audit reports issued?	Yes,	

Topic	Response	Remarks
6.3 Is the audit of the entity conducted according to the International Standards on Auditing?	Yes	
6.4 Were there any major accountability issues brought out in the audit report of the past three years?	Liquidation of advance over 14 days(20-30 days) - document of Inventory not dated - documents of clear payment without stamp - document receipts no post stamp - technical of payments - procurement and document preparation	
6.5 Does the external auditor meet with the audit committee without the presence of management?	NA	
6.6 Has the entity engaged the external audit firm for any non-audit engagements (e.g. consulting)? If yes, what is the total value of non-audit engagements, relative to the value of the audit services?	No	
6.7 Has the external auditor expressed any issues on the availability of complete records and supporting documents?	NA	
6.8 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures?	NA	
6.9 Are there any material issues noted during the review of the audited entity financial statements that were not reported in the external audit report?	NA	
External Audit – Project Level		
6.10 Will the entity auditor audit the project accounts or will another auditor be appointed to audit the project financial statements	NA	
6.11 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	yes	
6.12 Is the project subject to any kind audit from an independent government entity (e.g. Supreme audit institution) in addition to the external audit?	Yes	
6.13 Has the project prepared acceptable terms of reference for an annual project audit? Have these been agreed and discussed with the EA and the auditor?	Yes	
6.14 Has the project auditor identified any issues with the availability and completeness of records and supporting documents?	NA	

Topic	Response	Remarks
6.15 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6.16 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	NA	
6.17 (for second and subsequent projects) Were past audit reports complete and did they fully address the obligations under the loan agreements? Were there any material issues noted during the review of the audited project financial statements and related audit report that have remained unaddressed?	NA	
7. Reporting and Monitoring		
7.1 Are financial statements prepared for the entity? In accordance with which accounting standards?	Yes, Cambodia standards	
7.2 Are financial statements prepared for the implementing unit?	Yes	
7.3 What is the frequency of preparation of financial statements? Are the reports prepared in a timely fashion so as to useful to management for decision making?	Annual	
7.4 Does the reporting system need to be adapted to report on the project components?	Yes, depends on project components design	
7.5 Does the project have established financial management reporting responsibilities that specify what reports are to be prepared, what they are to contain, and how they are to be used?	Yes	
7.6 Are financial management reports used by management?	Yes.	
7.7 Do the financial reports compare actual expenditures with budgeted and programmed allocations?	Yes	
7.8 How are financial reports prepared? Are financial reports prepared directly by the automated accounting system or are they prepared by spreadsheets or some other means	Yes from quickbooks	
7.9 Does the financial system have the capacity to link the financial information with the projects physical progress? If separate systems are used to gather and compile physical data, what controls are in place to reduce the risk that the physical data may not synchronize with the financial data?	Yes	
7.10 Does the entity have experience in implementing projects of any other donors, co-financiers or development partners	Yes	

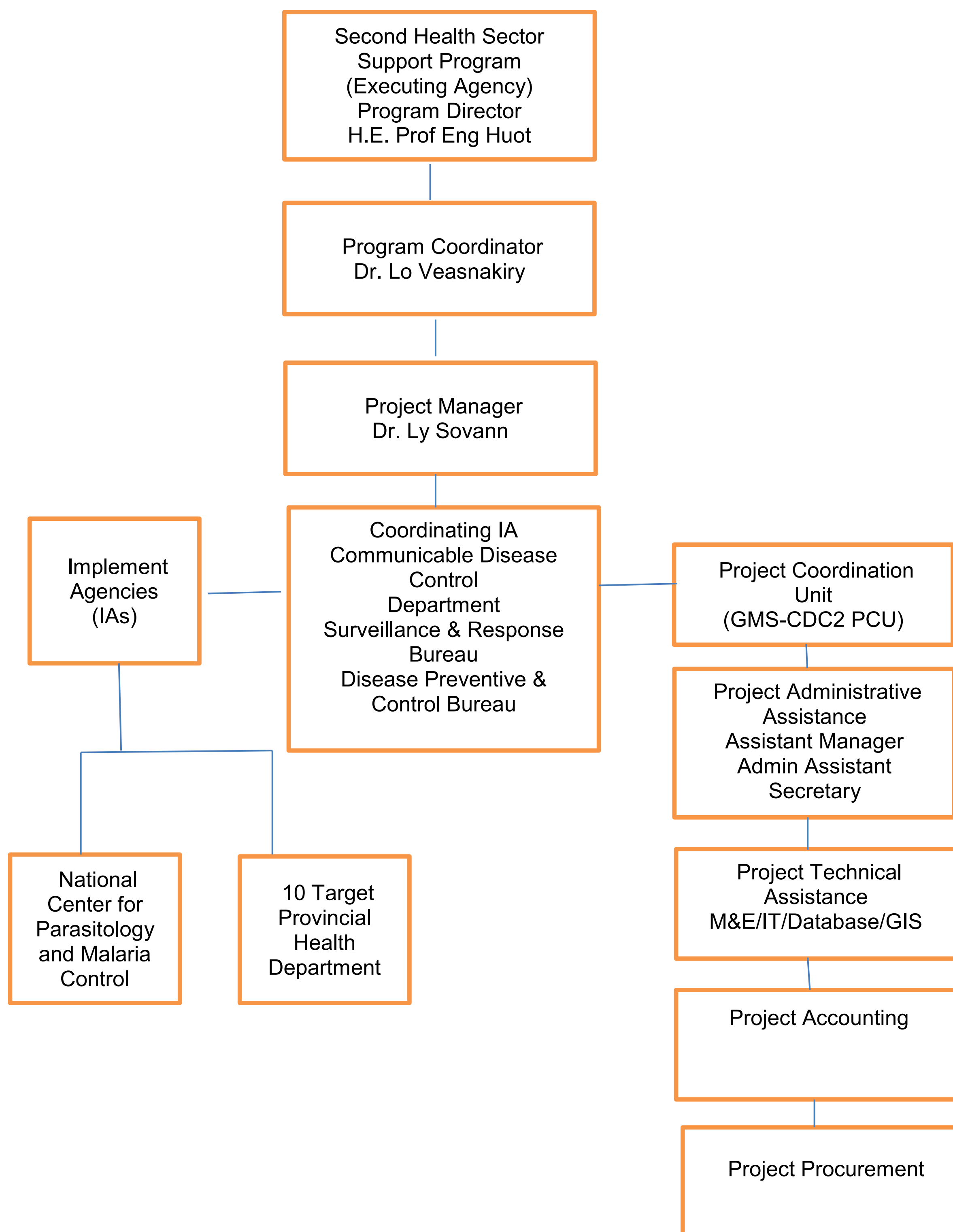
Topic	Response	Remarks
8. Information Systems		
8.1 Is the financial management system computerized?	MEF has developed FMIS but only used in the national treasury starting in 2015. The next step is to setup in the provincial treasury in 2016. For ministries no schedule yet. For now MOH using quickbooks for donor funds. For government use excel only.	
8.2 If computerized, is the software off the shelf or customized?	Off the shelf	
8.3 Is the computerized software standalone or integrated and used by all departments in the headquarters and field units using modules	standalone	
8.4 How are the project financial data integrated with the entity financial data? Is it done through a module in the enterprise financial system with automatic data transfer or does it entail manual entry?	NA	
8.5 Is the computerized software used for directly generating periodic financial statements or does it require manual intervention and use of Excel or similar spreadsheet software?	Yes	
8.6 Can the system automatically produce the necessary project financial reports	Yes	
8.7 Is the staff adequately trained to maintain computerized system	Yes	
8.8 Does the management organization and processing system safeguard the confidentiality, integrity and availability of the data?	Yes	
8.9 Are there back-up procedures in place?	NA	
8.10 Describe back up procedures – online storage, offsite storage, offshore storage, fire, earthquake and calamity protection for backups?	NA	

Appendix 2



Appendix 3

Organizational Chart of CPMU



FMA Annex 1

Financial Management Assessment
Ministry of Health
Republic of the Union of Myanmar

March 2016

ABBREVIATIONS

ADB	–	Asian Development Bank
ADF	–	Asian Development Fund
AGO	–	Auditor General Office
CPS	–	Country Partnership Strategy
DMS	–	Department of Medical Services
DP	–	Development partner
DPH	–	Department of Public Health
EA	–	Executing agency
FMA	–	Financial Management Assessment
FMAQ	–	Financial management assessment questionnaire
FMIRCRA		Financial Management Internal Control and Risk Assessment
FY	–	Fiscal year
IA	–	Implementing agency
MOF	–	Ministry of Economy and Finance
MOH	–	Ministry of Health
PEFA	–	Public Expenditure Financial Accountability
PFM	–	Public Financial management
PHD	–	Provincial Heath Department
SNA	–	Sub-National Authorities

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EXECUTIVE SUMMARY

1. The financial management assessment was conducted for the Ministry of Health as the executing agency for the proposed GMS Health Security Project. The FMA was prepared in accordance with ADBs Technical Guidance Note 2015 and incorporates the Financial Management Internal Control and Risk Management Assessment (FMICRA) required by the Guidelines. The assessment also made extensive use of the Public Expenditure Financial Accountability (PEFA) PFM in 2013, the World Bank assessment for Myanmar in 2014 as well as the two interim ADB Country Partnership Strategy (CPS) covering the period 2012- 2014 and 2015-2016.

2. The final PEFA report that was issued in 2013 concluded that in general PFM systems are weak. This is due to poor budgetary credibility, comprehensiveness and transparency along with weak internal controls. Financial regulations are out of date[1] and do not reflect the current practice. Due to the outdated regulations, rules to be adopted vary from Ministry to Ministry and are open to interpretation. This lack of fundamental financial management regulations mean that systems and procedures cannot be relied upon to produce accurate and timely financial information and ensure appropriate accountability. Furthermore, the weak control environment combined with the limited budget comprehensiveness and transparency suggest that the PFM is at risk of corruption.

3. Myanmar’s budget classification system is not fully consistent with modern classification structures. Budget comprehensiveness and transparency is severely affected by the high level of unreported government operations. All accounting records use a paper based manual system. Even the Myanmar Economic Bank accounting and reporting system is largely manual and paper based. Reporting is done monthly, but because the system is manual and paper based, the compilation and reconciliation of the financial records takes about 3 months to complete thus delaying the production of monthly financial reports. Furthermore, the consolidated monthly financial reports lack the analysis to assist management in making informed decisions. The manual system also makes it difficult to produce financial information in different formats that are needed for specific reporting purposes. International accounting standards for a cash based system are not met. The current form of the financial statements does not reflect the requirements of the cash based IPSAS. Year-end reports follow the same system of report preparation but these reports are not widely circulated.

4. The ADB Country Partnership Strategy assessed the major governance-related risks to be in governance and public finance management, procurement and corruption. PFM systems remain weak due to (i) the current accounting standards do not meet international standards for IPSAS cash based system; (ii) reconciliations are not performed regularly and information on available resources to meet obligations and disbursements is not on hand on a timely basis making it difficult to track budget efficiency.; (iii) oversight of the Auditor General is weak and the audited state budget reports are not published. Legislative review of the budget is also limited; (iv) budgets lack in multiyear fiscal planning and revenue forecasts are too ambitious due to weak forecasting capabilities at the Ministry of Finance and Revenue (MOFR). Public access to key information in the budget documents is also limited and affects budget credibility. For procurement, the system does not promote transparency, accountability and competition.

[1] The last financial regulations were revised in 1986

Furthermore, management capabilities in procurement are weak and will require reforms over the long term.

5. Using the Financial Management and Internal Control Risk Assessment (FMICRA) table, the overall inherent and control risks were assessed to be high. The overall combined risk was also assessed to be high. A summary of the risks and mitigating measures are presented in Table 1 below.

6. The GMS Health Security Project when implemented will (i) to prevent or control emerging infectious diseases and other infectious diseases of regional importance in a timely manner, (ii) enable the Viet Nam diagnostic system to provide accurate results in a safe and timely manner, thereby improving the health of patients and providing value for money and (iii) reducing the risk of nosocomial infection and increasing drug resistance by improving biosafety. Despite the weak financial management system currently in place, the proposed mitigating measures are assessed to be sufficient for the satisfactory implementation of the project.

Table 1: Summary of Risks and Mitigating Measures

Weakness	Risk Rating	Mitigating Measure
Staffing - lack of experience and skills in ADB procedures will affect the implementation of the project. Staff also lack the basic computer skills	High	• ADB should conduct rigorous training on ADB procedures including but not limited to financial management and procurement • Conduct computer literacy course for all staff
Internal Control - no functioning internal audit unit in MOH	High	• The inspection units in the departments should be elevated to internal audit unit status to strengthen internal audit function to ensure that the systems in place are strictly followed and conform to approved processes. • MOH to recruit more qualified staff with audit experience
Funds Flow - delays in liquidation of SOEs will delay the replenishment of the imprest accounts and sub-accounts resulting in the project activities not implemented on time	High	Monthly liquidation of project related expenditures to ensure that imprest account and sub-accounts will be replenished on time.
External Audit – audit reports are not available to the public and shows lack of transparency and accountability	High	Audit findings should be published and made available to the public to improve transparency and accountability. AGO should create a website and post all external audit reports of all line ministries and the different levels of government.

Accounting Policies and Procedures – the accounting policies and procedures are inadequate for the project	High	Accounting system should be upgraded to computerized accounting system for greater efficiency
Reporting and Monitoring - coordination between the 2 department co-managers of the project will be difficult and the consolidation of all financial management reports cannot be produced on time making monitoring of project implementation difficult.	High	Since the two departments are co-equal, a management committee should be created to oversee the project. The committee will be composed of the 2 DGs and supported by director level staff from each department who will manage the day-to-day activities of the project and to ensure that reports are consolidated at the end of each month and submitted to MOH and ADB.
Information Systems – use of MS Excel to generate financial statements is prone to errors and fraud and cannot be relied upon	High	MOF should approve the use of computerized accounting software for the project to generate financial statements

Source: Consultant's Assessment

I. Introduction

1. This Financial Management Assessment (FMA) for the GMS Health Security Project (the Project) of the Ministry of Health (MOH), Myanmar, was prepared in accordance with ADB's Technical Guidance Note for financial management[2]. The FMA includes a review of the accounting and reporting system, internal and external auditing arrangements, fund disbursement procedures, and information systems. The instrument used for the assessment was Asian Development Bank's (ADB) financial management assessment questionnaire (FMAQ). This FMA incorporates the Financial Management Internal Control and Risk Management Assessment required by the Guidelines. The completed FMAQ is in Appendix 1.

2. This assessment was prepared during the scoping phase of the TA preparation from September 19 to October 3, 2015. Preparation activities included reviewing documents, interviewing and discussing issues with counterparts from MOH and development partners. There was no previous FMA done by ADB for the MOH but the World Bank recently conducted an FMA as part of its Essential Health Services Access Project (EHSAP)[3].

II. Project Description

3. It is proposed that ADB help finance the GMS Health Security Project through a loan amounting to about US$ 12 million from the Asian Development Fund (ADF). The Program will be implemented over a 5-year period. The Government of the Union of Myanmar will likewise contribute parallel financing of about US$ 0.6 million equivalent to about 5% of the total project cost. Total Project cost is estimated to be about $ 12.6 million.

4. The Ministry of Health (MOH) is the executing agency (EA), represented by the Departments of Medical Services and Public Health. The Project will be implemented in five states and one region. As the EA, MOH will oversee the implementation of the Project and support the outputs covering; (i) regional cooperation and CDC in border areas; (ii) national strengthening of surveillance and response; (iii) improving laboratory services and infection control.

III. Country and Sector level Issues

A. Public Financial Management

5. Country Public Financial Management (PFM) systems were most recently assessed for the period 2008-2012 using the Public Expenditure Financial Accountability (PEFA) PFM Performance Measurement Framework in 2013. Under the PEFA framework, performance is assessed in relation to seven dimensions of public financial management using 28 indicators which are scored from A (best) to D (worse).[4] A summary of the 2010 PFM assessment framework is presented in the table 1 below.

---

[2] ADB. 2105. *Financial Management Assessment Technical Guidance Note.*

[3] ESHAP is a $100 million RBL loan to Myanmar to strengthen service delivery at the state/ regions health departments and capacity building.

[4] Credibility of the budget; comprehensiveness and transparency; degree to which the budget is prepared with due regard to: government policy; predictability and control in budget execution; accounting, recording and reporting; external scrutiny and audit operations; appropriateness of development partner practices in country; and intergovernmental fiscal relationships

6. A final report was issued in 2013 concluding that in general PFM systems are weak. This is due to poor budgetary credibility, comprehensiveness and transparency along with weak internal controls. Financial regulations are out of date[5] and do not reflect the current practice. Due to the outdated regulations, rules to be adopted vary from Ministry to Ministry and are open to interpretation. This lack of fundamental financial management regulations mean that systems and procedures cannot be relied upon to produce accurate and timely financial information and ensure appropriate accountability. The weak control environment combined with the limited budget comprehensiveness and transparency suggest that the PFM is at risk of corruption. Key weaknesses of the PFM include lack of effective connection between strategic plans and budgets and between recurrent and capital expenditure.

Table 1: Myanmar PFM Assessment Systems, Processes and Institutions

SUMMARY OF PERFORMANCE MEASUREMENT FRAMEWORK		Score
A. PFM outturns: Credibility of the budget		
PI-1	Aggregate expenditure out-turn compared to original approved budget	C
PI-2	Composition of expenditure out-turn to original approved budget	D+
PI-3	Aggregate revenue out-turn compared to original approved budget	B
PI-4	Stock and monitoring of expenditure payment arrears	NR
B. Key cross-cutting issues: Comprehensiveness and transparency		
PI-5	Classification of the budget	D
PI-6	Comprehensiveness of information included in budget documentation	D
PI-7	Extent of unreported government operations	D+
PI-8	Transparency of intergovernmental fiscal relations	D
PI-9	Oversight of aggregate fiscal risk from other public sector entities	C
PI-10	Public access to key fiscal information	D
C. Budget execution		
C. (i) Policy-based budgeting		
PI-11	Orderliness and participation in the annual budget process	C+
PI-12	Multiyear perspective in fiscal planning, expenditure policy, and budgeting	D+
C. (ii) Predictability and control in budget execution		
PI-13	Transparency of taxpayer obligations and liabilities	C+
PI-14	Effectiveness of measures for taxpayer registration and tax assessment	D+
PI-15	Effectiveness in collection of tax payments	D+
PI-16	Predictability in the availability of funds for commitment of expenditures	D+
PI-17	Recording and management of cash balances, debt, and guarantees	C+
PI-18	Effectiveness of payroll controls	D+
PI-19	Competition, value for money, and procurement controls	D
PI-20	Effectiveness of internal controls for non-salary expenditure	D+
PI-21	Effectiveness of internal audit	D+
C. (iii) Accounting, recording, and reporting		
PI-22	Timeliness and regularity of accounts reconciliation	C+
PI-23	Availability of information on resources received by service delivery units	D
PI-24	Quality and timeliness of in-year budget reports	C
PI-25	Quality and timeliness of annual financial statements	D+
C. (iv) External scrutiny and audit		
PI-26	Scope, nature, and follow-up of external audit	C+
PI-27	Legislative scrutiny of the annual Budget Law	NA
PI-28	Legislative scrutiny of external audit reports	NA

[5] The last financial regulations were revised in 1986

D. Donor practices		
D-1	Predictability of Direct budget Support	NA
D-2	Donor information for budgeting and reporting on project/program aid	D
D-3	Proportion of aid managed by national procedures	D

Source: Myanmar PEFA report 2013

7. The results of the PEFA assessment above highlighted the poor performance of PFM in the country with only one category receiving an "A" (revenue matches to the approved budget) and most scores are at the lower end of the range with mostly Ds and Cs. This highlights the challenges faced in PFM in Myanmar. The report concluded that[6]:

- The PFM report concluded that in general PFM systems are weak. This is due to poor budgetary credibility, comprehensiveness and transparency along with weak internal controls. Budget credibility is low due to high deviations between approved budgets and actual government revenues and expenditures. The credibility of the budget estimate and budget management is demonstrated by the difference between the approved budget and the actual expenditures and revenues. The smaller the difference the higher the rating as this reflects discipline in compliance with the original approved budget. PEFA rates that expenditure variances in the last three years prior to the PEFA assessment showed variances of the actual expenditures versus the approved budget to be in excess of 20 percent.

- Financial regulations are out of date[7] and do not reflect the current practice. Due to the outdated regulations, rules to be adopted vary from Ministry to Ministry and are open to interpretation. This lack of fundamental financial management regulations mean that systems and procedures cannot be relied upon to produce accurate and timely financial information and ensure appropriate accountability.

- Myanmar's budget classification system is not fully consistent with modern classification structures. Budget comprehensiveness and transparency is severely affected by the high level of unreported government operations, in particular extra-budgetary[8] expenditures. Furthermore, there is extensive use of Other Accounts (OA) in the budget. OAs basically accounts held in MEB by ministries and state economic enterprises (SEE) for management of own source revenues. The financial regulations only allow the Ministries of Defense and Home Affairs to open OAs without MFR permission but this has been interpreted as permission to include other Ministries as long as MFR permits. As of 2012, data from MEB and the budget department show a total OA receipts of 2.54 trillion kyat or about 44 percent of total budgeted revenue while expenditures are 2.26 trillion kyat or 28 percent of total budgeted expenditure

- All accounting records originate from the spending unit or revenue generating unit using a paper based manual system. Even the MEB accounting and reporting system is largely manual and paper based. Reporting is done monthly, but because the system is manual and paper based, the compilation and reconciliation of the financial records takes about 3 months to complete thus delaying the production of monthly financial reports. Furthermore, the consolidated monthly financial reports lack the analysis to

[6] Proposed Policy Based Loan, Lao PDR, Health Sector Governance Program, Financial Management Assessment, November 2014
[7] The last financial regulations were revised in 1986
[8] Extra budgetary means the funds are not reported or accounted for in the budget

assist management in making informed decisions. The manual system also makes it difficult to produce financial information in different formats that are needed for specific reporting purposes. International accounting standards even for a cash based system are not met. The current form of the financial statements does not reflect the requirements of the cash based IPSAS. Year-end reports follow the same system of report preparation but these reports are not widely circulated.

- Internal control environment is weak with the internal audit function was only recently established in line Ministries and SEEs. Capacity however is limited and underdeveloped with internal audits concentrating more on low value processes and less on analysis of results. The lack of internal audit in many government units does not give assurance that financial systems are being conducted effectively and adequately enforced.

- There is no procurement law that provides the framework for procurement. Prior to June 2011, all procurement is centralized through the Ministry of Commerce. In June 2011, the president ordered that ministries will henceforth be responsible for their own procurement to create more openness and competition. However, no implementing rules and regulations were issued on how to undertake open tendering. As a result, individual Ministries formulated their own internal procurement rules. Given the lack of a strong framework, there is strong risk that the intended outcome of open competition is weakened. There is also no formal complaints mechanism with regards to procurement.

B. ADB Country Partnership Strategy

8. The interim CPS for Myanmar identified preliminary but major governance-related risks. The risks identified are[9]:

9. **Governance and Public Financial Management.** Myanmar ranks poorly on most global governance indicators and ranks corruption a high risk in Myanmar. Priority spending is not sustainable and will require the reorientation of spending towards priority sectors in education, health and productive public infrastructures

10. **Procurement.** The procurement system does not promote transparency, accountability and competition. Furthermore, management capabilities in procurement are weak and will require reforms over the long term.

11. **Budgets.** There is a lack in multiyear fiscal planning and revenue forecasts are too ambitious due to weak forecasting capabilities at the Ministry of Finance and Revenue (MOFR). Public access to key information in the budget documents is also limited and affects budget credibility. Management of cash balances is weak and should be improved by upgrading forecasting capabilities.

12. **Accounting, recording and reporting.** Accounting standard do not meet international standards. Reconciliations are not performed regularly and information on available resources to meet obligations and disbursements is not on hand on a timely basis making it difficult to track budget efficiency.

13. **Audits and Fiduciary risks.** Oversight of the Auditor General is weak and the audited state budget reports are not published. Legislative review of the budget is also limited. Due to

[9] Interim Country Partnership Strategy: Myanmar 2012-2014

poor transparency and accountability, fiduciary risks are high. Internal audits within line ministries should also be enhanced.

14. While the interim CPS 2012-2014 offers a framework for ADB's progressive reengagement in Myanmar, a full CPS is proposed to cover 2017-2021. To bridge the gap, the interim CPS was extended to cover 2015-2016 to take into consideration the general elections in 2015. The extended CPS however indicated that the prior assessment remains valid.

IV. Project Financial Management System

A. Overview

15. The Project will be jointly managed by the Department of Medical Services and the Department of Public Health. Both departments however have limited experience in the management of donor-funded projects. The World Bank Essential Health Services Access Project, which was implemented in late 2014, provides direct budget support to the districts and no PMU was created

16. A central project management unit (CPMU) will be created but the overall leadership will be shared between the Department of Medical Services and Department of Public Health. To implement the project in the states and region, a PIU will be created in each of the 5 states and one region covered by the project. Both international and national consultants will support the CPMU and PIUs. A total of 47 person months of international and 262 person months of national consultants will be recruited. The consultants will be based mostly in the central level but will conduct regular visits to the districts.

17. The consulting team will be headed by a Chief Technical Adviser to be based in Nay Piy Taw over the five-year implementation period. The other team members will be composed of laboratory, IPC, gender and procurement specialists. The financial management of the project will continue to be managed by the CPMU. The CPMU will oversee the financial management arrangements in the PIUs.

B. Strengths

18. Grant funds from development partners and NGOs have been decreasing in recent years and MOH recognizes that this trend will continue. MOH also knows that to improve the delivery of health services, new sources of funds will have to be available as government budgets alone will be not be sufficient. Although MOH lacks the experience in implementing ADB funded projects, the proposed GMSHSP opens the door to new a financing opportunity for MOH and MOH will exert all efforts to ensure that the GMSHSP will be a success.

C. Weaknesses

19. The major weaknesses identified in the project financial management are:

Staffing. The finance staff of both departments has limited experience in the management of donor-funded projects and no specific experience in the management of ADB funded projects. The staff also lack computer literacy since very few offices have the computer hardware and software. Furthermore, the MOH has no experience in the establishment and operationalization of a PMU and PIU. All the staff will have to undergo intensive training on all ADB procedures including but not limited to financial management and procurement and basic computer skills.

Accounting Policy and Procedures. The manual accounting system at the MOH central and state levels is slow and will delay the generation of financial statements. Furthermore, the use of MS excel is also prone to errors and fraud. However, computerization of the accounting system to enhance the recording and financial reporting could result in layoffs due to redundancy as fewer number of staff will be needed in the recording of transactions and the financial statements could be generated directly from the computerized accounting software.

Internal Controls. MOH does not have an internal audit unit but they have inspection units in each of the departments under the Ministry. The inspection performed is to merely follow up on the issues identified by the external audit conducted by the AGO and report the findings to the Director General of the department. Although similar in scope to an audit, an inspection does not perform any analysis of the financial management systems (e.g. identification of risks) and also not subject to any audit standards. External audits are performed by the AGO every six months for each line ministry and all levels of government. The external audit reports are submitted within one week after performing the audit but the audit findings are not subject to parliamentary oversight. In addition, the audit finding remains confidential to the public and emphasizes the lack of transparency and accountability.

Financial Reporting and Monitoring. Since the project will be co-managed by two separate departments of MOH, each with its own finance and administration division, there could be problem in coordination and integration of all financial management reporting responsibilities making monitoring of project implementation difficult.

D. Personnel, Accounting Policies and Procedures, Internal and External Audit

20. **Personnel.** The proposed Project will be co-managed by the Departments of Medical Services and Public Health of the MOH. The two departments have an equal number of proposed staff at 96 each. Current staff level is also equal at 59 each and an equal number of vacant positions at 37 each. Most are permanent staff and those that are contracted hold long-term contracts. A large number of staff is needed in each finance division because of the manual accounting system. This could pose a problem if there will be shift to using computerized accounting software due to redundancy. Most of the current staff of the finance division possess high education but none of them hold an accounting degree.

21. **Internal Audit.** There is no internal audit unit within the DOH. There is an inspection department in each of the Departments of Public Health and Department of Medical Services. Its main function is to follow up on the findings of the external audits conducted by the AGO but no analysis is undertaken by the inspection team.

22. **External Audit.** External audits are conducted twice a year by the Auditor General Office (AGO). All government ministries and the different levels of government are included in the external audit and cover financial, performance and procurement. It is mandatory for ADB funded projects to have the annual financial statements audited by independent auditors acceptable to ADB and MOH and audit reports submitted to ADB within six months from the end of the fiscal year. For the project, ADB and MOH will have to agree whether to use the AGO report or to engage the services of an independent external auditor.

23. **Accounting Policy and Procedures.** Accounting for the project will be manual cash based system which is the current system being used by the two MOH departments. All accounting policies and procedures will also follow MOF accounting and financial management

guidelines. Recognizing that the system needs to be upgraded, the two finance divisions of the departments are open to using computerized accounting software. However, approval of the MOF will have to be sought.

E. Financial Reporting Systems

24. As one of the line ministries in the Union of Myanmar, all accounting, recording and financial reporting systems comply with the government accounting standards issued by the MOF. However, Myanmar's accounting standard does not conform to IPSAS cash based accounting. Since the project will be co-managed by two separate departments, each with its own finance and administration division, there could also be problem in coordination between the departments and integration of all financial management reports responsibilities also due to manual paper based accounting system.

F. Disbursement Arrangements and Funds Flow

25. The loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2012, as amended from time to time). Direct payment procedures will generally be used for contracts for the supply of goods and equipment and for consulting services contracts. An imprest account will be used for payment of eligible expenditures rather than reimbursement.

26. The MOF will open and manage two FGIA[10] to accept loan funds from the ADB. The first FGIA will be denominated in US dollars while the second FGIA will be denominated in the local currency "Kyat" to receive converted US dollar loan funds when needed. MOH will submit regular monthly SOEs to MOF. Upon the approval of MOF, the MOH can draw funds from the local currency denominated FGIA to support the operations of the CPMU including any project related disbursements. The opening and minimum fund balance of both FGIAs will be agreed upon between ADB and MOF. Replenishment of the US dollar denominated FGIA will be made by ADB when the fund balance reaches the minimum agreed amount and supported by monthly SOEs.

27. An SGIA[11] will also be opened by the state/ regional office of the MOF to accept funds from the FGIA. The funds to be deposited in the SGIA will be used to support the operations of the PIUs including any project related disbursements. The opening and minimum balances of the SGIAs will be agreed upon between MOF and MOH. The PIUs will submit statements of accounts (SOEs) to the CPMU every end of the month. Replenishment of the SGIA will be made when the fund balance reaches the minimum agreed amount and supported by monthly SOEs. Replenishment will not be allowed unless the PIUs are up to date in the submission of their respective SOEs. The proposed project funds flow for Myanmar is shown in Appendix 2.

[10] First generation imprest account
[11] Second Generation imprest account

V. Risk Description and Rating

Risk Description	Impact	Likelihood	Risk Assessment	Mitigation Measure
Inherent Risk				
1. Country Specific				
1. 1 Public financial management system does not conform to international standards.	High	Likely	High	MOF should move towards compliance with IPSAS cash basis standard
1.2 Weak internal controls does not assure that financial statements are being conducted effectively	High	Likely	High	Internal audit units should be established in all the line ministries
2. Entity Specific - accounting and financial reporting using MS Excel can be prone to errors or fraud making the generation of the financial statements slow and unreliable	High	Likely	High	Accounting system should upgrade to computerized accounting system for greater efficiency and to enable the production of monthly financial statements.
Overall Inherent Risk			**High**	
Control Risk				
1. Implementing Entity – Financial management policies are inadequate for the project	High	Likely	High	• The inspection units in the departments should be elevated to internal audit unit status to strengthen internal audit function to ensure that the systems in place are strictly followed and conform to approved processes. • MOH to recruit more qualified staff with audit experience
2. Funds Flow – delays in liquidation of SOEs will delay the replenishment of the imprest accounts and sub-accounts resulting in the project activities not implemented on time	High	Likely	Substantial	Monthly liquidation of project related expenditures to ensure that imprest account and sub-accounts will be replenished on time
3. Accounting Policies and Procedures – the accounting policies and procedures are inadequate	High	Likely	High	Accounting system should upgrade to computerized accounting system for greater efficiency
4. Staffing – lack the experience and skills in ADB procedures will affect the implementation of the project. Staff also lack the basic computer skills	High	Likely	High	• ADB should conduct rigorous training on ADB procedures including but not limited to financial management and procurement • Conduct computer literacy course for all staff
5. Internal Audit – no functioning internal audit unit in MOH	High	Likely	High	• The inspection units in the departments should be elevated to internal audit unit status to give more force to their function of ensuring that the systems in place are strictly followed and conform to approved processes. • MOH to recruit more qualified staff with audit experience

6. External Audit – audit reports are not published and shows lack of transparency	High	Likely	High	Audit findings should be published and made available to the public to improve transparency and accountability. AGO should create a website and post all external audit reports of all line ministries and the different levels of government.
7. Reporting and Monitoring –coordination between the 2 department co-managers of the project will be difficult and the consolidation of all financial management reports cannot be produced on time making monitoring of project implementation difficult.	High	Likely	High	Since the two departments are co-equal, a management committee should be created to oversee the project. The committee will be composed of the 2 DGs and supported by director level staff from each department who will manage the day-to-day activities of the project and to ensure that reports are consolidated at the end of each month and submitted to MOH and ADB.
8. Information Systems – use of MS Excel is prone to errors and fraud and cannot be relied upon	High	Likely	High	MOF should approve the use of computerized accounting software for the project to generate financial statements
Overall Control Risk			**High**	
Overall (Combined) Risk			**High**	

Source: Consultant's Assessment

VI. Proposed Time-Bound Action Plans

28. The following initial Financial Management Action Plan has been prepared based on the basic principles of sound financial management practices in the areas of (i) internal control, (ii) funds flow, (iii) accounting and financial reporting, (iv) and independent audits. This plan will be updated annually based on discussions with the government as well as based on the results of the annual fiduciary reviews conducted.

Weakness	Mitigating Action	Responsibility	Timeframe
Skills capacity of the staff is low	Intensive training on ADB procedures to include but not limited to financial management and procurement	ADB	Within six months of loan effectiveness
	Outsource the staff requirement in the states and region to support the PPIU. All the staff need to be trained in ADB procedures	MOH and State/Region	Staff recruitment within three months of loan effectiveness. In the first year, the staff will be guided by the implementation consultants. During the second year, the staff take over but with supervision from consultants. From the third year onwards by the staff.
	Conduct computer literacy course for all the staff	MOH	Within three months of loan effectiveness
Accounting policies and procedures are inadequate	Accounting system should upgrade to computerized accounting system for greater efficiency and enable the production of monthly financial statements.	MOF and MOH	Within six months of loan effectiveness

Lack of internal audit function in MOH	The inspection units in the departments should be elevated to internal audit to give more force to their function of ensuring that the systems in place are strictly followed and conform to approved processes.	MOH	• At loan effectiveness, MOH will upgrade the inspection units to an internal audit and to include the project in its annual audit plan • Conduct regular monthly audits of the project. This will be included as part of the loan covenants. • MOH to ensure that the internal audit unit will have sufficient and qualified staff in the internal audit unit to perform the increased tasks. New internal auditors to be hired at loan effectiveness
External Audit reports are not published and shows lack of transparency	Rigorous monitoring by MOH and MOF of any current external audit observations and audit issues should be resolved quickly.	MOH	Semi-Annual Monitoring

Source: Consultant's Assessment

VII. Suggested Financial Management Covenants

29. The following are suggested to be included as part of the financial management covenants:

a) At loan effectiveness, MOH will establish an internal audit unit in each department by elevating the current inspection units to be the internal audit units.
b) The newly established internal audit units to conduct regular monthly audits of project accounts and submit audit reports to ADB, the Director General of each department and the CPMU.
c) At loan effectiveness, MOH to recruit qualified staff with experience in auditing
d) Within six month of loan effectiveness, MOH with the approval of the MOF will use computerized accounting system for the project for greater efficiency and to ensure that financial statements are made available to ADB and MOH on a monthly basis. Computerized accounting system to be used by the CPMU and PIUs for easy monitoring.
e) On the second year of project implementation, AGO to create a website that will contain the results of the external audit findings on line ministries and the different levels of government.

VIII. Conclusion

30. The GMS Health Security Project when implemented will (i) to prevent or control emerging infectious diseases and other infectious diseases of regional importance in a timely manner, (ii) enable the Viet Nam diagnostic system to provide accurate results in a safe and timely manner, thereby improving the health of patients and providing value for money and (iii) reducing the risk of nosocomial infection and increasing drug resistance by improving biosafety.

Although several financial management risks were identified, the proposed mitigating measures are sufficient for the satisfactory implementation of the project.

Appendix 1

Table 2: Financial Management Assessment Questionnaire[12]
Department of Medical Services and Department of Public Health
Ministry of Health

Topic	Response	Remarks
1. Implementing Agency		
1.1 What is the entity's legal status / registration?	Government Ministry created under the 1986 constitution	
1.2 How much equity (shareholding) is owned by the Government	Not Applicable	
1.3 Obtain the list of beneficial owners of major blocks of shares (non-government portion), if any	Not Applicable	
1.4 Has the entity implemented an externally-financed project in the past (if so, please provide details)?	Yes, World Bank Essential Health Services Access Project (2014-2018)	
1.5 Briefly describe the statutory reporting requirements for the entity?	Prepares reports and accounts according to manual and instructions for Myanmar government institutions	
1.6 Describe the regulatory or supervisory agency of the entity	Ministry of Health	
1.7 What is the governing body for the project? Is the governing body for the project independent?	Governing body is the Ministry of Health and not independent	
1.8 Obtain organizational structure and describe key management personnel. Is the organizational structure and governance appropriate for the needs of the project?	The current organizational structure is appropriate to meet the needs of the project	
1.9 Describe the code of ethics in place?	NA	
1.10 Describe (if any) any historical issues reports of ethics violations involving entity and management. How were they addressed?	NA	
2. Funds Flow Arrangements		
2.1 Describe (proposed) project funds flow arrangements in detail, including a flow of funds diagram and explanation of the flow of funds from ADB, government and other financiers to the government, EA, IA, suppliers, contractors, ultimate beneficiaries	Conventional funds flow arrangements are proposed with direct payments and use of imprest accounts at the Union Government level Appendix 2 for the chart.	

[12] The responses to this questionnaire describe the existing situation in the two departments of the Ministry of Health (MOH) under its present legal status, structure and staffing.

Topic	Response	Remarks
2.2 Are the (proposed) arrangements to transfer the proceeds of the loan (from the government / Finance Ministry) to the entity satisfactory?	Yes. The proceeds of the loan from ADB will be transferred by the MOF (Budget Department) to the account to be managed at the Union Government level, through the Myanmar Economic Bank (Government Bank).	
2.3 Are the disbursement methods appropriate	Yes	
2.4 What have been the major problems in the past in receipt of funds by the entity?	NA	
2.5 In which bank will the Imprest Account be opened?	Myanmar Economic Bank	
2.6 Is the bank in which the imprest account is established capable of – • Executing foreign and local currency transactions • Issuing and administering letters of credit • Handling large volume of transactions • Issuing detailed monthly bank statements promptly	Yes	
2.7 Is the ceiling for disbursements from the imprest account and SOE appropriate/ required?	NA	
2.8 Does the (proposed) project implementing unit (PIU) have experience in the management of disbursements from ADB?	No	
2.9 Does the PIU have adequate administrative and accounting capacity to manage the imprest fund and statement of expenditure (SOE) procedures in accordance with ADBs loan disbursement handbook. Identify any concern or uncertainty about the PIUs administrative and accounting capability which would support the establishment of a ceiling on the use of the SOE procedure.	No	
2.10 Is the entity exposed to foreign exchange risks? If yes describe the entity's policy and arrangements for managing foreign exchange risk	Yes	
2.11 How are the counterpart funds accessed?	Counterpart funds from the Union will be taxes and duties and will be managed directly by MOF.	
2.12 How are payments made from the counterpart funds?	Counterpart funds are disbursed by MOF in accordance with the disbursement procedures.	
2.13 If part of the project is implemented by communities or NGOs, does the PIU have the necessary reporting and monitoring features built into its systems to track the use of project proceeds by such agencies?	NA	

Topic	Response	Remarks
2.14 Are the beneficiaries required to contribute to project costs? If beneficiaries have an option to contribute in kind (in the form of labor), are proper guidelines formulated to record and value the labor contribution?	NA	
3. Staffing		
3.1 What is the (proposed) organizational structure of the accounting department? Attach an organization chart.	To be determined	
3.2 Will existing staff be assigned to the project or will new staff be recruited	NA	
3.3 Describe the (proposed) accounts staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions and CVs of key accounting staff.	NA	
3.4 Is the project finance and accounting function staffed adequately?	The current staffing structure of the Finance Department is adequate for the Ministry's existing functions as well as for all the line ministries	
3.5 Are the finance and accounts staff adequately qualified and experienced?	Staff have higher education but no accounting degree	
3.6 Are the project accounts and finance staff trained in ADB procedures?	No	
3.7 What is the duration of the contract with the finance and accounts staff?	Most of finance and accounting staff have long term appointments.	
3.8 Identify key positions not contracted yet, and the estimated date of appointment.	All permanent staff are filled in Personal Service Books. It shows appointment date, position and biography of staffs by one by one.	
3.9 For new staff, describe the proposed project finance and accounting staff, including job title, responsibilities, educational background and professional experience. Attach job descriptions	NA	
3.10 Does the project have written position descriptions that clearly define duties, responsibilities, lines of supervision, and limits of authority for all of the officers, managers, and staff?	None	
3.11 What is the turnover rate for finance and accounting staff?	Low frequency. Staff transfers are also within the department.	
3.12 What is training policy for the finance and accounting staff?	Staff are trained in current accounting and finance practices.	
3.13 Describe the list of training programs attended by finance and accounting staff in the last 3 years	NA	

Topic		Response	Remarks
4.	**Accounting Policies and Procedures**		
4.1	Does the entity have an accounting system that allows for the proper recording of project financial transactions, including the allocation of expenditures in accordance with the respective components, disbursement categories, and sources of funds? Will the project use the entity accounting system?	Yes Manual cash based accounting using MS Excel and Word.	
4.2	Are controls in place concerning the preparation and approval of transactions, ensuring that all transactions are correctly made and adequately explained?	No controls yet since no project yet. For MOH there are controls such as PR, vouchers. But any purchase should be specified in the budget.	
4.3	Is the chart of accounts adequate to properly account for and report on project activities and disbursement categories?	Yes the current chart of accounts has been revised and is adequate.	
4.4	Are cost allocations to the various funding sources made accurately and in accordance with established agreements?	Yes	
4.5	Are the General Ledger and subsidiary ledgers reconciled and in balance?	Yes, these are reconciled every month. Bank recon conducted monthly	
4.6	Describe the EAs policy for retention of accounting records including supporting documents (e.g. ADBs policy requires that all documents should be retained at least 1 year after ADB receives the audited project financial statements for the final accounting period of implementation, or 2 years after the loan closing date whichever is later). Are all accounting and supporting documents retained in a defined system that allows authorized users' access?	Yes	
4.7	Describe any previous audit findings that have not been addressed	NA	
Segregation of Duties			
4.8	Are the following functional responsibilities performed by different units or persons: (i) authorization to execute a transaction; (ii) recording of the transaction; and (iii) custody of assets involved in the transaction?	Yes done by different persons	
4.9	Are the functions of ordering, receiving, accounting for, and paying for goods and services appropriately segregated?	Yes	

Topic		Response	Remarks
	Budgeting System		
4.10	Do budgets include physical and financial targets?	Only financial targets. The physical targets originate from the line ministry. Based on physical accomplishments, payment vouchers are made, reviewed and payments made	Budget adequately reflect the actual physical condition together with financial target
4.11	Are budgets prepared for all significant activities in sufficient detail to provide a meaningful tool with which to monitor subsequent performance?	Yes	
4.12	Are actual expenditures compared to the budget with reasonable frequency, and explanations required for significant variations from the budget?	Yes. Budget implementation is compared to budget estimates on a monthly basis. DMS revise their budget two to three times a year, and prepare detailed financial statements.	
4.13	Are approvals for variations from the budget required in advance or after the fact?	Approvals for variations from the budget are done in advance.	
4.14	Is there a ceiling, up to which variations from the budget may be incurred without obtaining prior approval	NA	
4.15	Who is responsible for preparation and approval of budgets?	The Director General of DOH (DMS & DPH) and submit to MOH. Each department (Department of Medical Service and Department of Public Health) prepares budget. Each department has its own director general and own admin and finance section	
4.16	Describe the budget process. Are procedures in place to plan project activities, collect information from the units in charge of the different components, and prepare the budgets?	Yes	

Topic	Response	Remarks
4.17 Are the project plans and budgets of project activities realistic, based on valid assumptions, and developed by knowledgeable individuals? Is there evidence of significant mid-year revisions, inadequate fund releases against allocations, or inability of the EA to absorb/spend released funds? Is there evidence that government counterpart funding is not made available adequately or on a timely basis in prior projects? What is the extent of over-or-under budgeting of major heads over the last 3 years? Is there a consistent trend either way?	Yes	
Payments		
4.18 Do invoice-processing procedures provide for: (i) Copies of purchase orders and receiving reports to be obtained directly from issuing departments? (ii) Comparison of invoice quantities, prices and terms, with those indicated on the purchase order and with records of goods actually received? (iii) Comparison of invoice quantities with those indicated on the receiving reports? (iv) Checking the accuracy of calculations?	Yes	I
4.19 Are all invoices stamped PAID, dated, reviewed and approved, and clearly marked for account code assignment?	Yes	
4.20 Do controls exist for the preparation of the payroll and are changes to the payroll properly authorized?	Yes	
Policies And Procedures		
4.21 What is the basis of accounting (e.g., cash, accrual)?	Accounting is on cash basis with opening and closing balance	
4.22 What accounting standards are followed (International Financial Reporting Standards, International Public Sector Accounting Standards – cash or accrual or national accounting standards or other?	Government accounting standard	
4.23 Does the project have an adequate policies and procedures manual to guide activities and ensure staff accountability?	The general policies and procedures comes from the Government Accounting procedure in financial instructions issued by MOF	
4.24 Is the accounting policy and procedure manual updated for the project activities?	Yes	
4.25 Do procedures exist to ensure that only authorized persons can alter or establish a new accounting principle, policy or procedure to be used by the entity?	Yes	The MOF can issue revisions in accounting policies and procedures but need parliament approval to change

Topic		Response	Remarks
4.26	Are there written policies and procedures covering all routine financial management and related administrative activities?	Yes the financial instructions from MOF	Specific policies and procedures will be prepared for the Project and included in the financial management for the project.
4.27	Do policies and procedures clearly define conflict of interest and related party transactions (real and apparent) and provide safeguards to protect the organization from them?	Yes	
4.28	Are manuals distributed to appropriate personnel?	Yes	
4.29	Describe how compliance with policies and procedures are verified and monitored	NA	
	Cash and Bank		
4.30	Indicate names and positions of authorized signatories in the bank accounts.	For the Medical Care Department, Dr.Than Htut Oo, Deputy Director General and for Public Health Department, Dr. Daw San San Myint, Director.	
4.31	Does the organization maintain an adequate, up-to-date cashbook, recording receipts and payments?	Yes	
4.32	Describe the collection process and cash handling procedures. Do controls exist for the collection, timely deposit and recording of receipts at each collection location?	Yes	
4.33	Are bank and cash reconciled on a monthly basis or more often? Is cash on hand physically verified and reconciled with the cash books? With what frequency is this done?	Yes every first week of each month.	
4.34	Are all reconciling items approved and recorded?	Yes	
4.35	Are all unusual items on the bank reconciliation reviewed and approved by a responsible official?	Yes	
4.36	Are there any persistent/ non-moving reconciling items?	NA	
4.37	Are there appropriate controls in safekeeping of unused cheques, USB keys and passwords, official receipts and invoices?	NA	
4.38	Are any large cash balances maintained at the head office or field offices? If so, for what purpose?	NA	
4.39	For online transactions, how many persons possess USB keys (or equivalent) and passwords? Describe the security rules on passwords and access controls	NA	
	Safeguard over Assets:		
4.40	What policies and procedures are in place to adequately safeguard or protect assets from fraud, waste and abuse?	Yes, have to follow rule & regulation (Admin & Financial)	

Topic	Response	Remarks
4.41 Does the entity maintain a fixed asset registry? Is the register updated monthly? Does the register record ownership of assets, any assets under lien or encumbered or have been pledged	NA	
4.42 Are subsidiary records of fixed assets, inventories and stocks kept up to date and reconciled with control accounts?	Yes	Changes in fixed assets and stock are recorded as they occur
4.43 Are there periodic physical inventories of fixed assets and stocks?	Yes	
4.44 Are there periodic physical inventories of fixed assets, inventories and stocks reconciled with the respective fixed assets and stock registers and discrepancies analyzed and resolved?	Yes	Reviews of physical inventories of fixed assists and stock are undertaken monthly and yearly.
4.45 Describe the policies and procedures in disposal of assets. Is the disposal of each asset appropriately approved and recorded? Are steps immediately taken to locate lost or repair broken assets?	NA	
4.46 Are the assets sufficiently covered by insurance policies?	Only buildings and vehicles are covered by insurance	
4.47 Describe the policies and procedures in identifying and maintaining fully depreciated assets from active assets	NA	
Other Offices and Implementing Entities		
4.48 Describe any other regional offices or executing entities participating in implementation	Yes at township level	
4.49 Describe staff, their roles and responsibilities in performing accounting and financial management functions of such offices as they relate to the project	NA	
4.50 Has the project established segregation of duties, controls and procedures for flow of funds and financial information, accountability and reporting and audits in relation to the other offices or entities?	No	
4.51 Does information among the different offices/ implementing agencies flow in an accurate and timely fashion? In particular, do the offices other than the head office use the same accounting and reporting system?	Yes	
4.52 Are periodic reconciliations performed among the different offices/ implementing agencies? Describe the project reporting and auditing arrangements between these offices and the main executing/ implementing agencies	Yes	
4.53 If any sub-accounts (under imprest account) will be maintained, describe the results of the assessment of the financial management capacity of the administrator of such sub-accounts	NA	
Contract Management and Accounting		

Topic	Response	Remarks
4,54 Does the agency maintain contract wide accounting records to indicate gross value of the contract and any amendments, variations and escalations, payments made, and undisbursed balances? Are the records consistent with physical outputs/ deliverables of the contract	NA	
4.55 If contract records are maintained, does the agency reconcile them regularly with the contractor?	NA	
Other		
4.56 Describe project arrangements for reporting fraud, corruption, waste and misuse of project resources. Has the project advised employees, beneficiaries and other recipients to whom to report if they suspect fraud, waste or misuse of project resources or property?	NA	
5. Internal Audit		
5.1 Is there an internal audit department in the entity?	There is an inspection unit within DOH that follows up on the external audit findings of the Office of the auditor general and reports the findings to the director general. External audits are conducted by the OAG every 6 months	
5.2 What are the qualifications and experience of audit department staff?	Most of them are Business Commerce degrees and other fields related to accounting, like Bachelor of Commerce, Diploma in Accounting, LCCI Accounting Course (London Chambers of Commerce and Industry)	
5.3 To whom does the internal auditor report?	Director, Deputy Director General, Director General, Minister	
5.4 Will the internal audit department include the project in its work program?	NA	
5.5 Are actions taken on the internal audit findings?	Yes	
5.6 What is the scope of the internal audit program?	NA	
5.7 Is the IA department independent?	NA	
5.8 Do they perform pre-audit of transactions	NA	
5.9 Who approves the internal audit program	NA	
5.10 What standards guide the internal audit program?	NA	
5.11 How are audit deficiencies tracked?	NA	
5.12 How long have the internal audit staff members been with the organization?	NA	

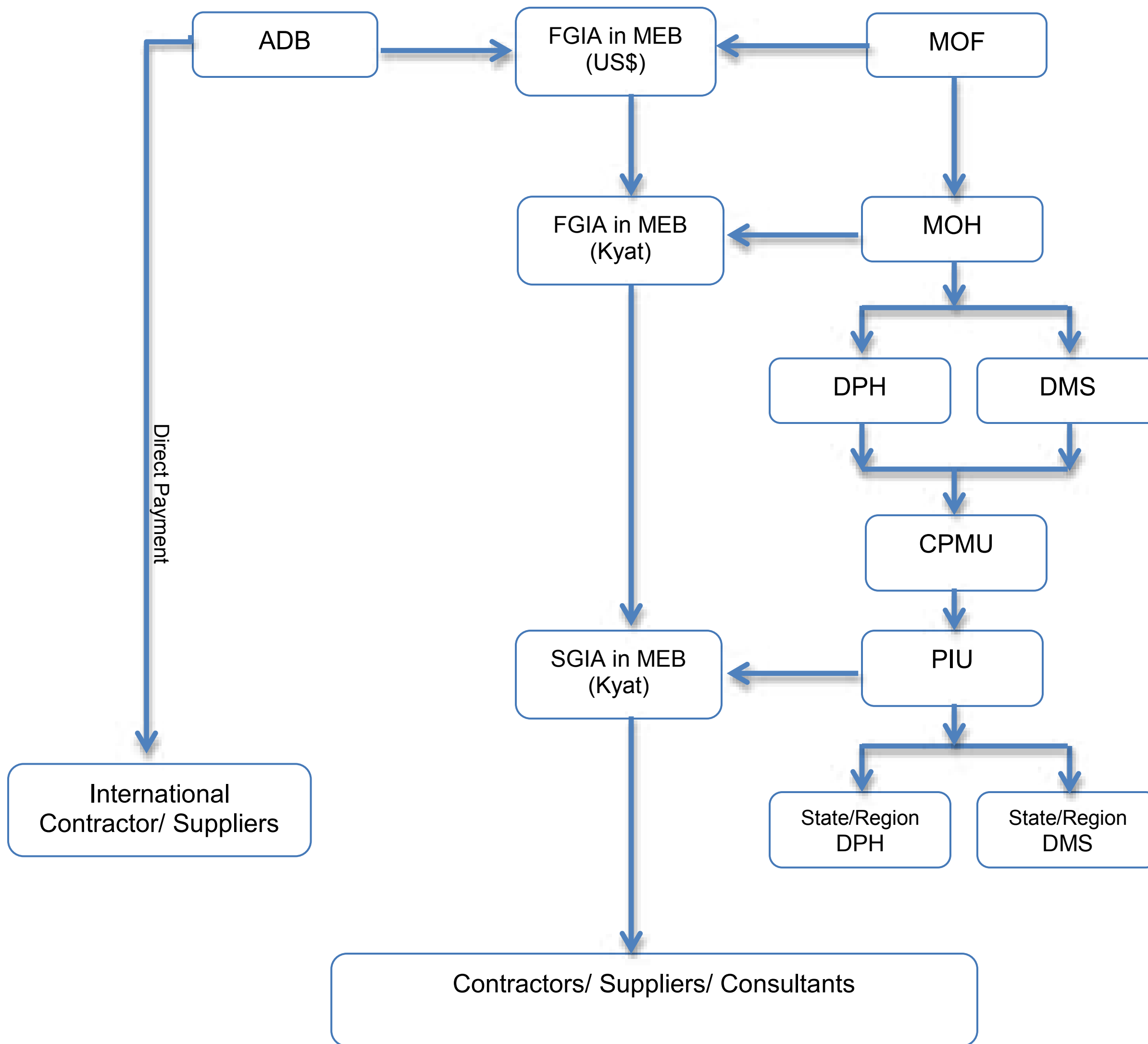
Topic	Response	Remarks
5.13 Does any of the internal audit staff have an IT background?	NA	
5.14 How frequent does the internal auditor meet with the audit committee without the presence of management	NA	
5.15 Has the internal auditor identified/ reported any issue with reference to availability and completeness of records	NA	
5.16 Does the auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6. External Audit		
6.1 Is the entity financial statement audited regularly by an independent auditor? Who is the auditor?	Financial records are audited by the auditor general every six months.	The AGO has adopted international audit standards and conducts mostly financial audits with some procurement and performance audits
6.2 Are there any delays in audit of the entity? When are the audit reports issued?	No delays. Audits are conducted every six months and the audit report is submitted within 1 week after completion of audit	
6.3 Is the audit of the entity conducted according to the International Standards on Auditing?	Yes according to instruction by AGO	
6.4 Were there any major accountability issues brought out in the audit report of the past three years?		
6.5 Does the external auditor meet with the audit committee without the presence of management?	NA	
6.6 Has the entity engaged the external audit firm for any non-audit engagements (e.g. consulting)? If yes, what is the total value of non-audit engagements, relative to the value of the audit services?	No	
6.7 Has the external auditor expressed any issues on the availability of complete records and supporting documents?	NA	
6.8 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures?	NA	
6.9 Are there any material issues noted during the review of the audited entity financial statements that were not reported in the external audit report?	NA	
External Audit – Project Level		

Topic	Response	Remarks
6.10 Will the entity auditor audit the project accounts or will another auditor be appointed to audit the project financial statements	AGO shall audit the project or may allow a private auditor acceptable to ADB to audit.	
6.11 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	No	
6.12 Is the project subject to any kind audit from an independent government entity (e.g. Supreme audit institution) in addition to the external audit?	Yes auditor general office	
6.13 Has the project prepared acceptable terms of reference for an annual project audit? Have these been agreed and discussed with the EA and the auditor?	The TOR for the audit will be part of the Project Financial Management Manual.	
6.14 Has the project auditor identified any issues with the availability and completeness of records and supporting documents?	NA	
6.15 Does the external auditor have sufficient knowledge and understanding of ADBs guidelines and procedures, including the disbursement guidelines and procedures	NA	
6.16 Are there any recommendations made by the auditors in prior audit reports or management letters that have not yet been implemented	NA	
6.17 (for second and subsequent projects) Were past audit reports complete and did they fully address the obligations under the loan agreements? Were there any material issues noted during the review of the audited project financial statements and related audit report that have remained unaddressed?	NA	
7. Reporting and Monitoring		
7.1 Are financial statements prepared for the entity? In accordance with which accounting standards?	For the Budget – Government Accounting Standards; For the Revolving Fund – Myanmar Accounting Standard for Revolving Fund.	
7.2 Are financial statements prepared for the implementing unit?	Yes	
7.3 What is the frequency of preparation of financial statements? Are the reports prepared in a timely fashion so as to useful to management for decision making?	Annually, semi-annually, quarterly and monthly.	
7.4 Does the reporting system need to be adapted to report on the project components?	Yes	
7.5 Does the project have established financial management reporting responsibilities that specify what reports are to be prepared, what they are to contain, and how they are to be used?	Yes	

Topic	Response	Remarks
7.6 Are financial management reports used by management?	Yes.	
7.7 Do the financial reports compare actual expenditures with budgeted and programmed allocations?	Yes	
7.8 How are financial reports prepared? Are financial reports prepared directly by the automated accounting system or are they prepared by spreadsheets or some other means	Financial reports for DMS & DPH are prepared using Microsoft Excel and Microsoft Word	
7.9 Does the financial system have the capacity to link the financial information with the projects physical progress? If separate systems are used to gather and compile physical data, what controls are in place to reduce the risk that the physical data may not synchronize with the financial data?	NA	
7.10 Does the entity have experience in implementing projects of any other donors, co-financiers or development partners	Yes	
8. Information Systems		
8.1 Is the financial management system computerized?	Financial reports are prepared manually with use of excel spreadsheets. 50% use of computer.	
8.2 If computerized, is the software off the shelf or customized?	Not Applicable	
8.3 Is the computerized software standalone or integrated and used by all departments in the headquarters and field units using modules	Not Applicable	
8.4 How are the project financial data integrated with the entity financial data? Is it done through a module in the enterprise financial system with automatic data transfer or does it entail manual entry?	NA	
8.5 Is the computerized software used for directly generating periodic financial statements or does it require manual intervention and use of Excel or similar spreadsheet software?	Excel	
8.6 Can the system automatically produce the necessary project financial reports	No	
8.7 Is the staff adequately trained to maintain computerized system	Yes	Training not sufficient
8.8 Does the management organization and processing system safeguard the confidentiality, integrity and availability of the data?	Not totally	
8.9 Are there back-up procedures in place?	NA	
8.10 Describe back up procedures – online storage, offsite storage, offshore storage, fire, earthquake and calamity protection for backups?	NA	

Appendix 2

Proposed Flow of Funds



Project Procurement Risk Assessment Report, Cambodia

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS

(as of 7 April 2016)

Currency Unit	–	riel (KHR)
KHR1.00	=	$0.000248
$1.00	=	KR4,029

NOTES

(i) The fiscal year (FY) of the Government of Cambodia and its agencies ends on 31 December. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

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ACRONYMS

ADB	Asian Development Bank
ACU	Anti-corruption Unit
AFD	Agence Française de Développement (French Development Agency)
BEC	Bid Evaluation Committee
CEC	Consultant Evaluation Committee
CDC	Communicable Disease Control
CQS	Consultants Qualification Selection
DC	Direct Contracting
DP	Development Partners
DPHIS	Department of Planning and Health Information Systems
EA	Executing Agency
GAVI	Global Alliance for Vaccines and Immunization
HSSP	Health Sector Support Program
IA	Implementing Agency
ICB	International Competitive Bidding
LIB	Limited International Bidding
MEF	Ministry of Economy and Finance
MOH	Ministry of Health
NCB	Non-competitive Bidding
NGO	Non-governmental Organization
NS	National Shopping
PMU	Project Management Unit
PRA	Procurement Risk Assessment
PRC	Procurement Review Committee
QCBS	Quality and Cost Based Selection
RGC	Royal Government of Cambodia
RFP	Request for Proposal
SBD	Standard Bidding Documents
SOA	Special Operation Agencies
SSS	Single Source Selection
SOP	Standard Operating Procedures
TA	Technical Assistance
TER	Technical Evaluation Report
TOR	Terms of Reference
WB	World Bank

EXECUTIVE SUMMARY

Overall Cambodia procurement risks is assessed to be Average to Low. While the Procurement Law was signed 14 January 2012, adequate rules and regulations governing procurement procedures have been in place and made mandatory by the Sub Decree No.14 dated 26.2.2007 & National: Sub-Decree No.105/2008. The Standard Operating Procedures (SOP) and the Procurement Manual were prepared with the assistance of the WB and the ADB to largely support externally funded projects and therefore the procedures do not conflict with the ADB guidelines on procurement of good and works and the procurement of consulting services. Development Partners (DP), including the ADB, periodically conducts procurement workshops and seminars for project staff as part of the capacity building exercise. None of the national practices run contrary to ADB's procurement policies. The SOP requires wide publicity of all procurements including inserting notices in the local newspapers and the Project website. It is also required that the procurement results are posted in the relevant project website and published in the local newspaper.

The Project Management Unit (PMU) is well equipped and staffed, and benefits from the experience gained in implementing CDC II, which was also financed by ADB. The same team in the procurement unit in CDC II has been nominated to participate in implementing GMS HSP. Based on the assessment, the executing agency (EA) has adequate procurement capacity to handle NCB (National Competitive Bidding) and Shopping. However, the weakness appears largely in the capacity of the PMU to handle complex International Competitive bidding (ICB) for complex health equipment. It is recommended that the PMU be supported by international procurement specialist through the initial stages and by national procurement specialist in the long term.

The PMU office has adequate facilities and experience in filing and storing procurement documents.

The EA has adequate procurement capacity to handle ICB, NCB (National Competitive Bidding) and Shopping. The PMU is quite familiar with the Governments SOP; most procurement will be centralized in the PMU in Phnom Penh where experienced procurement officers have been appointed. The strength stems from the years of experience (over ten years) the senior procurement officer has gained working with ADB financed projects.

The weaknesses are largely covering ICB and the recruitment of consultants following the Quality and Cost-Based Selection (QCBS) procedure and the General Procurement Environment in the country where the overall risk rating is assessed as high.

Generally, the procurement risks are low. The executing agency's procurement team is experienced in conducting this type of procurement. The procurement procedures and requirements of the government are aligned with the international practice. The executing agencies have recent experiences in selecting and managing contracts for goods and works, and consulting services. However, considering their unfamiliarity with ADB's guidelines, the PMUs will need training on ADB's guidelines particularly for procuring and managing complex health sector goods and equipment. To assist the PMUs with ADB's procedures and requirements, support consultants are recommended to be engaged to assist and provide on-the-job training for PMUs in procuring and managing the contracts.

The PMUs have sufficient practices and strengths in procurement under externally financed projects including experiences in preparing documents, evaluating bids, and administering

contracts for goods, works, and consulting services using ADB loan funds. There should be capacity development programs provided for the PMU to strengthen skills to procure and manage international contracts. Training should be provided as part of improved competencies in procurement and health security management.

Moreover, a long-term procurement reform will need to be continued to open competitive processes as well as streamline approval process, and the Ministry of Finance is still responsible for the procurement reform with support from development partners.

I. INTRODUCTION

1. As part of the Greater Mekong Subregion (GMS) Economic Development Program, the governments of Cambodia, the Lao PDR, Myanmar and Viet Nam have requested the Asian Development Bank (ADB) to consider supporting GMS Health Security Project (the Project). The purpose is to improve GMS health security systems, disease control in lagging communities, and capacity for cooperation, so as to enhance GMS health security and contribute to global health security. This follows several GMS projects supporting communicable diseases control (CDC), HIV/AIDS, malaria, dengue, and food safety, implemented from 2000 to 2015. The proposed Project is to enhance GMS health security based on ASEAN and WHO APSED/IHR (Asia Pacific Strategy for Emerging Diseases 2010, International Health Regulations 2005) standards, including improving (i) disease surveillance and response, (ii) laboratory services, (iii) hospital infection control, (iv) CDC in hotspots in border districts, and (v) GMS collaboration for outbreak control and related knowledge management. It is built on the achievements and lessons learned of the governments of the Greater Mekong Subregion (GMS), the Asian Development Bank (ADB), the World Health Organization (WHO) and other partners and networks in enhancing GMS health security and reducing the burden of communicable diseases in the past ten years. This was guided by the WHO regulations and strategies, regional networks, and national plans and policies. The total project in the 4 countries is estimated to cost US $135 million, including US $21 million for Cambodia. The Ministry of Health of Cambodia is requested to identify possible co-financing sources for both project loan and grant. The governments' contribution is tentatively proposed at 5%, with ADB and possible partners requested to finance 95% of loan costs and all technical assistance (TA) costs. ADB has programmed loan and TA assistance by end 2016 or early 2017.

2. With the total estimated project cost of US $21 million, the Health Security Project in Cambodia may have to process many procurement packages for office equipment, medical equipment, laboratory equipment, vehicles, consulting services and works, etc. with estimated values of up to US $ million per each procurement packages. Procurement for the proposed project is complex as it concerns a large number of items for many locations, including for laboratory equipment that needs to be of high quality and standardized as much as possible.

3. ADB wants to limit the number of procurement packages, while also being concerned about delays in procurements; and therefore, this Procurement Assessment is conducted with objectives as below.

(a) To evaluate the capability of the Ministry of Health, Cambodia and its adequacy of procurement procedures to comply with ADB's procurement guidelines,

(b) To identify the procurement arrangements to be adopted and the need to strengthen EA's capacity in undertaking the project procurement to minimize risks that may affect the procurement of the project; and

(c) To prepare procurement plan for the proposed project (Health Security Project/Cambodia) with appropriate procurement method as well as type of ADB review (prior or post).

4. An international consulting firm, Conseil Santé, has been engaged to conduct R-PPTA. The R-PPTA has four phases: inception, sector analysis, project preparation, and consolation. This report is prepared to provide information of Procurement Assessment result for Cambodia as a part of the R-PPTA. This Project Procurement Risk Assessment (PPRA) has been conducted during the period from September 2015 to June 2016, and the report prepared in accordance with ADB's latest Guidelines for Assessing Country, Sector and Project

Procurement Risks (issued August 2014). The PPRA considered the Ministry of Health (MOH) as the Executing Agency (EA), and its Department of Communicable Disease Control (CDC) as the proposed project Implementing Agency (IA) for the proposed GMS Health Sector Project (GMS-HSP) for Cambodia.

5. Conseil Santé has contracted one International Procurement Specialist and four National Procurement Specialists to conduct procurement assessment in the four countries in the context of the scope of the proposed GMS Health Security Project.

6. The purpose of the procurement assessment is to:

(i) Identify the capacity, procedural and organizational constraints that will hinder effective Project implementation and agree on an action plan with the Ministry of Health, Cambodia to address these constraints;

(ii) Determine the overall procurement risk, and establish appropriate review and supervision processes, including thresholds, to mitigate these risks;

(iii) Ensure that procurement is undertaken by a regular line unit within the Ministry of Health, Cambodia, and agree on the action plan to strengthen the ministry's procurement capacity, so that its capacity strengthening extends beyond the project's lifecycle;

(iv) Identify levels of reputational risk to ADB and put in place appropriate prior review and process thresholds to mitigate this risk, balanced with the needs for operational efficiency;

(v) Identify any implementation risks present in terms of procurement resources, structure and process, and propose mitigating measures.

7. The International Procurement Specialist reviewed all related information provided by the National Procurement Specialist that was collected through desk review, face to face interviews and field visits. In conducting of the procurement assessment, the International Procurement Specialist and the National Procurement Specialist have:

- Reviewed procurement organization and system in Cambodia (legal framework, agencies, roles and responsibilities) including processes to improve the procurement system, e-procurement and audit.
- Analyzed ADB procurement documents (guidelines, PAI…) against Cambodia procurement legal documents (procurement law, guidance degree, circulars, etc.) and clarified the differences between the Cambodia procurement procedures and the ADB guidelines.
- Developed questionnaires and interviewed officers in charge and relevant procurement staff of Ministry of Health and its implementing agencies (IAs), and requested Ministry and its IAs to meet for interview to complete a questionnaire.
- Analyzed procurement documents from previous projects of the Ministry of Health, Cambodia.
- Appraised the procurement capacity of Ministry and Project Implementing Units (PIUs) based on the filled questionnaire.
- Discussed about staff quantity, qualifications, procurement experience, size, type and period of procurement, and other issues such as equipment quality.

- Reviewed procurement monitoring and document keeping: monitoring information system, record of the procurement process, and document keeping.
- Proposed procurement capacity building, mentoring and supervision arrangements.

8. Five sets of Procurement Assessment Questionnaires have been prepared for the assessment purpose. One set of questionnaire was developed to get information about general procurement environment and other set about procurement capacity of the PMU. The questionnaires with guidance notes were not just simply distributed to the respondents to answer/complete. Answer responding to each individual question prescribed in the two questionnaires was received/accepted after face to face interview between the National Procurement Specialist and respective interviewees/respondents. The questionnaires were completed during the interview between the National Procurement Specialist and Procurement Unit of HSSP2 (Chief of Procurement Unit and Procurement Officer), and IT Specialist (CDC2 Project).

9. Three other questionnaires that contained the same set of questions were used in conducting interviews with three Special Operating Agencies (SOAs): Pornheakrek SOA in Tbong Khmum Province, Stung Treng SOA in Stung Treng Province and Poi Pet SOA in Banteay Meanchey Province. The three questionnaires were used to collect information regarding capacities of the SOAs and how they process procurements at the operational districts as well as their procurement record keeping.

10. The procurement assessment was conducted to identify the followings:

1- Procurement Legislative and Regulatory Framework
2- Institutional Framework and Management Capacity
3- Procurement Operations and Market Practices
4- Process and Oversight Control
5- E-Procurement
6- General Procurement Resource of the Ministry of Health
7- Past/Current Procurement experience
8- Procurement Records Keeping.

II. PROJECT PROCUREMENT RISK ASSESSMENT

A. Overview

11. ADB and World Bank funded a number of consultants through 2004 to mid of 2005 to produce Standard Operating Procedures (SOP) for Externally Assisted Projects of the Royal Government of Cambodia (RGC). The SOP was issued under Sub-decree in September 2005. Since they aligned with the policies, procedures and guidelines of the ADB and WB, the two banks approved their application to all ongoing and new projects.

12. Once again in late 2010, MEF, ADB and WB collaborated on a major update of the suite of SOP manuals using experience over the five years of their use. Again consultants were funded by ADB and WB to prepare the amendments, which were agreed by the three development partners (DPs) and was promulgated by Royal Government Sub-degree dated 22

May 2012 for use on all externally funded projects. The regulatory framework, the SOP, was designed with considerable input from DP procurement specialists. The SOP/PM consists of two volumes: (1) Policies and Procedures and (2) Standard Bidding Documents (SBD), in English, for Goods and Works up to the upper NCB threshold. Annex IV (a) is for Goods and Annex IV (c) is for Works and there are also SBD for shopping for both Goods and Works, with and without advertising.

13. ADB has played a leading part in funding intensive training of project executing and implementing agencies in the use of all volumes of the new SOP.

14. Administration of externally funded projects using the SOP is undertaken by the Department of Cooperation and Budget Management (DCBM) of the General Directorate of Budget (GDB) of MEF. Process of all procurement activities of all development projects/programs of the Royal Government of Cambodia funded by development partners are mandatory to follow procurement guideline as stipulated in a SOP that guides the administration/management of all the government externally funded projects/programs.

15. Procurement for externally assisted projects may be undertaken in accordance with procedures specified in the financing agreements if required by the donor. Normally, such procedures would be the policies and guidelines of the financing development partner, but MEF has confirmed that implementation in accordance with the provisions of the SOP is an acceptable alternative.

16. The Ministry of Health of Cambodia, like other executing agencies, has not created its own manual/procedures for its own procurement process other than the SOP promulgated in May 2012 as mentioned above. Procurement thresholds are defined in the SOP (Procurement Manual Volume 1, page 156) and were agreed by ADB during the SOP updating process in 2010-12. The major thresholds for goods and works stipulated are as below:

Table 1: Thresholds for Goods and Works

Goods	ICB	Procurement above $300,000
	NCB	Procurement above $100,000 up to $300,000
	Shopping with advertising	Procurement above $25,000 up to $100,000
	Shopping without advertising	Procurement above $500 up to $25,000
Works	ICB	Procurement above $1,000,000
	NCB	Procurement above $100,000 up to $1,000,000
	Shopping with advertising	Procurement above $25,000 up to $100,000
	Shopping without advertising	Procurement up to $25,000

17. To improve procurement performance, ADB had increased the upper threshold for Works procured by NCB to $3 million, and for Goods procured by NCB to $1 million via an official to MEF. The thresholds in the SOP are aligned with the new ADB thresholds.

18. The SOP make open competitive tendering the default method of procurement with clarity as to when other less competitive methods can be used. It supports non-discriminatory participation, transparent tender processes (including advertisement, tender documentation, tender evaluation, complaints mechanism). Generally, there are no restrictions and no domestic preference provision for NCB. However, individual DP eligibility rules are acknowledged and, for ADB, eligibility is limited to bidders from ADB member countries and the origin of goods and materials is also limited to ADB member countries.

19. A Pilot Country and Sector/Agency Procurement Risk Assessment for Cambodia was conducted by Operations Services and Financial Management Department of ADB, from late September 2014 to early March 2015. It has concluded that Cambodia is perhaps unique among ADB borrowing countries that, under the enabling law for procurement, it has developed a harmonized regulatory framework for all externally financed projects and programs, combining its own policies and procedures with those of ADB (and its other DPs including the WB) to produce the SOP. The procurement risk at country level and in the four sectors covered is assessed as moderate. The project procurement risk assessment and management plans (P-RAMPs) for country and sector level are identical and focus on two risks:

1- Lack of staff understanding of and compliance with some aspects of the SOP, including but not limited to procurement record keeping and tracking; and

2- Lack of an internationally recognized procurement professionalization program for RGC procurement officers.

20. Two mitigation measures are recommended from the risk assessment:

a) Continue to provide training for EA/IA staff on operationalizing the SOP, perhaps through mentoring rather than classroom style, and extend training to members of evaluation and procurement review committees; and

b) Support RGC through MEF to establish a procurement professionalization program in Cambodia by twinning a local seat of learning with an internationally recognized center of excellence.

Table 2: P-RAMP for Cambodia at Country level

Risk	Assessed Level of Risk	Mitigation Measures
Lack of staff understanding of and compliance with some aspects of the SOP, including but not limited to procurement record keeping and tracking.	Moderate	Assist RGC through MEF by continuing to provide training for EA/IA staff on operationalizing the SOP, perhaps through mentoring rather than classroom style. Training should extend to members of evaluation and procurement review committees.

Lack of an internationally recognized procurement professionalization program for RGC procurement officers.	Moderate	Support RGC through MEF to establish a procurement professionalization program in Cambodia by twinning a local seat of learning with an internationally recognized center of excellence in procurement.

21. The proposed P-RAMP for the health sector is identical to that for the country level assessment, with two risks: (1) lack of staff understanding in following some requirements of the SOP; and (2) lack of an internationally recognized procurement professionalization program for RGC procurement officers. The P-RAMP is shown in the table below.

Table 3: P-RAMP for Health Sector

Risk	Assessed Level of	Mitigation Measures
Lack of staff understanding of and compliance with some aspects of the SOP, including but not limited to procurement record keeping and tracking	Moderate	Assist RGC through MEF by continuing to provide training for EA/IA staff on operationalizing the SOP, perhaps through mentoring rather than classroom style. Training should extend to members of evaluation and procurement review committees.
Lack of an internationally recognized procurement professionalization program for RGC procurement officers.	Moderate	Support RGC through MEF to establish a procurement professionalization program in Cambodia by twinning a local seat of learning with an internationally recognized center of excellence.

Source: TA-8262 REG: Developing Procurement Capacity for Improved Procurement Outcomes

i. Organization and Staff Capacity

22. The institutional framework and the roles and responsibilities of all line ministries and other government agencies in the procurement process are fully described in the promulgated SOP.

23. The PMU works under leadership and guidance of Project/Program Director who is a government high ranking official, and currently in position of Secretary of State. Department directors of the Ministry were also appointed as Project Manager and Program Coordinator to assist the Project/Program Director in daily operations of the project and programs.

24. In adherence to the promulgated SOP, all evaluations of bids/proposals submitted for supply of Goods/Works or provision of Service under the projects/programs are done by a Bid Evaluation Committee (BEC) whose members consist of procurement staffs (procurement counterpart staffs and consultants), technical staff of the PMU and representative(s) from the Ministry of Economy and Finance. Bid/proposal evaluation reports prepared by the BEC need to be reviewed by a Procurement Review Committee (PRC) whose members consist of higher ranking officials in the PMU and representative(s) from the Ministry of Economy and Finance.

The composition of both the CEC and PRC varies depending on the size of tenders (contract amounts), which it is clearly described in the SOP.

- PMU: Project Management Unit (PMU) is established with the delegated authority to implement the project or TA in an efficient and effective manner. The PMU acts as the focal point for project implementation and carries out the day-to-day project management and administration. It undertakes all of the core procurement activities required by the project.
- PRC: The exclusive duty of the Procurement Review Committee (PRC) is to review, consider and approve bid and proposal evaluation reports (BER/TER/Combined Evaluation Report) for the award of goods, and civil works, and consulting services procured under the project. The PRC is the only authority to (1) approve the award of contracts, (2) review and approve evaluation of individual consultants, (3) Review and approve draft bid documents and RFPs, (5) review and approve shortlist of consulting firms, (6) Review and approve contract amendments and variations that increase original contract value or increase scope of works.
- BEC: The responsibility of the Bid Evaluation Committee (BEC) is to review all bids submitted and prepare Bid Evaluation Reports for the consideration of the PRC in respect of goods, and works. The BEC's Bid Evaluation Reports for goods and works must be submitted, by the BEC Chair to the PRC for review and final approval, before the contract may be awarded.
- CEC: The responsibility of CEC is to (1) Evaluate all Expression of Interests and select short list of firms, (2) Carry out evaluation of technical and financial proposals for consulting services, (3) Prepare the Technical Evaluation Report (TER), (3) Rank the firms after combined evaluation of technical and financial proposals, (4) Submit the TER and combined evaluation reports and recommendation for award of contracts to PRC for approval, and (5) Carry out evaluation of individual consultants.

25. There is no Procurement Department in the Program/Project Secretariat, but a Procurement Unit of the Secretariat instead. Historically, the Procurement Unit has undertaken many procurement tenders for complementary package of activities (CPA) for equipment, laboratory equipment, vehicle, and office equipment, construction of health center, hospital building, ARV drug, selection of Individual Consultant, NGOs, and consulting firm, etc. up to US $ million per contract.

26. The legal and regulatory framework is applied to all agencies preparing and implementing ADB funded projects and programs. The Procurement team of the PMU is responsible for all procurement activities of the program secretariat and reports to the Project Director.

27. Currently, the Ministry has assigned two of its technical staff from the Ministry's Departments to work in the Procurement Unit of the PMU as Procurement Officers. Both of them hold at least bachelor degree. However, although the PMU has been established and has been implementing projects/programs for almost 20 years, and the ministry's staffs assigned to work with hired procurement consultants have worked in the PMU's Procurement Team for so many years, they are still yet to be able to proceed procurement tenders on their own; and therefore, international and national procurement consultants are always hired to help them.

28. The procurement staff have attended many procurement training organized by the Ministry of Economy and Finance, ADB and the World bank.

29. The BEC members consist of procurement staff (procurement counterpart staff and consultants), technical staff of the PMU and representative(s) from the Ministry of Economy and Finance. All of them are provided with written job descriptions.

30. The Procurement Unit reports to the Project Director. There are 3 to 5 staff working in the Procurement Unit, depending on workload, and the head of the Procurement Unit has procurement experience of 10 years. One of the three staff (hired consultants) works full-time, while the other two work as seconded. They have English language skills sufficient to undertake procurement, and have participated in many training programs organized by DPs and MEF. They all would make it sufficient to undertake the additional procurement that will be required under the proposed project.

31. The procurement unit of the Program Secretariat is equipped with adequate facilities such as PCs, internet connections, photocopy facilities, printers, etc. to undertake the procurement.

32. Under current HSSP2, the Ministry's existing Special Operation Agencies (SOAs) are delegated with procurement role and responsibility at each operational district to procure goods, works and services with total estimated to be less than USD 50,000 per tender, as required/requested by their respective Operating Districts. The procurement team of the PMU also provides them with procurement technical assistance for carrying out the procurement process at the district level. But, it should be noted that the SOAs are entitled/allowed to procure only for goods, works and services to be paid by their annual bonuses which are calculated based on the volume of their annual activities committed. The SOAs also have to process procurement in compliance with rules under the SOP.

33. Procurement is tied to the Annual Operational Plan (AOP) of the Ministry of Health and can be started under advance action before DP financing is approved and becomes effective, up to but not including contract signing. The Procurement Unit tracks procurement process properly to foster efficiency through the use of adequate procurement planning. For DP funded projects, compliance with the SOP as required in financing agreements is overseen by the Department of Cooperation and Budget Management (DCBM) of MEF. The Chair of the PRC is independent from the head of the ministry. PRC members are not required to have received procurement training but their performance is monitored. In the SOP there is provision for individual PRC members to refer back to their management when they cannot agree on a recommendation. This reduces the full independence of the PRC.

34. There have been government sponsored and DP funded training programs since the original SOP were introduced in 2005, and they have increased in intensity since the amended SOP were issued in 2012. The Procurement staff have always attended the training.

35. Cambodia has extensive procurement experience with ODA in general and ADB projects following ADB procurement rules. Various agencies including the World Bank, ADB and bilateral partners like Korea have provided technical assistance to improve procurement systems. There is also substantial procurement experience in the health sector, but this experience is mixed.

36. The Ministry of Health has established a Project Management Unit (PMU), which is currently called "Program Secretariat", for implementing the ministry's projects/programs that are mostly funded by ADB, the World Bank, Koica, DFID, AusAID, AFD, GAVI, etc. There are four technical units in the PMU, namely Administration Unit, Technical Unit, Financial Management Unit and Procurement Unit. PMU staff consist of the ministry's technical officials and hired consultants. They all work together to implement projects/programs' activities. In every unit of the PMU, the Number of hired consultants is much higher than the number of the ministry's

counterpart staff. Hired consultants get paid by development partners' funds, and they provide technical assistance per their respective roles and expertise.

37. The Project Management Unit plays the role of implementing agency. It has the responsibility of carrying out all procurement activities including preparing procurement documents, proceeding with bidding from issuing call for bids to evaluation of bids, negotiation and signing contracts, and monitoring the implementation of all signed contracts. For implementing procurement activities of its externally funded projects/programs, the Ministry of Health has hired both international and national procurement consultants to provide technical assistance to the Procurement Unit for almost the whole life of project/program implementation. At the time of conducting this procurement assessment no international consultant was hired due to the fact that procurement works remaining were very few.

38. All procurement activities for all externally funded projects/programs of the Ministry of Health are implemented only by the PMU, and the PMU has experience in processing procurement for numerous tenders including procurements of goods, works and services. Therefore its capacity in procuring services is adequate.

39. The PMU has experiences in procuring Goods, Works and Service of up to millions of dollars per contract, but usually with supports of contracted national and international procurement consultants.

ii. Information Management

40. Procurement monitoring sheets are systematically used for tacking the status of the process of all procurement tenders. And, they are regularly updated by the responsible staff in the Procurement Unit of the PMU. All procurement documents are found to be kept in a good order and in a good manner for easy finding.

41. There is a referencing system for procurement files; original contracts are secured in a fire and theft proof location, copies of bids or proposals are retained with the evaluation reports, copies of the original advertisements are retained with the pre-contract files. There is a single contract file with a copy of the contract and all subsequent contractual correspondence; copies of invoices are included with contract papers. And, all procurement documents are kept by the ministry for a period of 10 years.

iii. Procurement Practices

42. The private sector has developed strongly over the last 10 years in bidding activities. It is competitive and responsive to public procurement opportunities. The Royal Government has a non-discriminatory policy on participation of foreign bidders and bidding periods are adequate, aligned with those of the DPs. A complaints handling mechanism is built into Standard Bidding Documents for NCB and is detailed in the Procurement Manual of the SOP, Section 4.6 for adding into the DPs' Standard Bidding Documents for ICB. There are very few cases of the complaints mechanism being used as Cambodian culture favors resolution of grievances through private negotiation.

43. There is a reasonably well functioning and competitive private sector with the Cambodia Constructor's Association and several suppliers' associations. Competition for large contracts has been increased in recent years.

44. The Ministry of Health has not established a database for cost estimating purposes. Contract amendments and price variations were done based on current market price, with referring to the Consumer Price Index (CPI) at the time of amendment/variation

45. The PMU has extensive experience in procuring goods, works and services for many projects/programs administered by ADB and the World Bank etc. And, currently, the PMU is implementing HSSP2 (Health Sector Support Program 2) with total fund of around $ 80 million provided by WB, DFID, AusAid and Koica. The HSSP2 is the 2nd phase of HSSP (Health Sector Support Program) that was implemented with a total budget of around $ 31 million provided by ADB and DFID. Many procurement packages under both HSSP and HSSP2 have values up to $ millions each.

46. Procurement methods of National Shopping (NS), Non Competitive Bidding (NCB), International Competitive Bidding (ICB), LIB, DC, SSS, QCBS, CQS, etc. have been applied by the PMU in procuring goods, works and services for projects/programs. And, procurement carried out by the PMU has been found satisfactory.

Procurement Processes for Goods and Works

47. The PMU has experience in procuring CPA equipment, laboratory equipment, vehicles, office equipment, constructions of health centers and hospital buildings, ARV drug, etc. Procurement methods of ICB, NCB and National Shopping have been applied by the Procurement Unit. So many procurement tenders with contract values of up to $ million have been processed by the Procurement Unit.

48. The procurement Unit has been undertaking procurement funded by ADB, WB, GAVI, AFD, etc., but there are some challenges because BEC members are not very knowledgeable about technical specifications of some major items. The procurement process is undertaken under the government promulgated SOP that was just updated in 2012.

49. Procurement needs are identified in a systematic way and the needs are reflected in the Ministry’s Annual Operational Plan (AOP). The technical specifications of items to be procured are drafted by the requesting agencies/units in consultation with MOH technical departments and/or the Procurement Unit and need to be approved by the Project Director.

50. Bidding documents for National Shopping and National Competitive Bidding need to follow the standard bidding documents in the SOP, and for ICB they need to follow respective DP’s standard bidding documents. The Procurement Unit is responsible for drafting bidding documents and managing the sale of the document in cooperation with the Financial Management Unit. In case of any queries regarding bidding documents or requests for clarification from bidders, responses are made in writing to all concerned bidders.

51. The minimum period for preparation of bids is 45 days for ICB, 30 days for NCB, and 14 days for NS. Bidding documents clearly state the date and time for opening. And the date and time for opening is usually just after the deadline for bid submission.

52. Bid opening is public. Late bids are not accepted and bids are not rejected at the opening. Minutes of bids opening are taken by the procurement staff during the opening and copied and distributed free of charge to the representatives of bidders participating in the bid opening and the Bid Opening Committee members.

53. Bids submitted are evaluated by the Bid Evaluation Committee (BEC) whose members consist of procurement officers and consultant(s) who have good general knowledge and have

participated in numerous procurement training. Technical staff also participate in bid evaluation whenever necessary. The decision of BEC is not binding and is subject to final approval of PCR that is chaired by the Project Director.

54. The period of time between the issuance of the invitation for bids and contact date of start is usually 70-80 days for ICB, 50-60 days for NCB, and 30 days for NS.

55. There is no specific process in place for the collection and clearance of cargo through ports of entry. Suppliers are always required to deliver goods procured at the final project sites. All goods received are recorded properly as assets or inventory. No official registration has been made for tracking warranty and latent defects liability periods, but warranty and defect liability periods are checked against delivery orders, warranty certificates and contract documents when it is necessary to do so.

56. The Procurement Unit is not very familiar with letters of credit; however, letters of credit are managed well by the Financial Management Unit.

Procurement Processes for Consulting Services

57. The PMU has much experience in selections of firms, NGOs, and individual consultants using procurement method of CQS, QCBS, SSS, DC, IC, etc. Services procured included Implementation of health equity fund, construction supervision, auditing services, and consulting services. Evaluation of technical proposals is the major challenge in the procurement for services conducted by the PMU.

58. The promulgated SOP updated lastly in 2012 is used as the manual for consulting services procurement. Implementing agencies identify the needs for consulting service requirements. And, the needs for consulting service are reflected in the Ministry's Annual Operational Plan. Terms of Reference (TOR) are drafted by implementing agencies in consultation with the Procurement Unit, and it follow the standard format such as background, tasks, inputs, objectives and Outputs. The Procurement Unit is responsible for advertising the request for expressions of interest, and preparing Request for Proposal.

59. The Selection Committee is formed with appropriate individual members in terms of procurement and technical expertise. Previous experience of the firms/NGOs expressing their interests is used as a criteria for evaluating Expressions of Interest. Firms, NGOs expressing interest are not required to pay for the proposal documents they received.

60. The proposal evaluation criteria follow a pre-determined structure as detailed in the issued Request for Proposal.

61. The Procurement Unit has never organized pre-proposal visits and meetings, but responses to queries from consulting firms/NGOs are always made in writing and are sent to all the concerned consulting firms/NGOs. The technical proposals are separated from the financial proposals, in different envelopes. Proposal Security is not required to be submitted along with the proposals. Both proposals are opened in public, but financial proposals are kept sealed and unopened until the technical evaluation is completed. Minutes of technical and financial proposals opening are systematically prepared and distributed by the procurement staff.

62. The Procurement Review Committee determines the final technical ranking after reviewing the evaluation report prepared by CEC. After approval of PRC, the technical scores

are published and sent to all participating firms. The financial proposals are then evaluated as per instructions stated in the Request for Proposals.

63. Usually, within 1 to 3 weeks depending on the tender being under post review or prior review, after completion of financial evaluation; the selected firm is invited to face to face contract negotiations that always take places at the Project/Program Secretariat. The negotiation usually focusses on discussions and clarifications on: (i) Scope of work and terms of reference, (ii) Work program and personnel schedule, (iii) Counterpart supports/facilities, (iv) Financial terms (tax, payment schedule, etc.), (v) Contract Performance evaluation, (vi) Mobilization and commencement of services, and (vii) Deliverables, etc. The minutes of contract negotiation are prepared by the Procurement Unit and signed by both parties of negotiation. Contracts are usually signed within 1 week after negotiations, and advance payment is made or not depending on agreements.

iv. Performance of E-procurement

64. The Ministry of Health has its own website at http://moh.gov.kh and the CDC2 project has a separate homepage (not a website) at http://www.cdcmoh.gov.kh. The project homepage contains CDC2 project information, surveillance, prevention and control, quarantine and it links to the Ministry of Health, WHO, US-CDC and Regional GMS-CDC2. The CDC2 Project Information consists of (1) Project Concept, (2) Project Management, (3) Project Implementation, (4) Project Events, (5) Procurement and (6) Job Opportunities.

65. The website is managed by a project staff member who is an IT Specialist. Visitors can download documents but cannot upload or use the Project's website for communication.

66. For procurement, the home page is uploaded with Invitation to Bids, Request for Proposals, Notices of Contract Wards, and Contract Agreements. The website administrators and procurement staff of the project know very little about the e-procurement system and procedures. They need to get trained so that they may be able to process e-procurement.

v. Effectiveness

67. Contractual performance is systematically monitored and reported upon, and the Project always monitors and tracks its contractual payment obligations. On average it takes from 1 to 2 weeks between receiving a firm's invoice and making payment, while the standard period for payment included in contracts is usually 30 days after receipt of invoice. Per terms of contract agreement, when payment is made late, the beneficiaries are entitled for interest payment but this has never been done. Payments are approved by the Project Director who also approves the invitation documents, evaluations, and contracts.

vi. Accountability Measure

68. Internal control requirements have been strengthened in the 2012 update of the SOP and line ministries and sector agencies are being trained to adopt them. Internal audit departments have been established in all line ministries and capacity building of staff is a work in progress, again with DP support. An Anti-Corruption Unit (ACU) that was established by Sub-Decree on 22 August 2006 is responsible to the Council of Ministers and the ACU's work was considerably strengthened with the enactment of the Law on Anti-Corruption on 1 April 2010.

69. Information on public procurement is available to civil society through the ministry/project's websites and media advertisement. There is a Civil Service Code of 1994 which includes requirements on staff conduct. The SOP requires that a code of ethical conduct is established at project level if one does not exist at ministry level.

70. Internal controls for DP funded projects are well covered in the Financial Management Manual, the third manual of the SOP suite. The Ministry of Health has established a General Directorate for Inspection to undertake internal audit. There is not a dedicated website created by the Ministry of Health for publishing all public procurement data, but the DPs and the Ministry publish details of upcoming opportunities as well as quarterly reports summarizing contract awards and a contract register.

71. There is a standard statement of ethics and those who are involved in procurement are required to formally commit to it. Those who are involved with procurement are required to declare any potential conflict of interest and remove themselves from the procurement process. The commencement of procurement is completely independent from external approvals outside of the budgeting process. The Project Director and the Project Manager who have much procurement experience approve procurement transactions.

72. Bidding documents, invitation to pre-qualify or request for proposal, advertisement of an invitation for bids, pre-qualification or call for expressions of interest, notice of award, invitation to consultants for contract negotiation, and contract agreements, all these documents need to be approved by the Project Director.

73. There is always a written auditable trail of procurement decisions attributable to individuals and committees, and procurement decisions and disputes are always supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment. A complaints resolution mechanism is described in national procurement documents, but there is no formal non-judicial mechanism for dealing with complaints.

B. Strengths

74. The major strength is that there is only one legal and regulatory framework covering all four sectors and it is designed to align Royal Government of Cambodia requirements with the policies and practices of ADB and other multilateral development partners. The existing SOP of the RGC was established in harmonization with all the DPs' procurement procedures/guidelines, especially ADB's and the World Bank's, and the thresholds in the SOP are also aligned with the new ADB thresholds.

75. All procurement activities for all externally funded projects/programs of the Ministry of Health are done by the only PMU, and the PMU has experiences in processing procurement for numerous tenders including procurements of goods, works and services. The PMU procurement team is well-equipped with office equipment and other facilities necessary to process procurement and it competently manage to use them.

C. Weaknesses

76. Lack of a thorough understanding of the SOP by MOH staff involved in procurement is considered the main weakness. They face big challenges in processing ICB and selection of consulting firms/NGOs, particularly through the QCBS method of procurement.

77. The weaknesses relate mainly to the need for further capacity building and the absence of a professionalization program. Highly focused training on operationalizing the SOP is ongoing and should address the capacity weaknesses but the lack of a procurement professionalization program in the country is also the cause of insufficient capability in procurement activities. The ministry project implementation staff have been given intensive training on application of SOP, but not with a professionalization program.

78. Although the PMU has been establishing and implementing projects/programs for almost 20 years ago, and the MOH's staffs assigned to work with hired procurement consultants have been working in the PMU procurement team for many years, they still lack autonomy to proceed procurement tenders; and international and national procurement consultants are still hired to assist them, as their capacity regarding procurement still needs to be improved.

79. SOP Procurement Manual, Volume 1, Section 4.6 provides a detailed complaints handling mechanism covering complaints and protests of various types. However, to date, no official channel of complaints handling has been set up by the Ministry of Health .

80. The Ministry of Health, like other executing agencies, has not created its own manual/procedures for carrying out procurement process containing more practical details than the SOP.

81. There is currently no public e-procurement in Cambodia. All public procurement activities are carried out offline. Knowledge of e-procurement among EA/IA procurement practitioners is very limited. The procurement staff and administrator of the Project's website know very little about e-procurement and would require training to implement e-procurement.

D. Procurement Risk Assessment and Management Plan (P-RAMP)

82. The procurement risks in the proposed executing agency as identified in the assessment were identical to the ones identified in the Cambodia Pilot Country and Sector/Agency Procurement Risk Assessment conducted from late September 2014 to early March 2015, which are:

1) Lack of staff understanding of and compliance with some aspects of the SOP, including but not limited to processing the selection of consulting service providers, and
2) There is no internationally recognized procurement professionalization program has been conducted/provided to the MoH's staff.

83. The two measures below are recommended to mitigate the risks in the proposed GMS Health Security project (Cambodia).

3) Continue to provide training for procurement staff (particularly the counterpart staff of the Ministry) on operationalizing the SOP through mentoring and extend training to members of evaluation and procurement review committees.
4) ADB further support Royal Government of Cambodia through the Ministry of Economy and Finance to establish a procurement professionalization program in the country by twinning a

local seat of learning with an internationally recognized institute, and the MoH trying to engage its procurement officers in the training.

III. PROJECT SPECIFIC PROCUREMENT THRESHOLDS

84. Except as the Asian Development Bank (ADB) may otherwise agree, the following process thresholds shall apply to procurement of goods, works and services for the proposed project.

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
International Competitive Bidding for Goods	$1,000,000	
National Competitive Bidding for Goods	Beneath that stated for ICB, Goods	
Shopping for Goods	Below $100,000	
Consulting Services		
Method	**Comments**	
Individual Consultant Selection		

IV. PROCUREMENT PLAN

85. Proposed procurement plan for the GMS Health Security Project (Cambodia) is attached in Appendix 3.

V. CONCLUSION

86. The proposed PMU has experiences in procuring Goods, Works and Service of up to multimillion dollars of contract prices, but usually with the support of national and international procurement consultants although the Ministry of Health has sufficient number of experienced staff to undertake the additional procurement that will be required under the proposed project.

VI. RECOMMENDATIONS

87. While preparing and negotiating the development agreement, both parties, the Royal Government of Cambodia and the ADB, should consider the following:

- Although the thresholds in the SOP are aligned with the new ADB thresholds, the project financing agreement should state that the new thresholds supersede those given in the SOP.
- The preface to the NCB Standard Bidding Documents states that they can be used for procurement exceeding the current NCB thresholds if the respective DP and MEF have agreed and if it is specified in the approved Project Procurement Plan. Therefore, it should be clearly confirmed in discussions with MEF that the Standard Bidding Documents can be used up to the new higher ADB thresholds.
- The financing agreement for the proposed project should also state that the new thresholds supersede those given in the SOP if it is the case.
- Procurement planning should start during project preparation and link to the national budget formulation process with respect to counterpart funding requirements. The SOP mandates Project Readiness Filters (PRF) that determine whether a proposed project is prepared sufficiently for negotiations and board consideration, and one PRF requires that advance action on procurement shall have commenced before negotiations start.

- The Ministry of Health may request ADB to use its existing team arrangement to undertake procurement activities.
- Delegation procurement role and responsibility to the SOAs is not seen appropriate for the proposed GMS Health Security Project. But if it is a case, procurement capacity building for the procurement teams of all SOAs is a must.
- Existing good practices of the Procurement Unit in the bidding process should be maintained, like: (a) procurement record keeping; (b) undertaking procurement tracking, (3) Updating of the Procurement Tracking Form as required by the SOP/PM Section 12.3 and Appendix 1d to identify where procurement delays are occurring and how to address them.

APPENDIX 1-A – QUESTIONNAIRE ON GENERAL PROCUREMENT ENVIRONMENT

MINISTRY OF HEALTH, CAMBODIA
Greater Mekong Sub-region Health Security Project
Project Preparatory Technical Assistant

GENERAL PROCUREMENT ENVIRONMENT ASSESSMENT QUESTIONNAIRE

Responded by Procurement Unit (Program/Project Secretariat-MOH)

Indicators	Response /Clarification	Assessment
1. Legislative and Regulatory Framework		
1.1 Is there a comprehensive public procurement law, with supporting regulations, standard bidding documents and operational manuals/guides?	Yes, the Law on Public Procurement, adopted on 3 January 2012. Article 3 of the Law permits DP-funded projects to utilize procurement systems specified in project financing agreements. The SOP were developed and amended under technical assistance provided by ADB and WB in 2004-05 and by ADB in 2010-11, and contain a comprehensive Procurement Manual in two volumes with regulations and standard bidding documents for National Competitive Bidding (NCB) and Shopping.	Good = Moderate
1.2 Does the legal framework make open competitive tendering the default method of procurement with clarity as to when other less competitive methods can be used?	Yes, SOP Procurement Manual Volume 1, Sections 3.3, 10.2 and 10.3	Above Average = Low
1.3 Does the legal framework support non-discriminatory participation, transparent tender processes (including advertisement, tender documentation, tender evaluation, complaints mechanism)?	Yes, SOP Procurement Manual Volume 1, Sections 2.1, 3.4, 4.6 and 6.2	Above Average = Low
1.4 Are there restrictions or preferences on the nationality of bidders, consulting firms and/or origin of goods, works and services?	Generally, there are no restrictions and no domestic preference provision for NCB. However, individual DP eligibility rules are acknowledged and, for ADB, eligibility is limited to bidders from ADB member countries and the origin of goods and materials is also limited to ADB member countries. (SOP Procurement Manual Volume 1, Section 5.2)	Above Average = Low
2. Institutional Framework and Management Capacity		
2.1 Is the procurement cycle required to be tied to an annual budgeting cycle (i.e. can a procurement activity commence only when budget has been duly appropriated for it?	For DP funded projects, the budgeting cycle is equivalent to the project implementation period. Procurement is tied to Annual Operational Plan (AOP) of the Ministry of Health and can be started under advance action before DP financing is approved and becomes effective, up to but not including contract signing.	Above Average = Low
2.2 Does the system foster efficiency through the use of adequate planning?	Yes, SOP Procurement Manual Volume 1, Section 12. The Procurement Unit of the MOH Program/Project Secretariat track their procurement properly.	Good = Moderate
2.3 Does the procurement system feature an oversight/regulatory body?	Yes, the General Directorate of Public Procurement (GDPP) of the Ministry of Economy and Finance (MEF) is the regulatory and oversight body for public procurement, being responsible for line agency compliance with the Law. For DP funded projects, compliance with the SOP as required in financing agreements is overseen by the Department of Cooperation and Budget Management (DCBM) of MEF.	Good = Moderate
2.4 Is there a nationwide public procurement capacity development or	There have been government sponsored and DP funded training programs since the original SOP were introduced in 2005, and they have increased in intensity since the amended SOP were	Average = High?

professionalization program?	issued in 2012. The Procurement staff have always attended the training. However, there is no internationally recognized professionalization program.	
2.5 Is the Procurement Review Committee independent?	Yes, the Chair of the PRC is independent of the head of the ministry. PRC members are not required to have received procurement training but their performance is monitored. There is provision in the SOP for individual PRC members to refer back to their management when they cannot agree on a recommendation and this happens fairly frequently. This reduces the full independence of the PRC.	Good = Moderate
3. Procurement Operations and Market Practices		
3.1 Is private sector competitive, well organized and able to access the market?	Yes, there is a reasonably well functioning and competitive private sector with a Cambodia Constructor's Association and several suppliers' associations. Competition for large contracts has increased in recent years.	Good = Moderate
3.2 Do measures exist to ensure the adequacy and accuracy of cost estimates before bidding, and to manage contract price variations?	The Ministry of Health has not established a database for cost estimating purposes. Contract amendments and price variations were done based on market price at the time.	Average = High?
3.3 Is there a mechanism to receive and handle observations, complaints and protests?	SOP Procurement Manual, Volume 1, Section 4.6 provides a detailed complaints handling mechanism covering complaints and protests of various types. However, this is no official channel of complaint handling has been set up.	Above Average = Low
4. Integrity and Transparency of the Public Procurement System		
4.1 Is there a formal internal control and audit framework?	Internal controls for DP funded projects are well covered in the Financial Management Manual, the third manual of the SOP suite. The ministry of Health has established a Directorate General for Inspection to undertake internal audit.	Good = Moderate
4.2 Is information pertaining to public procurement easy to find, comprehensive and relevant?	Yes. There is no single website created by the Ministry of Health for publishing all public procurement data, but the DPs and the ministry publish details of upcoming opportunities as well as quarterly reports summarizing contract awards and a contract register.	Good = Moderate
4.3 Does the country have ethics and anticorruption measures in place?	Yes. The Law on Anti-Corruption became effective on 01 April 2010. The ministry when implementing DP funded projects has, with the DP's help, prepared a code of ethical conduct for staff and many ministries have incorporated their codes into their staff rules. The National Audit Authority regularly conducts auditing at the MOH's Project.	Good = Moderate
4.4 Does the Procurement Unit keep procurement records?	The Procurement Unit keeps good records of procurement documents.	Above Average = Low
5. E-Procurement		
5.1 Does the Program/Project Secretariat have websites?	Yes, the Ministry of Health has its own website at http://moh.gov.kh and the CDC2 project has a separate homepage (not a website) at http://www.cdcmoh.gov.kh/	Good = Moderate
5.2 What is the content of the Project's website?	The project website contains CDC2 project information, Surveillance, Prevention and Control, Quarantine and is linkage to the Ministry of Health, WHO, US-CDC and Regional GMS-CDC2. The CDC2 Project Information consists of (1) Project Concept, (2) Project Management, (3) Project Implementation, (4) Project Events, (5) Procurement and (6) Job Opportunities.	Good = Moderate
5.3 To what degree is the website interactive? Can visitors download any information or upload anything (e.g. comments) or use it as a method of contacting the EA/IA?	Visitors can download documents but cannot upload or use the Project's website for communication.	Average = High?
5.4 Is the website managed internally in the sector/agency or	The website is managed by a project staff member who is an IT Specialist.	Good = Moderate

externally by a third party? Please describe.		
5.5 What is project's view on e-procurement, meaning to use CDC2 Project's website to assist the procurement process, or to undertake the whole process electronically?	The procurement officer of the project knows a very little about the e-procurement system and procedures. He requested to get trained so that he may be able to process e-procurement.	Below average = High?

APPENDIX 1-B – QUESTIONNAIRE FOR HSSP, MOH AS EA

MINISTRY OF HEALTH, CAMBODIA
Greater Mekong Sub-region Health Security Project
Project Preparatory Technical Assistant

PROCUREMENT CAPACITY ASSESSMENT QUESTIONNAIRE

Responded by Procurement Unit (Program/Project Secretariat-MOH)

Part A. General Agency Resource Assessment		
A.1.	Is there a procurement department?	There is no Procurement Department in the Program/Project Secretariat, but Procurement Unit of the Program/Project Secretariat instead.
A.2.	What procurement does it undertake?	Procurement for CPA Equipment, laboratory equipment, vehicle, and office equipment, construction of health center, and hospital building, ARV drug, selection of Individual Consultant, NOGs, and consulting firm, etc.
A.3.	What is the size of procurement under taken by the Procurement Unit for Good, Work, and Service?	Good, Work, and Service up to US$ million per tender.
A.4.	Who are the members of BEC?	BEC members consist of procurement staffs (procurement counterpart staffs and consultants), technical staff of the PMU and representative(s) from the Ministry of Economy and Finance.
A.5.	Are the staff provided with written job descriptions?	Yes.
A.6.	How many years of experience does the head of the procurement unit have in a direct procurement role?	10 years.
A.7.	How many staff in the Procurement Unit are?	(3 to 5 depending on workloads.)
	i. Full-time?	1 to 3 depending on workloads.
	ii. Part-time?	0
	iii. Seconded?	2
A.8.	At what level does the Procurement Unit report to (the head of agency, deputy, etc.)?	Project Director (Chair of PRC)
A.9.	Do the staff that will be involved with the procurement have English language skills sufficient to undertake procurement?	Yes.
A.10.	Is the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes.
A.11.	Does the unit have adequate facilities such as PCs, internet connections, photocopy facilities, printers, etc. to undertake the expected procurement?	Yes.

A.12. Is there a procurement training program?	Yes, there have been many training programs organized by DPs and MEF.
Part B. Procurement Processes for Goods and Works	
B.1. Has the Procurement Unit undertaken foreign assisted procurement of goods or works recently (last 12 months, or last 36 months)? (If yes, funded by whom and name of the project)	Yes, funded by ADB, WB, GAVI, AFD, etc.
B.2. If the above is yes, what were the major challenges?	The BEC member does not know much about technical specifications of some major items.
B.3. Is there a procurement process manual for goods and works?	Yes, the SOP.
B.4. If there is a manual, is it up to date, and does it cover foreign-assisted procurement?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
B.5. Is there a systematic process to identify procurement requirements (1 year or more)?	Yes, in also reflected in the MOH's Annual Operational Plan (AOP).
B.6. Who drafts the specifications?	The technical specifications are drafted by respective requesting units in consultation with MOH technical departments and/or the procurement unit.
B.7. Who approves the specification?	The Project Director.
B.8. Are there standard bidding documents in use and have they been approved for use on ADB funded projects?	Yes. For NS and NCB use the standard bidding documents in the SOP, and for ICB use DP's standard bidding documents.
B.9. Who drafts the bidding documents?	The Procurement Unit.
B.10. Who manages the sale of the document?	The Procurement Unit in cooperation with the Financial Management Unit of the Program/Project Secretariat.
B.11. Are all queries from bidders replied to in writing?	Yes.
B.12. Is there a minimum period for preparation of bids and if yes how long?	Yes. ICB = 45 days, NCB = 30 days and NS = 14 days.
B.13. Does the bidding document state the date and time of opening and how close is it to the Deadline for submission?	Yes. Just after the dead line for bid submission.
B.14. Is the opening public?	Yes.
B.15. Can late bids be accepted?	No.
B.16. Can bids be rejected at bid opening?	No.
B.17. Are minutes taken?	Yes.
B.18. Who may have a copy of the minutes?	The representative of bidder participating in the bid opening and the Bid Opening Committee members.
B.19. Are the minutes free of charge?	Yes.

B.20. Who undertakes the evaluation (individual(s), permanent committee, ad-hoc committee)?	Bid Evaluation Committee (BEC).
B.21. What are the qualifications of the evaluators in respect to procurement and the goods and works under evaluation?	The member of Bid Evaluation Committee consists of procurement officers and consultant(s) who have good general knowledge and have participated in many procurement training. Technical staff also participate in bid evaluation when necessary.
B.22. Is the decision of the evaluators final or is the evaluation subject to additional approvals?	The decision of BEC is subjected to final approval of PCR that is chaired the Project Director.
B.23. Using at least three real examples how long between the issue of the invitation for bids and Contact effectiveness?	ICB = 70-80 days NCB= 50-60 days NS= 30 days
B.24. Are there processes in place for the collection and clearance of cargo through ports of Entry?	No, suppliers are always required to deliver goods procured at the final project sites.
B.25. Are there established goods receiving procedures?	Yes. Review of delivery supporting documents and goods inspection are mandatory.
B.26. Are all goods received recorded as assets or inventory in a register or similar?	Yes.
B.27. Is the Procurement Unit familiar with letters of credit?	Yes. Letters of Credit are managed by the Financial Management Unit.
B.28. Does the Procurement Unit register and track warranty and latent defects liability Periods?	No official registration has been made, but warranty and latent defects liability periods are checked against delivery orders, warranty certificates and contract documents when it is necessary to do so.
Part C. Procurement Processes for Consulting Services	
C.1. Has the agency undertaken foreign assisted procurement of consulting services recently (last 12 months, or last 36 months)?	Yes.
C.2. If the above is yes, what where the major challenges?	Technical proposal evaluation.
C.3. Is there a procurement process manual for consulting services procurement?	Yes, the SOP.
C.4. Is the manual up to date and does it cover foreign assisted projects?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
C.5. Who identifies the need for consulting services requirements?	Implementing agencies. It is also reflected in the MOH's Annual Operational Plan.
C.6. Who drafts the TOR?	Implementing agencies in consultation with the Procurement Unit.
C.7. Do the ToR follow a standard format such as background, tasks, inputs, objectives and Outputs?	Yes.
C.8. Who prepares the request for proposals?	The Procurement Unit.
C.9. Are assignments advertised and expressions of interest called for?	Yes.
C.10. Is a consultants' selection committee formed with appropriate individuals in terms of Procurement and technical expertise?	Yes.

C.11. What criteria is used to evaluate EOIs?	Previous experiences of Firms/NGOs expressing their interests.
C.12. Historically what is the most common method used (QCBS, QBS etc.)	CQS, QCBS, SSS, DC, IC.
C.13. Do firms have to pay for the proposal document?	No.
C.14. Does the evaluative criteria follow a pre-determined structure and is it detailed in the RFP?	Yes.
C.15. Are pre-proposal visits and meetings arranged?	No. Have never arranged so far.
C.16. Are minutes prepared and circulated after pre-proposal meetings?	N/A.
C.17. To whom are minutes distributed?	N/A.
C.18. Are all queries from consultants answered to in writing?	Yes.
C.19. Are the financial and technical proposals in separate envelopes?	Yes.
C.20. Are proposal securities required?	No.
C.21. Are technical proposals opened in public?	Yes.
C.22. Do the financial proposals remain sealed until technical evaluation is completed?	Yes.
C.23. Are minutes of technical opening distributed?	Yes.
C.24. Who determines the final technical ranking and how?	PRC determine the final technical ranking after reviewing evaluation report prepared by CEC.
C.25. Are the technical scores published and sent to all firms?	Yes.
C.26. Is the financial proposal opening public?	Yes.
C.27. Are there minutes taken and distributed of financial proposal opening?	Yes.
C.28. How is the financial evaluation completed?	According to criteria set in the RFP.
C.29. Are face to face contract negotiations held?	Yes.
C.30. How long after financial evaluation the selected firm is invited to contract negotiation?	1 to 3 weeks depending on the tender being under post review or prior review.
C.31. What is the usual basis for negotiation?	- Scope of work and terms of reference, - Work program and personnel schedule, - Counterpart supports/facilities, - Financial terms (TAX, payment schedule, etc.) - Contract Performance evaluation, - Mobilization, and commencement of services.

	- Deliverables, etc.
C.32. Are minutes of negotiation taken and signed?	Yes.
C.33. How long after negotiations until the contract is signed?	Usually within 1 Week.
C.34. Are advance payments made?	Yes, depending on agreements.
Part D. Process Oversight and Control	
D.1. Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes.
D.2. Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes.
D.3. Is the commencement of procurement dependent on external approvals (formal or de-facto) outside of the budgeting process?	No.
D.4. Who approves procurement transactions and do they have procurement experience and qualifications?	The Project Director and Project Manager who have much procurement experience.
D.5. Which of the following actions require approval outside of the procurement unit or a permanent evaluation committee and who grants the approval?	
(i) Bidding document, invitation to pre-qualify or request for proposal	The Project Director.
(ii) Advertisement of an invitation for bids, pre-qualification or call for expressions of interest	The Project Director.
(iii) Evaluation reports	PRC.
(iv) Notice of award	The Project Director.
(v) Invitation to consultants to negotiate	The Project Director.
(vi) Contracts	The Project Director.
D.6. Is contractual performance systematically monitored and reported upon?	Yes.
D.7. Does the agency monitor and track its contractual payment obligations?	Yes.
D.8. On average how long is it between receiving a firm's invoice and making payment?	1 to 2 weeks
D.9. What is the standard period for payment included in contracts?	30 days after receipt of invoice.
D.10. When payment is made late are the beneficiaries paid interest?	Yes, per contract agreement. But has never paid actually.
D.11. Are payments authorized by the same individuals empowered to approve invitation documents, evaluations and contracts	Yes, the Project Director.
D.12. Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes.

D.13.	Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes.
D.14.	Is there a formal non-judicial mechanism for dealing with complaints?	No.
D.15.	Is a complaints resolution mechanism described in national procurement documents?	Yes.
Part E. Records Keeping		
E.1.	Is there a referencing system for procurement files?	Yes.
E.2.	Are original contracts secured in a fire and theft proof location?	Yes.
E.3.	Are copies of bids or proposals retained with the evaluation?	Yes.
E.4.	Are copies of the original advertisements retained with the pre-contract files	Yes.
E.5.	Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes.
E.6.	Are copies of invoices included with contract papers?	Yes.
E.7.	For what period are records kept?	Up to 10 years.

APPENDIX 1-C – QUESTIONNAIRE FOR THE PROVINCES

MINISTRY OF HEALTH, CAMBODIA

Greater Mekong Sub-region Health Security Project
Project Preparatory Technical Assistant

Procurement Capacity Assessment Questionnaire – Pornhea Krek SOA (Tbong Khmum Province)

Part A. General Agency Resource Assessment	
A.1. Is there a procurement department?	There is no procurement department in the SOA, but Procurement Team instead.
A.2. What procurement does it undertake?	Office equipment, Medical Equipment, Motorcycles, etc.
A.3. What is the size of procurement under taken by the SOA for Good, Work, and Service?	Not greater than USD 50,000.
A.4. Who are the member of SOA Procurement Committee?	- OD Director, - Vice OD Director, - Chief of Accounting Unit, and - Chief of Administration Unit.
A.5. Are the staff provided with written job descriptions?	No job description for each individual member of procurement team. But, there are job description for the whole Procurement Team written in the Ministry of Health's notice.
A.6. How many years of experience does the head of the Procurement Team have in a direct procurement role?	The head of Procurement Team, the OD Director, used to be a member of OD Procurement Evaluation Committee for 8 years.
A.7. How many staff in the Procurement Team are:	4 in the SOA Procurement Team
i. Full-time?	0
ii. Part-time?	0
iii. Seconded?	4
A.8. At what level does the Procurement Team report to (the head of agency, deputy, etc.)?	Project Director (at national level).
A.9. Do the staff that will be involved with the procurement have English language skills sufficient to undertake procurement?	Moderately sufficient.
A.10. Is the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes.
A.11. Does the unit have adequate facilities such as PCs, internet connections, photocopy facilities, printers, etc. to undertake the expected procurement?	Yes.

A.12. Is there a procurement training program?	Members of the Procurement Team have never participated any procurement training.
Part B. Agency Procurement Processes, Goods and Works	
B.1. Has the SOA undertaken foreign assisted procurement of goods or works recently (last 12 months, or last 36 months)? (If yes, funded by whom and name of the project)	Yes, funded by the World Bank under HSSP2.
B.2. If the above is yes, what were the major challenges?	Bid Evaluation and Familiarity with technical Specification of goods being procured.
B.3. Is there a procurement process manual for goods and works?	Yes, the SOP.
B.4. If there is a manual, is it up to date, and does it cover foreign-assisted procurement?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
B.5. Is there a systematic process to identify procurement requirements (1 year or more)	No, but there is Annual Operational Plan that is prepared with involvement representatives from Health Centers, Referral Hospitals and Provincial Department of Health.
B.6. Who drafts the specifications?	The Procurement Team.
B.7. Who approves the specification?	The OD Director.
B.8. Are there standard bidding documents in use and have they been approved for use on ADB funded projects?	Yes. The standard bidding documents in the SOP.
B.9. Who drafts the bidding documents?	The Procurement Team.
B.10. Who manages the sale of the document?	Chief of Accounting Unit.
B.11. Are all queries from bidders replied to in writing?	Yes.
B.12. Is there a minimum period for preparation of bids and if yes how long?	Yes, depending on the estimated cost of tender.
B.13. Does the bidding document state the date and time of opening and how close is it to the Deadline for submission?	Yes. Just after the dead line for bid submission.
B.14. Is the opening public?	Yes.
B.15. Can late bids be accepted?	No.
B.16. Can bids be rejected at bid opening?	No.
B.17. Are minutes taken?	Yes.
B.18. Who may have a copy of the minutes?	The representative of bidders participating in the bid opening and the Bid Opening Committee members.

B.19. Are the minutes free of charge?	Yes.
B.20. Who undertakes the evaluation (individual(s), permanent committee, ad-hoc committee)?	The Procurement Team.
B.21. What are the qualifications of the evaluators in respect to procurement and the goods and works under evaluation?	Members of Evaluation Committee have not received procurement training, but most of them have relevant knowledges.
B.22. Is the decision of the evaluators final or is the evaluation subject to additional approvals?	The decisions of the Procurement Team are subjected to final approvals from the Project Director at national Level.
B.23. Using at least three real examples how long between the issue of the invitation for bids and Contact effectiveness?	It takes: 15 days for invitation, 18 to 20 days for evaluation, and 5 to 7 days for contract signing.
B.24. Are there processes in place for the collection and clearance of cargo through ports of Entry?	No, suppliers are always required to deliver goods procured at the final project sites.
B.25. Are there established goods receiving procedures?	Yes, goods inspection and checking of delivery supporting documents need to be done.
B.26. Are all goods received recorded as assets or inventory in a register or similar?	Yes, all goods received are recorded as assets by OD.
B.27. Is the Procurement Team familiar with letters of credit?	No. But, the contract amounts are always less than USD 50,000.
B.28. Does the procurement department register and track warranty and latent defects liability Periods?	No. But, warranty and latent defects liability periods are checked against delivery orders, warranty certificates and contract documents as necessary.
Part C. Agency Procurement Processes, Consulting Services	
C.1. Has the agency undertaken foreign assisted procurement of consulting services recently (last 12 months, or last 36 months)?	No.
C.2. If the above is "Yes" what where the major challenges?	N/A
C.3. Is there a procurement process manual for consulting services procurement?	Yes, the SOP.
C.4. Is the manual up to date and does it cover foreign assisted projects?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
C.5. Who identifies the need for consulting services requirements?	OD Director and Chiefs of Referral Hospitals and Health Centers.
C.6. Who drafts the TOR?	OD Director and Chiefs of Referral Hospitals and Health Centers.
C.7. Do the ToR follow a standard format such as background, tasks, inputs, objectives and Outputs?	Yes.
C.8. Who prepares the request for proposals?	The Procurement Team.

C.9. Are assignments advertised and expressions of interest called for?	Yes.
C.10. Is a consultants' selection committee formed with appropriate individuals in terms of Procurement and technical expertise?	Yes, majority of the selection committee members are health specialists.
C.11. What criteria is used to evaluate EOIs?	Previous experiences of Firms/NGOs expressing their interests.
C.12. Historically what is the most common method used (QCBS, QBS etc.)	N/A.
C.13. Do firms have to pay for the proposal document?	No.
C.14. Does the evaluative criteria follow a pre-determined structure and is it detailed in the RFP?	Yes.
C.15. Are pre-proposal visits and meetings arranged?	No.
C.16. Are minutes prepared and circulated after pre-proposal meetings?	N/A
C.17. To whom are minutes distributed?	N/A
C.18. Are all queries from consultants answered to in writing?	Yes.
C.19. Are the financial and technical proposals in separate envelopes?	Yes.
C.20. Are proposal securities required?	No.
C.21. Are technical proposals opened in public?	Yes.
C.22. Do the financial proposals remain sealed until technical evaluation is completed?	Yes.
C.23. Are minutes of technical opening distributed?	Yes.
C.24. Who determines the final technical ranking and how?	The Project Director at national level, after reviewing and verifying the technical revaluation report submitted to by the OD.
C.25. Are the technical scores published and sent to all firms?	Yes.
C.26. Is the financial proposal opening public?	Yes.
C.27. Are minutes of financial proposal opening taken and distributed?	Yes.
C.28. How is the financial evaluation completed?	According to criteria set in the RFP.
C.29. Are face to face contract negotiations held?	Yes.

C.30. How long after financial evaluation is the selected firm to negotiate?	Within 1 to 2 weeks.
C.31. What is the usual basis for negotiation?	- Terms of reference, - Work program and personnel schedule, - Counterpart supports/facilities, - Financial terms (TAX, payment schedule, etc.) - Mobilization, and commencement of services. - Deliverables, etc.
C.32. Are minutes of negotiation taken and signed?	Yes.
C.33. How long after negotiations until the contract is signed?	Within 1 weeks.
C.34. Are advance payments made?	Yes, depending on agreements.
Part D. Process Oversight and Control	
D.1. Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes.
D.2. Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes.
D.3. Is the commencement of procurement dependent on external approvals (formal or de-facto) outside of the budgeting process?	No.
D.4. Who approves procurement transactions and do they have procurement experience and qualifications?	By the OD Director, who used to be a member of OD Procurement Evaluation Committee for 8 years.
D.5. Which of the following actions require approval outside of the procurement unit or a permanent evaluation committee and who grants the approval?	
(i) Bidding document, invitation to pre-qualify or request for proposal	The OD Director.
(ii) Advertisement of an invitation for bids, pre-qualification or call for expressions of interest	The OD Director.
(iii) Evaluation reports	The Project Director (at national level).
(iv) Notice of award	The OD Director.
(v) Invitation to consultants to negotiate	The OD Director.
(vi) Contracts	The OD Director.
D.6. Is contractual performance systematically monitored and reported upon?	Yes.
D.7. Does the agency monitor and track its contractual payment obligations?	Yes.

D.8. On average how long is it between receiving a firm's invoice and making payment?	Within 15 days.
D.9. What is the standard period for payment included in contracts?	Within 30 days.
D.10. When payment is made late are the beneficiaries paid interest?	Yes, per contract agreement. But, has never paid late so far.
D.11. Are payments authorized by the same individuals empowered to approve invitation documents, evaluations and contracts	Yes, by the same OD Director. But bid Evaluations are approved by the Project Director.
D.12. Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes.
D.13. Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes.
D.14. Is there a formal non-judicial mechanism for dealing with complaints?	No.
D.15. Is a complaints resolution mechanism described in national procurement documents?	Yes.
Part E. Records Keeping	
E.1. Is there a referencing system for procurement files?	Yes.
E.2. Are original contracts secured in a fire and theft proof location?	Yes.
E.3. Are copies of bids or proposals retained with the evaluation reports?	Yes.
E.4. Are copies of the original advertisements retained with the pre-contract files?	Yes.
E.5. Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes.
E.6. Are copies of invoices included with contract papers?	Yes.
E.7. For what period are records kept?	Up to 10 years.

MINISTRY OF HEALTH, CAMBODIA

Greater Mekong Sub-region Health Security Project
Project Preparatory Technical Assistant

Procurement Capacity Assessment Questionnaire – Stung Treng SOA (Stung Treng Province)

Part A. General Agency Resource Assessment	
A.1. Is there a procurement department?	There is no procurement department in the SOA, but Procurement Team instead.
A.2. What procurement does it undertake?	Office Equipment, Medical Equipment, etc.
A.3. What is the size of procurement under taken by the SOA for Good, Work, and Service?	Not greater than USD 50,000.
A.4. Who are the member of SOA Procurement Committee?	- OD Director, - Vice OD Director, - Chief of Technical Unit, - Chief of Accounting Unit, and - Staff of Administration Unit.
A.5. Are the staff provided with written job descriptions?	No job description for each individual member of procurement team. But, there are job description for the whole Procurement Team written in the Ministry of Health's notice.
A.6. How many years of experience does the head of the Procurement Team have in a direct procurement role?	The head of Procurement Team, the OD Director, has no procurement experience.
A.7. How many staff in the Procurement Team are:	5 in the SOA Procurement Team
i. Full-time?	0
ii. Part-time?	0
iii. Seconded?	5
A.8. At what level does the Procurement Team report to (the head of agency, deputy, etc.)?	Project Director (at national level).
A.9. Do the staff that will be involved with the procurement have English language skills sufficient to undertake procurement?	Sufficient.
A.10. Is the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes.
A.11. Does the unit have adequate facilities such as PCs, internet connections, photocopy facilities, printers, etc. to undertake the expected procurement?	Yes.

A.12. Is there a procurement training program?	Members of the Procurement Team have never participated any procurement training.
Part B. Agency Procurement Processes, Goods and Works	
B.1. Has the SOA undertaken foreign assisted procurement of goods or works recently (last 12 months, or last 36 months)? (If yes, funded by whom and name of the project)	No, not yet.
B.2. If the above is yes, what were the major challenges?	N/A.
B.3. Is there a procurement process manual for goods and works?	Yes, the SOP.
B.4. If there is a manual, is it up to date, and does it cover foreign-assisted procurement?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
B.5. Is there a systematic process to identify procurement requirements (1 year or more)	No, but there is Annual Operational Plan that is prepared with involvement representatives from Health Centers, Referral Hospitals and Provincial Department of Health.
B.6. Who drafts the specifications?	The Procurement Team.
B.7. Who approves the specification?	The OD Director.
B.8. Are there standard bidding documents in use and have they been approved for use on ADB funded projects?	Yes. The standard bidding documents in the SOP.
B.9. Who drafts the bidding documents?	The Procurement Team.
B.10. Who manages the sale of the document?	The Procurement Team.
B.11. Are all queries from bidders replied to in writing?	Yes.
B.12. Is there a minimum period for preparation of bids and if yes how long?	Yes, and depending on the estimated cost of tender.
B.13. Does the bidding document state the date and time of opening and how close is it to the Deadline for submission?	Yes. The opening is just after the dead line for bid submission.
B.14. Is the opening public?	Yes.
B.15. Can late bids be accepted?	No.
B.16. Can bids be rejected at bid opening?	No.
B.17. Are minutes taken?	Yes.
B.18. Who may have a copy of the minutes?	The representative of bidders participating in the bid opening and the Bid Opening Committee members.

B.19. Are the minutes free of charge?	Yes.
B.20. Who undertakes the evaluation (individual(s), permanent committee, ad-hoc committee)?	The Procurement Team.
B.21. What are the qualifications of the evaluators in respect to procurement and the goods and works under evaluation?	Members of Evaluation Committee have not received procurement training, but most of them have relevant knowledges.
B.22. Is the decision of the evaluators final or is the evaluation subject to additional approvals?	The decisions of the Procurement Team are subjected to final approvals from the Project Director at national level.
B.23. Using at least three real examples how long between the issue of the invitation for bids and Contact effectiveness?	It takes: 15 days for invitation, 15 to 20 days for evaluation, and 3 to 5 days for contract signing.
B.24. Are there processes in place for the collection and clearance of cargo through ports of Entry?	No, suppliers are always required to deliver goods procured at the final project sites.
B.25. Are there established goods receiving procedures?	Yes, goods inspection and checking of delivery supporting documents need to be done.
B.26. Are all goods received recorded as assets or inventory in a register or similar?	Yes, all goods received are recorded as assets by OD.
B.27. Is the Procurement Team familiar with letters of credit?	No. But, the contract amounts are always less than USD 50,000.
B.28. Does the procurement department register and track warranty and latent defects liability Periods?	No. But, warranty and latent defects liability periods are checked against delivery orders, warranty certificates and contract documents as necessary.
Part C. Agency Procurement Processes, Consulting Services	
C.1. Has the agency undertaken foreign assisted procurement of consulting services recently (last 12 months, or last 36 months)?	No.
C.2. If the above is "Yes" what where the major challenges?	N/A
C.3. Is there a procurement process manual for consulting services procurement?	Yes, the SOP.
C.4. Is the manual up to date and does it cover foreign assisted projects?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
C.5. Who identifies the need for consulting services requirements?	OD Director and Chiefs of Referral Hospitals and Health Centers.
C.6. Who drafts the TOR?	OD Director and Chiefs of Referral Hospitals and Health Centers.
C.7. Do the ToR follow a standard format such as background, tasks, inputs, objectives and Outputs?	Yes.
C.8. Who prepares the request for proposals?	The Procurement Team.

C.9. Are assignments advertised and expressions of interest called for?	Yes.
C.10. Is a consultants' selection committee formed with appropriate individuals in terms of Procurement and technical expertise?	Yes, majority of the selection committee members are health specialists.
C.11. What criteria is used to evaluate EOIs?	Previous experiences of Firms/NGOs expressing their interests.
C.12. Historically what is the most common method used (QCBS, QBS etc.)	N/A.
C.13. Do firms have to pay for the proposal document?	No.
C.14. Does the evaluative criteria follow a pre-determined structure and is it detailed in the RFP?	Yes.
C.15. Are pre-proposal visits and meetings arranged?	No.
C.16. Are minutes prepared and circulated after pre-proposal meetings?	N/A
C.17. To whom are minutes distributed?	N/A
C.18. Are all queries from consultants answered to in writing?	Yes.
C.19. Are the financial and technical proposals in separate envelopes?	Yes.
C.20. Are proposal securities required?	No.
C.21. Are technical proposals opened in public?	Yes.
C.22. Do the financial proposals remain sealed until technical evaluation is completed?	Yes.
C.23. Are minutes of technical opening distributed?	Yes.
C.24. Who determines the final technical ranking and how?	The Project Director at national level, after reviewing and verifying the technical revaluation report submitted to by the OD.
C.25. Are the technical scores published and sent to all firms?	Yes.
C.26. Is the financial proposal opening public?	Yes.
C.27. Are minutes of financial proposal opening taken and distributed?	Yes.
C.28. How is the financial evaluation completed?	According to criteria set in the RFP.
C.29. Are face to face contract negotiations held?	Yes.

C.30. How long after financial evaluation is the selected firm to negotiate?	Within 1 to 2 weeks.
C.31. What is the usual basis for negotiation?	- Terms of reference, - Work program and personnel schedule, - Counterpart supports/facilities, - Financial terms (TAX, payment schedule, etc.) - Mobilization, and commencement of services. - Deliverables, etc.
C.32. Are minutes of negotiation taken and signed?	Yes.
C.33. How long after negotiations until the contract is signed?	Within 1 weeks.
C.34. Are advance payments made?	Yes, depending on agreements.
Part D. Process Oversight and Control	
D.1. Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes.
D.2. Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes.
D.3. Is the commencement of procurement dependent on external approvals (formal or de-facto) outside of the budgeting process?	No.
D.4. Who approves procurement transactions and do they have procurement experience and qualifications?	By the OD Director, but he does not have procurement experience before.
D.5. Which of the following actions require approval outside of the procurement unit or a permanent evaluation committee and who grants the approval?	
(i) Bidding document, invitation to pre-qualify or request for proposal	The OD Director.
(ii) Advertisement of an invitation for bids, pre-qualification or call for expressions of interest	The OD Director.
(iii) Evaluation reports	The Project Director (at national level).
(iv) Notice of award	The OD Director.
(v) Invitation to consultants to negotiate	The OD Director.
(vi) Contracts	The OD Director.
D.6. Is contractual performance systematically monitored and reported upon?	Yes.
D.7. Does the agency monitor and track its contractual payment obligations?	Yes.

D.8. On average how long is it between receiving a firm's invoice and making payment?	Within 15 days.
D.9. What is the standard period for payment included in contracts?	Within 30 days.
D.10. When payment is made late are the beneficiaries paid interest?	Yes, per contract agreement. But, has never paid late so far.
D.11. Are payments authorized by the same individuals empowered to approve invitation documents, evaluations and contracts	Yes, by the same OD Director. But bid Evaluations are approved by the Project Director.
D.12. Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes.
D.13. Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes.
D.14. Is there a formal non-judicial mechanism for dealing with complaints?	No.
D.15. Is a complaints resolution mechanism described in national procurement documents?	Yes.
Part E. Records Keeping	
E.1. Is there a referencing system for procurement files?	Yes.
E.2. Are original contracts secured in a fire and theft proof location?	Yes.
E.3. Are copies of bids or proposals retained with the evaluation reports?	Yes.
E.4. Are copies of the original advertisements retained with the pre-contract files?	Yes.
E.5. Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes.
E.6. Are copies of invoices included with contract papers?	Yes.
E.7. For what period are records kept?	Up to 10 years.

MINISTRY OF HEALTH, CAMBODIA

Greater Mekong Sub-region Health Security Project
Project Preparatory Technical Assistant

Procurement Capacity Assessment Questionnaire – Poi Pet SOA (Banteay Meanchey Province)

Part A. General Agency Resource Assessment	
A.1. Is there a procurement department?	There is no procurement department in the SOA, but Procurement Team instead.
A.2. What procurement does it undertake?	Has not processed procurement before, but was going to start soon for office Equipment.
A.3. What is the size of procurement under taken by the SOA for Good, Work, and Service?	Not greater than USD 50,000.
A.4. Who are the member of SOA Procurement Committee?	- OD Director, - Vice OD Director, - Chief of Technical Unit, - Chief of Accounting Unit, and - Staff of Technical Unit.
A.5. Are the staff provided with written job descriptions?	No job description for each individual member of procurement team. But, there are job description for the whole Procurement Team written in the Ministry of Health's notice.
A.6. How many years of experience does the head of the Procurement Team have in a direct procurement role?	The head of Procurement Team, the OD Director, has no procurement experience.
A.7. How many staff in the Procurement Team are:	5 in the SOA Procurement Team
i. Full-time?	0
ii. Part-time?	0
iii. Seconded?	5
A.8. At what level does the Procurement Team report to (the head of agency, deputy, etc.)?	Project Director (at national level).
A.9. Do the staff that will be involved with the procurement have English language skills sufficient to undertake procurement?	Moderately sufficient.
A.10. Is the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes, moderately.
A.11. Does the unit have adequate facilities such as PCs, internet connections, photocopy facilities, printers, etc. to undertake the expected procurement?	Yes.

A.12. Is there a procurement training program?	Members of the Procurement Team have participated any procurement training conducted by Department of Budget for 2 times and by HSSP2 for 1 time.
Part B. Agency Procurement Processes, Goods and Works	
B.1. Has the SOA undertaken foreign assisted procurement of goods or works recently (last 12 months, or last 36 months)? (If yes, funded by whom and name of the project)	No, not yet.
B.2. If the above is yes, what were the major challenges?	N/A.
B.3. Is there a procurement process manual for goods and works?	Yes, the SOP.
B.4. If there is a manual, is it up to date, and does it cover foreign-assisted procurement?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
B.5. Is there a systematic process to identify procurement requirements (1 year or more)	No, but there is Annual Operational Plan that is prepared with involvement representatives from Health Centers, Referral Hospitals and Provincial Department of Health.
B.6. Who drafts the specifications?	The Procurement Team.
B.7. Who approves the specification?	The OD Director.
B.8. Are there standard bidding documents in use and have they been approved for use on ADB funded projects?	Yes. The standard bidding documents in the SOP.
B.9. Who drafts the bidding documents?	The Procurement Team.
B.10. Who manages the sale of the document?	The Procurement Team.
B.11. Are all queries from bidders replied to in writing?	Yes.
B.12. Is there a minimum period for preparation of bids and if yes how long?	Yes, and depending on the estimated cost of tender.
B.13. Does the bidding document state the date and time of opening and how close is it to the Deadline for submission?	Yes. The opening is just after the dead line for bid submission.
B.14. Is the opening public?	Yes.
B.15. Can late bids be accepted?	No.
B.16. Can bids be rejected at bid opening?	No.
B.17. Are minutes taken?	Yes.

B.18. Who may have a copy of the minutes?	The representative of bidders participating in the bid opening and the Bid Opening Committee members.
B.19. Are the minutes free of charge?	Yes.
B.20. Who undertakes the evaluation (individual(s), permanent committee, ad-hoc committee)?	The Procurement Team.
B.21. What are the qualifications of the evaluators in respect to procurement and the goods and works under evaluation?	Members of Evaluation Committee have received procurement trainings, and most of them have relevant knowledges.
B.22. Is the decision of the evaluators final or is the evaluation subject to additional approvals?	The decisions of the Procurement Team are subjected to final approvals from the Project Director at national level.
B.23. Using at least three real examples how long between the issue of the invitation for bids and Contact effectiveness?	It takes: 15 days for invitation, 10 to 20 days for evaluation, and 3 to 5 days for contract signing.
B.24. Are there processes in place for the collection and clearance of cargo through ports of Entry?	No, suppliers are always required to deliver goods procured at the final project sites.
B.25. Are there established goods receiving procedures?	Yes, goods inspection and checking of delivery supporting documents need to be done.
B.26. Are all goods received recorded as assets or inventory in a register or similar?	Yes, all goods received are recorded as assets by OD.
B.27. Is the Procurement Team familiar with letters of credit?	No. But, the contract amounts are always less than USD 50,000.
B.28. Does the procurement department register and track warranty and latent defects liability Periods?	No. But, warranty and latent defects liability periods are checked against delivery orders, warranty certificates and contract documents as necessary.
Part C. Agency Procurement Processes, Consulting Services	
C.1. Has the agency undertaken foreign assisted procurement of consulting services recently (last 12 months, or last 36 months)?	No.
C.2. If the above is “Yes” what where the major challenges?	N/A
C.3. Is there a procurement process manual for consulting services procurement?	Yes, the SOP.
C.4. Is the manual up to date and does it cover foreign assisted projects?	Yes, and the SOP was just updated in 2012 after being updated in 2010 and 2005.
C.5. Who identifies the need for consulting services requirements?	OD Director and Chiefs of Referral Hospitals and Health Centers.
C.6. Who drafts the TOR?	OD Director and Chiefs of Referral Hospitals and Health Centers.
C.7. Do the ToR follow a standard format such as background, tasks, inputs, objectives and Outputs?	Yes.

C.8. Who prepares the request for proposals?	The Procurement Team.
C.9. Are assignments advertised and expressions of interest called for?	Yes.
C.10. Is a consultants' selection committee formed with appropriate individuals in terms of Procurement and technical expertise?	Yes, majority of the selection committee members are health specialists.
C.11. What criteria is used to evaluate EOIs?	Previous experiences of Firms/NGOs expressing their interests.
C.12. Historically what is the most common method used (QCBS, QBS etc.)	N/A.
C.13. Do firms have to pay for the proposal document?	No.
C.14. Does the evaluative criteria follow a pre-determined structure and is it detailed in the RFP?	Yes.
C.15. Are pre-proposal visits and meetings arranged?	No.
C.16. Are minutes prepared and circulated after pre-proposal meetings?	N/A
C.17. To whom are minutes distributed?	N/A
C.18. Are all queries from consultants answered to in writing?	Yes.
C.19. Are the financial and technical proposals in separate envelopes?	Yes.
C.20. Are proposal securities required?	No.
C.21. Are technical proposals opened in public?	Yes.
C.22. Do the financial proposals remain sealed until technical evaluation is completed?	Yes.
C.23. Are minutes of technical opening distributed?	Yes.
C.24. Who determines the final technical ranking and how?	The Project Director at national level, after reviewing and verifying the technical revaluation report submitted to by the OD.
C.25. Are the technical scores published and sent to all firms?	Yes.
C.26. Is the financial proposal opening public?	Yes.
C.27. Are minutes of financial proposal opening taken and distributed?	Yes.
C.28. How is the financial evaluation completed?	According to criteria set in the RFP.

C.29. Are face to face contract negotiations held?	Yes.
C.30. How long after financial evaluation is the selected firm to negotiate?	Within 1 to 2 weeks.
C.31. What is the usual basis for negotiation?	- Terms of reference, - Work program and personnel schedule, - Counterpart supports/facilities, - Financial terms (TAX, payment schedule, etc.) - Mobilization, and commencement of services. - Deliverables, etc.
C.32. Are minutes of negotiation taken and signed?	Yes.
C.33. How long after negotiations until the contract is signed?	Within 1 weeks.
C.34. Are advance payments made?	Yes, depending on agreements.
Part D. Process Oversight and Control	
D.1. Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes.
D.2. Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes.
D.3. Is the commencement of procurement dependent on external approvals (formal or de-facto) outside of the budgeting process?	No.
D.4. Who approves procurement transactions and do they have procurement experience and qualifications?	By the OD Director, but he does not have procurement experience before.
D.5. Which of the following actions require approval outside of the procurement unit or a permanent evaluation committee and who grants the approval?	
(i) Bidding document, invitation to pre-qualify or request for proposal	The OD Director.
(ii) Advertisement of an invitation for bids, pre-qualification or call for expressions of interest	The OD Director.
(iii) Evaluation reports	The Project Director (at national level).
(iv) Notice of award	The OD Director.
(v) Invitation to consultants to negotiate	The OD Director.
(vi) Contracts	The OD Director.
D.6. Is contractual performance systematically monitored and reported upon?	Yes.

D.7. Does the agency monitor and track its contractual payment obligations?	Yes.
D.8. On average how long is it between receiving a firm's invoice and making payment?	Within 15 days.
D.9. What is the standard period for payment included in contracts?	Within 30 days.
D.10. When payment is made late are the beneficiaries paid interest?	Yes, per contract agreement. But, has never paid late so far.
D.11. Are payments authorized by the same individuals empowered to approve invitation documents, evaluations and contracts	Yes, by the same OD Director. But bid Evaluations are approved by the Project Director.
D.12. Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes.
D.13. Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes.
D.14. Is there a formal non-judicial mechanism for dealing with complaints?	No.
D.15. Is a complaints resolution mechanism described in national procurement documents?	Yes.
Part E. Records Keeping	
E.1. Is there a referencing system for procurement files?	Yes.
E.2. Are original contracts secured in a fire and theft proof location?	Yes.
E.3. Are copies of bids or proposals retained with the evaluation reports?	Yes.
E.4. Are copies of the original advertisements retained with the pre-contract files?	Yes.
E.5. Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes.
E.6. Are copies of invoices included with contract papers?	Yes.
E.7. For what period are records kept?	Up to 10 years.

APPENDIX 1-D – OVERALL CAPACITY ASSESSMENT

Cambodia: PROCUREMENT CAPACITY ASSESSMENT

Proposed Project Name:	Proposed Amount:
Executing Agency:	Source of Funding: ADB: Government:
Assessor: Counseil Santé, PPTA Consultants	Date: January- February 2016

Expected Procurement The procurement covers the following subprojects:
Goods and works will be procured under the project. Large lots will be offered to the market by International Competitive Bidding while National Competitive Bidding will be used for the smaller packages according to the ADB thresholds. The EAs will manage the project with support from the consultants recruited under the loan to supplement the EAs' resources.
General Procurement Environment Assessment Risk Assessment: OVERALL RISK RATING Average to Low While the Procurement Law was signed 14 January 2012, adequate rules and regulations governing procurement procedures have been in place and made mandatory by the Sub Decree No.14 dated 26.2.2007 & National: Sub-Decree No.105/2008. The SOP and the Procurement Manual were prepared with the assistance of the WB and the ADB to largely support externally funded projects and therefore the procedures do not conflict with the ADB guidelines on procurement of good and works and the procurement of consulting services. Development Partners (DP), including the ADB, periodically conducts procurement workshops and seminars for project staff as part of the capacity building exercise. None of the national practices run contrary to ADB"s procurement policies. The SOP requires wide publicity of all procurements including inserting notices in the local newspapers and the Project website. It is also required that the procurement results are posted in the relevant project website and published in the local newspaper. Summary of Findings: The Project Management Unit (PMU) is well equipped and staffed, and benefits from the experience gained in implementing CDC II, which was also financed by ADB. The same team in the procurement unit in CDC II has been nominated to participate in implementing GMS HSP. Based on the assessment, the EA has adequate procurement capacity to handle NCB (National Competitive Bidding) and Shopping. However, the weakness appears largely in the capacity of the PMU to handle complex International Competitive bidding (ICB) for complex health equipment. It is recommended that the PMU be supported by international procurement specialist through the initial stages and by national procurement specialist in the long term. Information Management Risk Assessment: Summary of Findings: The PMU office has adequate facilities and experience in filing and storing procurement documents. Procurement Practices Procurement of Goods and Works Summary of Findings: The EA has adequate procurement capacity to handle ICB, NCB (National Competitive Bidding) and Shopping.

Summary of Findings: The PMU is quite familiar with the Governments SOP; most procurement will be centralized in the PMU in Phnom Penh where experienced procurement officers have been appointed. The strength stems from the years of experience (over ten years) the senior procurement officer has gained working with ADB financed projects. The weaknesses are largely covering ICB and the recruitment of consultants following the QCBS procedure and the General Procurement Environment in the country where the overall risk rating is assessed as high.

Accountability Measures

Summary of Findings: While there is no procurement law in Cambodia, adequate rules and regulations are in place and made mandatory by the Sub Decree No.14 dated 26.2.2007 & National: Sub-Decree No.105/2008. The SOP and the Procurement Manual were prepared with the assistance of the WB and the ADB to largely support externally funded projects and therefore the procedures do not conflict with the ADB guidelines on procurement of good and works and the procurement of consulting services. The Development Partners (DP) including the ADB periodically conducts procurement workshops and seminars for project staff as part of the capacity building exercise. None of the national practices run contrary to ADB"s procurement policies. The SOP requires wide publicity of all procurements including inserting notices in the local newspapers and the Project website.

Summary Assessment and Recommendations

Generally, the procurement risks are low. The executing agencies' procurement teams are experienced in conducting this type of procurement. The procurement procedures and requirements of the government are aligned with the international practice. The executing agencies have recent experiences in selecting and managing contracts for goods and works, and consulting services. However, considering their unfamiliarity with ADB's guidelines, the PMUs will need training on ADB's guidelines particularly for procuring and managing complex health sector goods and equipment.

Specific Recommendations on Project Implementation

Capacity Constraints	Recommended Action	Responsibility and Comment
To assist the PMUs with ADB's procedures and requirements.	Support consultants will be engaged to assist and provide on-the-job training for PMUs in procuring and managing the contracts.	Individual international & national consultants engaged under the project to help project implementation and procurement.

General Recommendations on EA Capacity

Capacity Constraints	Recommended Action	Responsibility and Comment
Procurement assessment questionnaires and field investigation demonstrate that the PMUs have sufficient practices and strengths in procurement under externally financed projects including experiences in preparing documents, evaluating bids, and administering contracts for goods, works, and consulting services using ADB loan funds.	Capacity development programs will be provided for the PMUs to strengthen skills to procure and manage international contracts.	Training will be provided as part of improved competencies in procurement and health security management.

General Recommendations on Procurement Environment

Capacity Constraints	Recommended Action	Responsibility and Comment
The Procurement Law, manuals and SOPs.	Long-term procurement reform will continue to open competitive processes as well as streamline approval process.	Ministry of Finance is responsible for the procurement reform with support from the development partners.

APPENDIX 2 – LIST OF PROCUREMENT LEGAL DOCUMENTS AND NATIONAL STANDARD BIDDING DOCUMENTS

PROCUREMENT LEGAL DOCUMENTS

No.	Reference Document	Dated
1	Sub-Decree No. 14 RNK/BK, on Promulgation of Procedures for implementing the Asian Development Bank and the World Bank Financed Projects/Programs in Cambodia	February 26 2007
2	Procedures for implementing the Asian Development Bank and the World Bank Financed Projects/Programs in Cambodia	February 2007
3	The Royal Kram No. NS/RKM/0112/004 on Promulgating the Law on the Public Procurement.	14 January 2012
4	Sub-degree on Promulgating the Updated Standard Procedures for Implementing All Externally Financed Projects/Programs	22 May 2012
5	Updated Standard Procedures for Implementing All Externally Financed Projects/Programs	May 2012
6	ADB Guidelines on The Use of Consultants by Asian Development Bank and Its Borrowers	March 2013
7	ADB Procurement Guidelines	April 2015
8	ADB Guide on Assessing Procurement Risks and Determining Project Procurement Classification	August 2014
9	Standard Bidding Document (NCB for Goods)	May 2012
10	Standard Bidding Document (NCB for Works)	May 2012
11	Standard Bidding Document (NS for Goods blow advertising Threshold)	May 2012
12	Standard Bidding Document (NS for Works blow advertising Threshold)	May 2012
13	MEF's Prakas on Delegation on Empowerment of Decision Making in Procurement Process in Foreign-funded Projects/Programs	01 June 2010
14	ADB Draft Final Report of Cambodia Pilot Country and Sector/Agency Procurement Risk Assessment	March 2015
15	Cambodia - Country Procurement Assessment Report, by the World Bank	14 September 2004
16	Financial Policies and Procedure, HSSP, MoH	May 2007

National Standard Bidding Documents

The following national standard bidding documents are available and in use in Cambodia

Procurement of Goods	NCB	
Procurement of Goods	NS	
Procurement of Goods	NS	Below Advertising Threshold
Procurement of Works	NCB	
Procurement of Works	NS	
Procurement of Works	NS	Blow Advertising Threshold

NCB – National Competitive Bidding

NS – National Shopping

Note: Soft copies of above mentioned SBDs available with the consultants.

APPENDIX 3 – DRAFT PROCUREMENT PLAN

PROCUREMENT PLAN

Basic Data

Project Name:	
Project Number:	**Approval Number**:
Country: CAMBODIA	**Executing Agency**:
Project Procurement Classification: {A or B}	**Implementing Agency:**
Procurement Risk: {High, Substantial, Moderate, or Low}	
Project Financing Amount: $ {amount} **ADB Financing:** **Cofinancing (ADB Administered):** **Non-ADB Financing:**	**Project Closing Date:**
Date of First Procurement Plan {loan/grant approval date}:	**Date of this Procurement Plan**: {dd / mm / year}

A. Methods, Thresholds, Review and 18-Month Procurement Plan

1. Procurement and Consulting Methods and Thresholds

Except as the Asian Development Bank (ADB) may otherwise agree, the following process thresholds shall apply to procurement of goods and works.

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
International Competitive Bidding for Goods	$1,000,000	
National Competitive Bidding for Goods	Beneath that stated for ICB, Goods	
Shopping for Goods	Below $100,000	

Consulting Services	
Method	**Comments**
Individual Consultant Selection (ICS)	

2. Goods and Works Contracts Estimated to Cost $1 Million or More

The following table lists goods and works contracts for which the procurement activity is either ongoing or expected to commence within the next 18 months.

Package Number	**General Description**	**Estimated Value**	**Procurement Method**	**Review** [Prior / Post/Post (Sampling)]	**Bidding Procedure**	**Advertisement Date** (quarter/year)	**Comments**
MOH/ADB/GMS/HSP/ICB/Lab-Con/01/2017	Supply and Delivery of Central, Regional, Provincial and District Laboratory Consumable	1,028,000	ICB	Prior (Sampling)	1S1E	Q2/2017	

3. Consulting Services Contracts Estimated to Cost $100,000 or More

The following table lists consulting services contracts for which the recruitment activity is either ongoing or expected to commence within the next 18 months.

Package Number	General Description	Estimated Value	Recruitment Method	Review (Prior / Post)	Advertisement Date (quarter/year)	Type of Proposal	Comments
MOH/ADB/GMS/ HSP/IC/Pro-Spe/01/2017	International Procurement Specialist	297,000	ICS	Prior	Q1/2017	Bio Data	International

4. Goods and Works Contracts Estimated to Cost Less than $1 Million and Consulting Services Contracts Less than $100,000 (Smaller Value Contracts)

The following table groups smaller-value goods, works and consulting services contracts for which the activity is either ongoing or expected to commence within the next 18 months.

Goods and Works								
Package Number	General Description	Estimated Value	Number of Contracts	Procurement Method	Review [Prior / Post/Post (Sampling)]	Bidding Procedure	Advertisement Date (quarter/ year)	Comments
MOH/ADB/GMS/ HSP/NCB/Lab-Equ/02/2017	Supply, Delivery and Installation of Central, Regional, Provincial and District Medial Laboratory Equipment	954,000.00	1	NCB	Post	1S1E	Q4/2017	
MOH/ADB/GMS/ HSP/NCB/Lab-Mai/01/2017	Central, Regional and Provincial Lab Maintenance and Minor Repairs	900,000.00	1	NCB	Prior (Sampling)	1S1E	Q1/2017	
MOH/ADB/GMS/ HSP/Shopping/Off-Equ/01/2017	Supply, Delivery and Installation of Computer Equipment for Central, Regional, Provincial and District Labs	10,500.00	1	Shopping	Prior (Sampling)	1S1E	Q1/2017	
MOH/ADB/GMS/ HSP/NCB/Lab-Equ/03/2017	Supply, Delivery and Installation of Central, Regional, Provincial and District Medial Laboratory Equipment	209,000.00	1	NCB	Post	1S1E	Q3/2017	

Goods and Works								
Package Number	General Description	Estimated Value	Number of Contracts	Procurement Method	Review [Prior / Post/Post (Sampling)]	Bidding Procedure	Advertisement Date (quarter/ year)	Comments
MOH/ADB/GMS/ HSP/Shopping/Air-Con/02/2017	Air Conditioners for District Labs	12,000.00	1	Shopping	Post	1S1E	Q4/2017	
MOH/ADB/GMS/ HSP/Shopping/Ref/03/2017	Refrigerators Conditioner for District Labs	16,000.00	1	Shopping	Post	1S1E	Q4/2017	
MOH/ADB/GMS/ HSP/Shopping/Lab-Con/04/2017	Supply and Delivery of District Laboratory Consumable	31,000.00	1	Shopping	Post	1S1E	Q4/2017	
MOH/ADB/GMS/ HSP/NCB/Lab-Mai/04/2017	District Lab Maintenance and Minor Repairs	200,000.00	1	NCB	Post	1S1E	Q3/2017	

Consulting Services								
Package Number	General Description	Estimated Value	Number of Contracts	Recruitment Method	Review (Prior / Post)	Advertisement Date (quarter/ year)	Type of Proposal[8]	Comments[9]
-								
-								
-								

B. Indicative List of Packages Required Under the Project

The following table provides an indicative list of goods, works and consulting services contracts over the life of the project, other than those mentioned in previous sections (i.e., those expected beyond the current period).

Goods and Works							
Package Number	General Description	Estimated Value (cumulative)	Estimated Number of Contracts	Procurement Method	Review [Prior / Post/Post (Sampling)]	Bidding Procedure[6]	Comments[7]

Consulting Services							
Package Number	General Description	Estimated Value (cumulative)	Estimated Number of Contracts	Recruitment Method	Review (Prior / Post)	Type of Proposal[8]	Comments[9]

C. List of Awarded and On-going, and Completed Contracts

The following tables list the awarded and on-going contracts, and completed contracts.

1. Awarded and On-going Contracts

Goods and Works							
Package Number	General Description	Estimated Value	Awarded Contract Value	Procurement Method	Advertisement Date (quarter/ year)	Date of ADB Approval of Contract Award[10]	Comments[11]

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.
[11] Indicate the Contractor's name and the contract signing date.

Consulting Services							
Package Number	General Description	Estimated Value	Awarded Contract Value	Recruitment Method	Advertisement Date (quarter/year)	Date of ADB Approval of Contract Award[10]	Comments[12]

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.
[12] Indicate the Consulting Firm's name and the contract signing date.

2. Completed Contracts

Goods and Works								
Package Number	General Description	Estimated Value	Contract Value	Procurement Method	Advertisement Date (quarter/ year)	Date of ADB Approval of Contract Award[10]	Date of Completion[13]	Comments

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.
[13] The Date of Completion is the physical completion date of the contract.

Consulting Services								
Package Number	General Description	Estimated Value	Contract Value	Recruitment Method	Advertisement Date (quarter/ year)	Date of ADB Approval of Contract Award[10]	Date of Completion[13]	Comments

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.
[13] The Date of Completion is the physical completion date of the contract.

D. Non-ADB Financing

The following table lists goods, works and consulting services contracts over the life of the project, financed by Non-ADB sources.

Goods and Works				
General Description	Estimated Value (cumulative)	Estimated Number of Contracts	Procurement Method	Comments

Consulting Services				
General Description	Estimated Value (cumulative)	Estimated Number of Contracts	Recruitment Method	Comments

National Competitive Bidding

A. Regulation and Reference Documents

1. The procedures to be followed for national competitive bidding shall be those set forth for the "National Competitive Bidding" method in the Government's Procurement Manual issued under Sub-Decree Number 74 ANKR.BK, updated version dated 22 May 2012 with the clarifications and modifications described in the following paragraphs. These clarifications and modifications are required for compliance with the provisions of the Procurement Guidelines.

2. For the procurement of ADB financed contracts under National Competitive Bidding (NCB) procedures, the use of harmonized national bidding documents (NCB and National Shopping) developed in consultation with development partners including ADB, is mandatory except where the Government and ADB have agreed to amendments to any part of the documents. The Procurement Manual also advises users to check the ADB website from time to time for any update on ADB documents, which form the basis, among others, of the existing harmonized national bidding documents.

B. Procurement Procedures

1. Application

3. Contract packages subject to National Competitive Bidding procedures will be those identified as such in the project Procurement Plan. Any change to the mode of procurement of any procurement package in the Procurement Plan shall be made through updating of the Procurement Plan, and only with prior approval of ADB.

2. Sanctioning

4. Bidders shall not be declared ineligible or prohibited from bidding on the basis of barring procedures or sanction lists, except individuals and firms sanctioned by ADB, without prior approval of ADB.

3. Rejection of all Bids and Rebidding

5. The Borrower shall not reject all bids and solicit new bids without ADB's prior concurrence. Even when only one or a few bids is/are submitted, the bidding process may still be considered valid if the bid was satisfactorily advertised and prices are reasonable in comparison to market values.

4. Advertising

6. Bidding of NCB contracts shall be advertised on the ADB website via the posting of the Procurement Plan. Borrowers have the option of requesting ADB to post specific notices in the ADB website.

C. Bidding Documents

5. Use of Bidding Documents

7. The Standard National Competitive Bidding Documents provided with the Government's Procurement Manual shall be used to the extent possible both for the master bidding documents and the contract-specific bidding documents. The English language version of the procurement documents shall be submitted for ADB review and approval in accordance with agreed review procedures (post and prior review) as indicated in the Procurement Plan. The ADB-approved procurement documents will then be used as a model for all procurement financed by ADB for the project.

6. Bid Evaluation

8. Bidders shall not be eliminated from detailed evaluation on the basis of minor, non-substantial deviations.

9. A bidder shall not be required, as a condition for award of contract, to undertake obligations not specified in the bidding documents or otherwise to modify the bid as originally submitted.

7. Employer's Right to Accept or Reject Any or All Bids

10. The decision of the Employer to accept or reject any or all bids shall be made in a transparent manner and involve an obligation to inform of the grounds for the decision through the bid evaluation report.

8. ADB Policy Clauses

11. A provision shall be included in all NCB works and goods contracts financed by ADB requiring suppliers and contractors to permit ADB to inspect their accounts and records and other documents relating to the bid submission and the performance of the contract, and to have them audited by auditors appointed by ADB.

12. A provision shall be included in all bidding documents for NCB works and goods contracts financed by ADB stating that the Borrower shall reject a proposal for award if it determines that the bidder recommended for award has, directly or through an agent, engaged in corrupt, fraudulent, collusive, or coercive practices in competing for the contract in question.

13. A provision shall be included in all bidding documents for NCB works and goods contracts financed by ADB stating that ADB will declare a firm or individual ineligible, either indefinitely or for a stated period, to be awarded a contract financed by ADB, if it at any time determines that the firm or individual has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive or obstructive practices or any integrity violation in competing for, or in executing, ADB-financed contract.

Project Procurement Risk Assessment Report, Lao PDR

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS

(as of 11 May 2015)

Currency unit	–	kip (KN)
KN1.00	=	$0.000123
$1.00	=	KN8,096

NOTES

(i) The fiscal year (FY) of the Government of Lao People's Democratic Republic and its agencies ends on 31 December. "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

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ACRONYMS

ADB	Asian Development Bank
CQS	consultant's qualification selection
DPIC	Department of Planning and International Cooperation
HSGP	health sector government program
ICS	individual consultant selection
MOH	Ministry of Health
PMU	project management unit
PrMO	procurement monitoring office
QCBS	quality and cost based selection
PRA	procurement risk assessment
SOE	state-owned enterprises

Executive Summary

The Governments of Cambodia, Lao PDR, Myanmar and Viet Nam have requested the Asian Development Bank (ADB) to support the Greater Mekong Subregion (GMS) Health Security Project (the Project). The project is to strengthen health security systems in terms of regional cooperation, CDC in border areas, surveillance and response, laboratory services, and hospital infection prevention and control. The total project cost in the Lao PDR is $12.6 million for implementation in 12 provinces. Almost half of the project costs is to procure laboratory, hospital and outreach equipment, and vehicles. The Ministry of Health (MOH) is the Executing Agency, represented by the Department of Planning and International Cooperation (DPIC), which will establish the project management unit (PMU) and carry out all procurement.

In each country, a Procurement Risk Assessment (PRA) was prepared to determine the overall procurement risk of the project, establish appropriate measures to mitigate these risks, and prepare the procurement plan for the proposed project with the proposed packages and procurement methods. For MOH Lao PDR, the overall project procurement risk was assessed as *moderate*. This PRA reports on the findings in the Lao PDR.

The overall procurement environment in Lao PDR is characterized by a complex and unclearly defined process with poor application of sanctions and penalties for incorrect or fraudulent procurement processes. Generally, the procurement capacity in the public service is weak, especially at the provincial level and the engagement of private sector suppliers is not fully developed and transparent.

However, the project is placed in more favorable conditions in DPIC of MOH. The established procurement unit within DPIC has extensive experience with procurement for ADB-funded projects and has the staff, facilities and network to provide this function for the project. MOH has continuously engaged chief technical advisers to further strengthen management capacity.

Weaknesses and risks include limited procurement capacity at provincial level, PMU governance risks for small procurements using shopping, delay in procurement processing due to slow approval processes, and procurement of substandard equipment.

Procurement will be centralized in view of limited provincial capacity. Procurement training will be provided for the PMU. Procurement will be monitored to ensure that it is in compliance with government and ADB procedures. Procurement processing steps will be carefully monitored and delays will be reported. Consultants will be engaged to ensure high quality specification for procurement of equipment.

I. INTRODUCTION

1. The procurement risk assessment (PRA) for the proposed Greater Mekong Subregion (GMS) Health Security Project (the project) was prepared in accordance with ADB's Guidelines for Assessing Country, Sector and Project Procurement Risks. For the Lao PDR, a national procurement specialist, with the guidance of an international procurement specialist and ADB, conducted a 3 months PRA during the period October 2015 to February 2016.

2. The project aims to contribute to regional health security by strengthening the health security system and communicable diseases control (CDC) coverage with 3 outputs: (i) improved regional cooperation and CDC in border areas, (ii) strengthened national disease surveillance and response capacity; (iii) improved laboratory capacity and infection prevention and control in hospitals.

3. The project is estimated to cost $135 million including $12.6 million for the Lao PDR. In the Lao PDR, MOH is the executing agency, represented by the Department of Planning and International Cooperation (DPIC). Implementing agencies are the National Center for Laboratory and Epidemiology (NCLE), which is also responsible for surveillance and response, the Department of Health Services, and 12 provincial health offices of the 12 targeted provinces. However, in view of capacity constraints, all procurement will be centralized and carried out by DPIC in cooperation with concerned technical departments, institutions and provinces.

4. Procurement for this project is simple in terms of small independent items being procured, but complex in that it concerns a large number of items for many locations, and that it includes laboratory equipment that needs to be of high quality and standardized as much as possible. ADB also wants to limit the number of procurement packages, while also being concerned about delays in procurements.

5. Major procurement packages are for (i) vehicles, (ii) provincial laboratory equipment, (iii) equipment for infection control in hospitals,(iv) consulting services, and (v) repair of laboratories and wards.

6. The Lao PDR has extensive procurement experience with ADB projects following ADB procurement rules. Various agencies including the World Bank, ADB and bilateral donors have provided technical assistance to improve procurement systems. However, there have been challenges with procurement as summarized under the heading "effectiveness".

7. The following PRA activities were conducted:

- Review country procurement organization and system (legal framework, agencies, roles and responsibilities) including processes to improve procurement, e-procurement and audit
- Review ADB procurement experiences and documentation
- Review country procurement legal documents (procurement law, guidance degree, circulars…)
- Identify discrepancies between national procurement procedures and donor guidelines
- Collect views of officer in charge and procurement staff of the Executing Agency (DPIC) and 2 Implementing Agencies (2 provinces).
- Conduct PRA based on EA and IAs questionnaire

- Review procurement documents from previous projects
- Assess procurement capacity of the Executing Agency (EA) and Project Implementing Agencies (IAs).
- Review procurement monitoring and document keeping: monitoring information system; record of the process; document keeping
- Propose procurement plan and capacity building, mentoring and supervision arrangements.

8. The PRA examines five aspects including (i) organizational and staff capacity; (ii) information management; (iii) procurement practices; (iv) effectiveness, and (v) accountability measures. It then summarizes strengths and weaknesses, presents the procurement risk assessment and management plan (P-RAMP), refers to procurement thresholds, and proposes a procurement plan. The completed PRA questionnaires of the procurement environment and the central procurement unit are in Appendix 1. The assessment of provincial IAs has not been included as these will not conduct any substantive procurement. Appendix 2 presents the procurement plan, and Appendix 3 the draft master bidding documents.

II. PROJECT PROCUREMENT RISK ASSESSMENT

A. Overview

i. Organization and Staff Capacity

9. Procurement legislation in Lao PDR, as detailed in the *Decree of the Prime Minister on Government Procurement of Goods, Construction, Maintenance and Services*, *No. 03/PM dated 09 January 2004,* and Ministry of Finance *Guidelines of the Implementing Rules and Regulations No. 0063/MOF, dated 12 March 2004* are generally in accordance with best international standards, including publication of information about tenders and contract awards.

10. With the exception however, that the legislation excludes any provision for independent dispute resolution mechanism to deal with complaints. This legislation is the only basic legal framework on the procurement system to improve transparency, efficiency and openness in public procurement in Lao PDR for application by line Ministries, agencies, provinces as well as SOEs.

11. In 2009 a Procurement Monitoring Office (PrMO) was established within the Ministry of Finance (MOF) to play a pivotal role in procurement reform, providing training, making harmonized standard bidding documents and developing procurement policy. A start has been made to train staff in the correct procurement procedures and capacity is improving. However, this training needs to be rolled out throughout the country, and action is needed to see that proper procurement procedures are consistently applied. A Procurement Manual was issued in 2009 by PrMO, but it is confusing and cumbersome to apply (a technical assistance supported by ADB to revise the document is planned but has not yet been implemented).

12. The Procurement Unit (PU) with the Project Coordination Unit (PCU) of DPIC of MOH was established in 2002 to manage procurement of ADB-funded projects in the health sector. A similar PU was also established within DPIC to manage procurement for World Bank-funded projects. DPIC is attempting to set up one Integrated Project Administration Unit (IPAU) in MOH to improve efficiency. A more feasible step would be to combine the two procurement units for ADB and WB funded projects.

13. The ADB PU in DPIC has three staff, two of which have served since 2002 and have a long and varied experience of procurement under ADB's procedures. The PU is well equipped and has sufficient resources to carry out its functions. The PU will support procurement for ADB's Health Sector Government Program (HSGP) approved in 2015, and will also support the project.

14. The project has a limited role for procurement at provincial level. While HSGP supports the devolution of procurement functions to the provincial level, given the scope of this project, with similar procurement of high tech equipment across many provinces, centralized procurement is preferred.

ii. Information Management

15. The DPIC Procurement Unit maintains and stores all relevant records relating to procurement (advertisement, bid evaluation and contracts) in accordance with ADB's requirements. Hard copy records have been kept for 10 years since the unit was established in 2002. Soft copy records are also kept. However, the electronic information management system and storage can be improved.

iii. Procurement Practices

16. **Goods and works**. The PU follows the ADB guidelines and is experienced in procurement of goods under national competitive bidding (NCB) and shopping and procurement of consulting services under QCBS and ICS. It is also familiar with procurement under the government procurement rules.

17. The supporting documents required by ADB and MOH are somewhat different, usually, MOH require more detailed supporting documents than ADB, which can lead to delays in the finalization of contracts and procurement. The time taken for the preparation of bidding documents and for getting approval of bidding documents by the various parties also adds to the delay, including the ADB's letter of no objection. In exceptional case delays of up to one year have occurred.

18. In some cases, there has been a delay in the delivery of goods by suppliers after the award of a contract, usually without enforcement of penalty.

19. **Consulting services**. The PU is experienced in the procurement of consulting services under QCBS, CQS and ICS following ADB guidelines and this has not caused any major issues for the PU, apart from delay in the recruitment of consultants on some occasions due to delays in approvals and confirming the terms of reference/scope of work.

iv. Effectiveness

20. Within the health sector, there is substantial procurement experience, but this experience is mixed. Some of the key issues causing delayed and inappropriate procurement that may affect the effectiveness of procurement are as follows, in processing order:

- Insufficient assessment of facilities and equipment requirements;
- Lack of confirmation of IA that staff, supplies, and maintenance to operate the equipment; meaning is not clear: a verb is missing
- Request for change in procurement method and in procurement packages;

- Specifications being either too narrow, limiting the procurement to one supplier, or too broad, resulting in poor quality goods being procured;
- Large procurement packages with too many items that cannot be provided by one supplier;
- Insufficient cost estimates and price increases for items to be procured;
- Delay in procurement due to long procurement processes;
- Technical and procurement evaluation delays;
- Preference for national competitive bidding where international competitive bidding would be more appropriate;
- Risk of price fixing and rent seeking with limited suppliers;
- Risk of price fixing and invitation of non-competitive bids in shopping;
- Insufficient or lacking commissioning of equipment.

v. Accountability Measures

21. The CPS 2012-2016[1] reports: "In the Lao PDR, the major governance-related risks are in public finance management, procurement, corruption, and accountability. These could be mitigated and addressed by strengthening public finance management, instilling financial control (internal audit), enhancing external audit, curbing corruption (with the principles of the Second Governance and Anticorruption Action Plan) and reinforcing capacity. Internal and external auditing of government accounts remains weak, and will be addressed under the CPS through the governance and capacity-building intervention. Government staff have inadequate knowledge of the procurement system stipulated by the government and development partners. This is due to lack of training and language difficulties, especially relating to commercial and legal terms, and frequent rotation of project staff and their replacement, often by inexperienced new staff."

22. There has not been a systematic assessment of procurement practices for ADB projects in the Lao PDR. However, within the health sector, a project performance evaluation report[2] and subsequent inspection (audit) of the first GMS CDC Project was carried out and major irregularities were found.

23. While language problems and rotation of project staff are not issues in the PU of DPIC, MOH, there are some accountability challenges. Procurement staff in the PU do not follow, or have not received any accountability reinforcement in the extra responsibilities of managing procurement, apart from a code of ethics that applies to all government staff. This situation also applies to provincial staff involved in procurement. The risk of conflict of interest is not closely monitored, and the fact that provincial staff involved with procurement may also perform work outside their regular work to support suppliers and contractors bidding for contracts is an added risk. There have been instances where procurement of equipment and supplies is broken into small packages to qualify as direct purchase under the 3 million Kip threshold so that it can be purchased without the need to provide three quotations that applies for packages greater than 3 million Kip.

[1] ADB 2012. Lao PDR Country Partnership Strategy.

[2] ADB. 2014. Project Performance Evaluation Report for ADB Grants 0025/0026/0027: Greater Mekong Subregion (GMS) Regional Communicable Diseases Control Project (Cambodia, Lao People's Democratic Republic, and Viet Nam).

24. All documentation during the procurement process requires the approval of staff not connected to the PU and receipt of no objection from ADB. A written auditable trail of procurement decisions attributable to individuals and committees is kept on record.

25. The PU does not systematically monitor and report on contractual performance or payment obligations for procurement contracts that have been awarded. There is no formal complaints mechanism described in the government's procurement guideline and there is no formal non-judicial mechanism for dealing with complaints. Consequently there has been no complaint recorded. In addition there is no systematic oversight and monitoring of the PUs performance.

B. Strengths

26. The Procurement Unit within PCU of DPIC of MOH has now 13 years of experience managing procurement of ADB-funded projects in the health sector and its staff has a long and varied experience of procurement using ADB's procedures. The PU is well equipped and has sufficient resources to carry out its functions. A long term international consultant assists with technical advice and oversight. A similar PU within MOH is also experienced in procurement for WB-funded projects.

C. Weaknesses

27. Generally, institutional arrangements for dissemination and enforcement of the procurement legislation in Lao PDR have been inadequate, because of a lack of knowledge of the staff responsible for procurement of the government's and donor's procurement procedures, credit agreements and standard bid documents. There is a shortage of staff and resources especially at the provincial level, which is exacerbated by frequent rotation of project staff and their replacement with inexperienced procurement officers.

28. There appears to have been widespread use of procurement methods that fall short of open competition, and no mechanism has yet been established to deal with complaints effectively. Many national contractors also lack full understanding of the procedures, reflected in poor quality of bids and delays during evaluation while bid deficiencies are resolved. These ambiguities and lack of transparency leave the system vulnerable to corrupt practices.

D. Procurement Risk Assessment and Management Plan (P-RAMP)

29. Procurement for this project is simple in terms of small independent items being procured, but complex in that it concerns a large number of items for many locations, and that it includes laboratory equipment that needs to be of high quality and standardized as much as possible. ADB also wants to limit the number of procurement packages, but which may also result in delayed procurement.

30. The overall risk rating concluded from the results of the general procurement environment risk assessment and the agency procurement risk assessment is Moderate. The summary assessment is provided in tables 1 and 2. The assessment questionnaires are in Appendix 1. Assessments of other institutional and provincial implementing agencies are not included as these will not conduct any substantial procurement.

Table 1: Summary Ratings General Procurement Environment Risk Assessment

Criterion	Risk
A. Legal and Regulatory Framework	Moderate
B. Institutional Framework	Moderate
C. Procurement Market and Operations	High
D. Integrity of the Procurement System	Moderate
Overall Risk Rating	**Moderate**

Table 2: Summary Ratings Agency Procurement Risk Assessment

Criterion	Risk
A. Organization and Staff Capacity	Low
B. Information Management	Low
C. Procurement Practices	Moderate
D. Effectiveness	High
E. Accountability Measures	Moderate
Overall Risk Rating	**Moderate**

31. The Project Procurement Risk Assessment and Management Plan (P-RAMP) is shown in table 3.

Table 3: Procurement Risk Assessment and Management Plan (P-RAMP)

Risk Description	Risk Assessment	Mitigation Measures or Risk Management Plan
Legal and Regulatory Framework		
The national procurement regulations are not clear in some aspects and the procurement manual is cumbersome. The Procurement Decree is quite complex and does not clearly defined what type of procurement methods are to be used for different levels of expenditure.	Moderate	ADB procedures to be followed. Legal procurement reforms are beyond the scope of his project. A project consultant to provide technical support.
Institutional Framework		
The Procurement Monitoring Office (PrMO) in the MOF has full oversight function for all public procurement in Lao PDR. However, it still has limited number of staff and the financial resources to fulfill its roles and responsibilities properly. It has the mandate to build capacity, but lacks resources to conduct a nationwide procurement training program.	Moderate	The existing PU in the proposed IA is experienced with procurement in relation to ADB-funded projects having been involved in this since 2002. IA staff will participate in training and refresher programs provided through the ADB resident mission when available.
Procurement Market and Operations		
Given the lack of control in the procurement system, there are procurement risks of poor quality bids, and inappropriate and fraudulent practices.	High	The project will include consulting services to provide technical assistance and training in procurement to provincial PHO and DHO staff.
There is a risk of procurement to be broken into small packages that come under the threshold in direct purchase and collusion with suppliers. The Assets Register is not kept up to date.		The Procurement consultant will be hired soon after project startup to provide fulltime support for the initial two years of project implementation.
Integrity of the Procurement System		

Risk Description	Risk Assessment	Mitigation Measures or Risk Management Plan
No specific procurement audits are conducted. Projects generally rely on procurement audits conducted at the request of the donor). National procurement regulations are cumbersome and do not have a clearly defined complaints and disputes resolution process. The auditing of the procurement process and identification of irregular practices is not linked to disciplinary actions. Regulations for dealing with fraud and corruption although stated in the Decree are not enforced in practice and sanctions are rarely applied.	Moderate	ADB will have the right to conduct special audits of the PU is necessary. Timely audits of procurement to monitor compliance with the regulations/ procedures.
Organization and Staff Capacity		
Generally adequate capacity of the central implementing agency	Low	Requires laboratory equipment specialist for this Project
Information Management		
Generally adequate record keeping	Low	Improve the electronic storage system
Procurement Practices		
There are risks with current procurement practices relating to flexible procedures that result in less competitive bidding processes and less transparency	Moderate	Consider increased use of advertising and lowering thresholds for shopping with 3 quotations and use NCB instead. This needs to be balanced with delay of procurement. It may be more useful for items with large quality and price fluctuations such as standard equipment for hospitals and laboratories.
Effectiveness		
Mechanisms for tracking contractual performance and complaints are weak.	High	The arrangements for systematically tracking contractual performance and complaints need to be put in place.
Accountability Measures		
Insufficient implementation of accountability mechanisms	Moderate	Ensure that accountability mechanism are fully implemented
Overall risk rating	**Moderate**	

III. PROJECT SPECIFIC PROCUREMENT THRESHOLDS

32. The applicable government and ADB thresholds are indicated in Table 4 and 5. Both Government and ADB thresholds must be followed. The main concern is with the lack of competitive bidding for shopping.

Table 4: Procurement Method Thresholds of Goods and Works

Procurement of Goods and Works			
Method	**Government Threshold**	**ADB Threshold**	**Comments**
International Competitive Bidding for Goods	No threshold, used if goods are locally not available	$3,000,000	Prior review shall be applied for all contracts for all IAs Evaluation and approval by tender board/committee
National Competitive Bidding for Goods	Above about $62,000, no ceiling	From $100,000 to $3 million	Prior review shall be applied for first contract of each IA Evaluation and approval by tender board/committee
Shopping for Goods and Works	About $62,000 and below	$100,000 and below	Prior review shall be applied for first contract of each IA. Use 3 quotations. Government does not require advertisement up to $37,500, nor public opening/disclosure
Direct purchase	About $350 or less		Prior review shall be applied for first contract for each IA As per No need for quotations. Government does not require advertisement, nor public opening/disclosure
Community Participation Procurement	Not known	$10,000 and below	Prior review shall be applied for first contract for each IA No need for quotations. Government does not require advertisement, nor public opening/disclosure

Table 5: Procurement Method Thresholds of Consulting Services

Consulting Services	
Method	**Comments**
Consultant Qualification Selection	Prior review shall be applied for: • **Firms**: the first contract for each method regardless of value and all contracts equal or above $0.5 m; all TORs and cost estimates; shortlist for audit contracts. • **Individuals**: all contracts equal or above $50,000; single source selection (SSS); all TORs and cost estimates;
Least-Cost Selection	
Individual Consultants Selection	

IV. PROCUREMENT PLAN

33. The proposed procurement plan for the project is attached as Appendix 2. The proposed NCB threshold is $3 million for works and $1 million for goods, above which ICB will be used, even if the Government allows NCB. One ICB package for hospital equipment has been identified in the first 18 months. The threshold for shopping for works and goods is $100,000, but NCB may also be used if shopping is not considered suitable. International and national consultants will be engaged as individual consultants using Consultants' Qualification Selection (CQS). One accounting firm and one audit firm will be engaged using Least Cost Selection (LCS). It is proposed that advance contracting of key consultants for the DPIC PMU will be carried out before project effectiveness.

1. **Scope of procurement**: the proposed project procurement will include goods including vehicles, laboratory equipment, hospital equipment, outbreak equipment and IT equipment. The civil works will be for small repairs of laboratories and hospital wards. Consulting services recruitment will be for individual international and national consultants.
2. **Packaging**: The procurement plan includes 1 package for vehicles for $7,525,000 to be procured through ICB. Laboratory high-tech equipment packages for $17,290,000, laboratory standard equipment packages for $7,480,000 and hospital equipment packages for $2,985,000 will be procured through NCB. Laboratory small equipment packages for $230,000, outbreak equipment packages for $230,000, IT and office equipment and small civil packages for $3,343,999 will be procured through the shopping method. Consulting services to be provided by a firm to be selected through least cost selection method, and individual consultant selection shall be applied for individual consultants.
3. **Advance action and retroactive financing:** these are not proposed for the project.
4. The proposed project procurement plan is attached in Appendix 2.

V. CONCLUSION

34. Although the procurement unit in DPIC which will have responsibility for procurement for HSP is experienced through its involvement in earlier programs there are major legal, institutional and governance issues with procurement that do add risk to the procurement process. A particular concern is the use of the shopping method which lack advertisement and transparency.

35. This factor is recognized and the project design includes support for procurement through international and national procurement specialists, and setting up a procurement monitoring system. In addition, the Health Governance Reform Program will provide support to strengthen the overall procurement environment, although this will mostly become effective after the first procurements.

36. Four types of procurement risks have been identified, regarding (1) staff procurement capacity, (2) complex procurement procedures, (3) differences in ADB and government procedures, and (4) procurement of substandard equipment. Capacity in provincial health departments for complex procurement procedures is much less. Also considering the nature of

the project, centralized procurement by DPIC is preferred but based on careful provincial assessment of requirements.

37. Overall risks are assessed as moderate. While DPIC has substantial experience in ADB project procurement, it needs to assure sufficient capacity to mitigate these risks, among others through timely engagement of an international and a national procurement consultant, for which MOH had a poor track record. A procurement risk assessment and management plan was prepared with appropriate mitigation measures. Procurement monitoring during project implementation will help identify procurement issues to be addressed, as well as compliance with ADB's procurement guidelines.

APPENDICES:

1. Project Procurement Risk Assessment questionnaire (provincial assessments on request)
2. Procurement Plan (to be updated based on final budget)

Appendix 1

A. General Environment Procurement Risk Assessment Questionnaire

Question	Yes/No	Narrative Explanation	Risk
A. LEGAL AND REGULATORY FRAMEWORK			
1. Is there a procurement law? *Is there a single law governing procurement that is consistent with internationally accepted principles and practices; or is procurement governed through various laws, decrees etc.?*	Yes	Decree of the Prime Minister on Government Procurement of Goods, Construction, Maintenance and Services, No. 03/PM dated 09 January 2004.	Low
2. Does the procurement law have implementing regulations? *Does the procurement law have implementing rules and regulations that support it by providing the details that are not normally found in a law? Are these clear, comprehensive and consolidated as a set of regulations that are available in a single and accessible place? Are these regularly updated?*	Yes	Implementing Rules and Regulations on the Decree of the Prime Minister on Government Procurement of Goods, Construction, Maintenance and Services, No. 0063/MOF Dated 12 March 2004.	Low
3. Are the procurement law and regulations clear and concise? *If there is a single law that is easy to follow, then the risk is "low". If the law is complex and difficult to follow, then the risk is "average". If there is no single law, then the risk is "extremely high" or "high".*	No	The procurement Decree is quite complex and does not clearly mention what type of procurement (NCB, ICB, etc.) is to be followed for different levels of expenditure.	Moderate
4. What does the procurement law/regulation cover? *If there is a single law, the risk will be "low" if it covers drafting and use of standard bidding documents, evaluation, contracting through to the management of contracts, including payment, warranty and defects liability periods. The less the procurement process is covered the higher the risk. If there is no single law, then the risk is "extremely high" or "high".*		There is only a single Decree of Prime Minister that covers the procurement process in Lao PDR, including standard bidding documents, evaluation, contracting and so on. It is amended from time to time.	Moderate
5. Does the procurement law/regulation cover the procurement of consulting services? *If there is a single procurement law that also covers consulting services, then the risk is "low". If consulting services are not covered, or there is no law, then the risk is "extremely high" or "high".*	Yes	The Procurement Decree covers all three types of procurement such as procurement of goods, works and services within the same decree.	Low
6. Does the procurement law/regulation differentiate between processes for goods, works and consulting services? *If there is a single law that deals separately with consulting services, then the risk is "low". If there is a single law that provides some differentiation, but the processes are similar, then the risk is "average". If there is no single law, or it applies the same processes to consulting services as for goods and works, then the risk is "extremely high" or "high".*	No	It has the same process for all categories (unlike the ADB what has a different process for goods and for services).	Low

Question	Yes/No	Narrative Explanation	Risk
7. Does the law/regulation require the advertisement of all procurement opportunities? *A "low" risk may be indicated if advertisement is required for all procurements above $25,000. An "average" risk may be indicated if advertisement is required only for procurements above $100,000. A "high" risk may be indicated if advertisement is required for all procurements above a threshold that is higher than $100,000. An "extremely high" risk should be indicated if no advertisement is required.*	Yes	The regulations require that public bidding with the value of Kip300 million or equivalent to $37,500 and above must be advertised in a Lao language newspaper and notices provided to each ministry, province or district depending on the value of the procurement. However the regulations are not enforced and the penalty for non-compliance is not stipulated.	Moderate
8. Are contract awards advertised? *The same thresholds as stated at A7 should be applied.*	Yes	As for (7.) above, but the Decree does not clearly mention the penalty level in the case of non-compliance for advertising.	Moderate
9. Are there restrictions on goods, works and services on the basis of origin? *If there is no limitation, restriction and/or preference scheme, then the risk is "low". If there are restrictions or a national preference scheme, then the risk is "average". If procurement is solely limited to those of national origin, then the risk is "extremely high" or "high".*	No	No restriction on the basis of origin of goods, works and services except for some materials procured for the Defense sector;	Low
10. Does the procurement law or relevant legislation and regulation provide acceptable provisions for the participation of state-owned enterprises (SOEs)? *If an exception is given to SOEs that are legally and financially autonomous and are not dependent agencies of the purchaser/employer, then the risk is "low". Otherwise, the risk is "extremely high" or "high".*	Yes	All SOEs can participate in bidding process provided that they have not been involved in the preparation of the project. The law is not clear on the eligibility of SOEs.	High
11. Are there restrictions on the nationality of bidders and consulting firms to be invited? *If there is no limitation, restriction and/or preference scheme, then the risk is "low". If there are nationality restrictions or a national preference scheme, then the risk is "average". If procurement is solely limited to national firms and individuals, then the risk is "extremely high" or "high".*	No	There are no restrictions on the nationality of bidders.	Low
12. Are foreign bidders and consultants forced to submit offers through or with local partners? *If this is never required, then the risk is "low". If this is required under certain circumstances, then the risk is "average". If this is always required, then the risk is "extremely high" or "high".*	No	The Decree does not require for offers to be submitted through local partners, although there is a preference to have a local partner.	Low
13. Is there a domestic preference scheme? *If there is no scheme, then the risk is "low". If it is applied in limited*	No		Low

Question	Yes/No	Narrative Explanation	Risk
circumstances, then the risk is "average". If a domestic preference scheme is applied across the board, then the risk is "extremely high" or "high".			
14. Is there a national standard mandated for the use for quality control purposes? *If there are no mandated national standards or if these have direct and accessible international equivalents, then the risk is "low". If there are mandated national standards that have no international equivalents, then the risk is "high".*	Yes	Quality control of bidding documents, etc. is undertaken by the local procurement committee in each level.	Low
15. Are any agencies or parts of public expenditure exempt from the procurement law/regulation? *If yes, such as defense equipment, then the risk may range from "average" to "extremely high, depending on the extent of the exemption. For example, if an exemption is outrightly granted to medicines, text books or other similar commodities, then the risk is "extremely high".*	Yes	Procurement by government for national security and defense equipment is exempt.	Low
16. Is the default method for procurement open competition? *If yes, then the risk is "low". If no, or if it is not clearly established, then the risk may be "extremely high" or "high".*	Yes	There is a threshold for public procurement but this is not always evoked.	High
17. Is open competition easily avoided? *If avoidance requires the approval of an oversight agency, then the risk is "low". If open competition can be avoided by senior management decision, then the risk is "average". If the procurement law/regulation allows the avoidance of open competition above a certain national threshold on the basis of circumstances that are not in response to natural disasters, i.e. simple urgency, then the risk is "extremely high" or "high".*	Yes	Although the Decree does not easily allow the avoidance of open competition, in practice the approving party may be the same as the user of the goods and services, and procurement may be split into small packages to avoid competitive quotes.	High
18. Does the procurement law/regulation require pre-qualification? *If it is only for complex or high value contracts, then the risk is "low". If no pre-qualification is allowed, then the risk is "average". If it applies to all contracts, then the risk is "high".*	No	The Decree says that prequalification may be applied to minimize the number of unqualified bidders for complex and high value contracts, but this is rarely applied.	Low
19. Does the procurement law/regulation require the pre-registration of bidders? *If no pre-registration is required, then the risk is "low". If it is only required for special types of goods, such as medicines, then the risk is "average". If yes, then the risk is "extremely high" or "high".*	No	The Decree does not clearly state if pre-registration is required.	Moderate
20. Does the procurement law/regulation mandate the use of standard documents? *If it does and there are documents for goods, works and consultants services, then the risk is "low". If it is required just*	Yes	The Ministry of Finance have a Decree from 2009 that stipulates the need to have standard bidding documents although these do not stipulate that they should be in	Moderate

Question	Yes/N	Narrative Explanation	Risk
for only two of the three procurement types, then the risk is "average". If it is required for only one of the procurement types, or it is required but no documents have yet been issued, then the risk is "high". If standard documents are not required, then the risk is "extremely high".		English as is required by ADB requirements.	
21. Have these standard documents been approved for use on ADB projects? *If yes, then the risk is "low". If some, but not all, then the risk is "average". If no, then the risk is "extremely high" or "high".*	Yes	Some ADB projects use the government's standard documents for local shopping but for NCB the ADB Bidding Documents must be used. The government, ADB and WB are in the process of harmonizing	Low
22. Is there a national procurement manual or guide? *If an omnibus procurement manual or guide exists, then the risk is "low". If a manual exists, but it is out of date or is not widely used/ distributed, then the risk is "average". If there is no manual, then the risk is "extremely high" or "high".*	Yes	A Procurement Manual was issued in May 5, 2009 by PrMO, but it is confusing. A TA to revise the document has produced a new draft but it is not yet finalized.	Moderate
B. INSTITUTIONAL FRAMEWORK			
23. Which body oversees public procurement? *If there is a regulatory body at an adequate level in government, and financing is secured by the legal/regulatory framework, then the risk is "low". If the body is at an adequate level, but financing is subject to administrative decisions and can be changed easily, then the risk is "average". If the level of the body is too low or financing is inadequate for proper discharge of its responsibilities, then the risk is "high". If there is no body, or the body is too low with no independence to perform its obligations, then the risk is "extremely high".*		Procurement Monitoring Office (PrMO), Ministry of Finance, Lao PDR.	Moderate
24. What powers does the oversight body have? *The rating may range from "low" to extremely high", depending on whether the body exercises all, some, a few or none of the following responsibilities: providing advice to contracting entities, drafting amendments to the legal/regulatory framework, monitoring public procurement, providing procurement information, managing statistical databases, reporting on procurement to other parts of government, developing/supporting the implementation of initiatives for improvements to the public procurement system, and providing implementation tools and documents to support capacity development.*		PrMO has a full oversight function for all public procurement in Lao PDR. However, it still has limited staff and the financial resources to fulfill its roles and responsibilities properly.	High

25. Is there a nationwide procurement training plan? *If procurement trainings are regularly implemented nationwide and needs are regularly assessed, then the risk is "low". If there is an existing program, but it is insufficient to meet national needs, then the risk is "high". If there is no formal training program, then the risk is "extremely high". Consider also the existence of a helpdesk.*	No	PrMO has the mandate to build capacity but does not have enough resources to conduct a nationwide procurement training program. They provide some training in procurement for specific projects.	Moderate
26. Is there a procurement accreditation or professionalization program? *If there is an externally recognized program, then the risk is "low". If it is a government sponsored program, then the risk is "average". If there is no accreditation or professionalization program, then the risk is "high".*	No	No such program. Senior officers in PrMO are not accredited.	High
27. Are major projects identified within agencies' appropriations or budgets? *If yes, then the risk is "low". If no, but a system is in place for the ring-fencing of project funds, then the risk is average. If neither condition exists, then the risk is "high".*			Low
28. Is the procurement cycle tied to an annual budgeting cycle, *i.e.* can procurement activity only commence once a budget is approved? *If yes, and a medium-term expenditure framework is in place, then the risk is "low". If an activity may start up to, but excluding contract award, then the risk is "average". If the procurement cycle is not tied to an annual budget, then the risk is "extremely high" or "high".*	Yes/No	The Decree says that procurement can only occur if the item is included in the annual budget and procurement plan. However, in practice there are many instances where off-budget items have been procured, especially at the provincial level.	High
29. Once an appropriation or budget is approved, will funds be placed with the agency or can the agency draw them down at will? *If yes, then the risk is "low". If not, such as when additional bureaucratic controls are imposed (such as a cash release system), then the risk is "extremely high" or "high".*	Yes/No	In principle, the approved funds will be available for the procuring agency from MOF according to the budget law. However, the request for fund withdrawal from national treasury often will take some time due to fiscal constraints.	High
30. Is there a nationwide system for collecting and disseminating procurement information, including tender invitations, requests for proposals, and contract award information? *If there is an integrated information system that provides up-to-date information and is easily accessible at no or minimum cost, then the risk is "low". If there is such an integrated information system that covers majority of contracts, but access is limited, then the risk is "average". If there is a system, but it only provides information on some of the contracts and is not easily accessible, then the risk is "high". If there is no procurement information system, except*	Yes/No	In principle, there is a system but in practice there is not an integrated information system that provides information nationwide and procurement information is not freely available for the public. It is only released in some advertisements in local newspapers and is not available through a website.	High

Question	Yes/No	Narrative Explanation	Risk
for some individual agency systems, then the risk is "extremely high".			
31. When an agency is implementing a project using funds from the national budget, are there general experiences/reports of funding delays that significantly hamper procurement? *If no, then the risk is low. If yes, then the risk is "extremely high" or "high".*	Yes	Because the implementing agencies use national funds there are often delays in the release of funds. There is a problem of limited experience and capacity of procurement staff, worsened by frequent of staff rotation.	High
32. Is consolidated historical procurement data available to the public? *If yes, then the risk is "low". If the data is too much or too little, then the risk is "average". If none, then the risk is "extremely high" or "high".*	No	Limited procurement data is available to the public.	Moderate
33. Does the law/regulation require the collection of nationwide statistics on procurement? *If yes and statistics are actually collected, then the risk is "low". If yes, but data is not collected or used, then the risk is "average". If there is no requirement, then the risk is "extremely high" or "high".*	No	There is no centralized system to collect and archive nationwide statistics on procurement. Projects generally keep documents for 10 years but they are not consolidated into a central registry.	High
C. PROCUREMENT MARKET AND OPERATIONS			
34. Do formal mechanisms exist to encourage dialogue and partnerships between the government and the private sector, and are these well established in the procurement law/regulation? *If such mechanisms exist, such as programs to build the capacity of private companies and small businesses to participate in public procurement, and these are effective, then the risk is "low". If such mechanisms exist, but there is no proof of its effectiveness, then the risk is "average". If no such mechanisms exist, then the risk is "extremely high" or "high".*	No	There is no mechanism or program to encourage private and small businesses to participate in public procurement.	High
35. Are private sector institutions well organized and able to facilitate access to the market? *If the private sector is competitive, well organized and able to participate in open competition, then the risk is "low". If there is a reasonably well functioning private sector, but competition for large contracts is concentrated in a relatively small number of firms, then the risk is "average". If the private sector is relatively weak and/or competition is limited owing to monopolistic or oligopolistic features in important segments of the market, then the risk is "high". If the private sector is not well organized and lacks capacity and access to information for participation in the public procurement market, then the risk is "extremely high".*	Yes	In theory, according to government policy, the private sector is able to participate in open competitive bidding. However, in practice for some procurement, especially state budget procurement in provinces, the bid invitations announcements are still limited and there is no official IT system (website) to advertise the bids widely, and so the private sector may be have barriers to access of information on public procurement.	High
36. Is there an alternative disputes resolution process independent of the government and courts?	Yes	Provision is made for disputes resolution in the Decree, but the procedure is not clearly stipulated	High

Question	Yes/No	Narrative Explanation	Risk
If there is an arbitration law with an independent process, then the risk is "low". If there is no arbitration law, but the standard contracts use ICC or similar dispute resolution provisions, then the risk is "average". If alternative dispute resolution is not practiced, or if arbitration is through the courts or can be overturned by the courts, then the risk is "extremely high" or "high".			
D. INTEGRITY OF THE PROCUREMENT SYSTEM			
37. Are there systematic procurement process audits? *If yes, then the risk is "low". If only financial audits are conducted, then the risk is "average". If no systematic audits are conducted, then the risk is "extremely high" or "high".*	Yes	The State Audit Organization (SAO) conducts two-yearly audits as part of the general audit, but no specific procurement audits have been conducted so far. Projects generally rely on procurement audits conducted at the request of the donor (ADB, WB, etc.).	High
38. Does the procurement law/regulation contain provisions for dealing with misconduct, such as fraud and corruption? A cross reference to an anti-corruption law will suffice. *If yes, then the risk is "low". If no, then the risk is "extremely high" or "high".*	Yes,	The regulations are stated in the Decree (but in practice there is no enforcement system in place and they are not applied).	Low
39. Is fraud and corruption in procurement regarded as a criminal act, whereby the penalty includes imprisonment? *If yes, then the risk is "low". If no, then the risk is "extremely high" or "high".*	Yes		Low
40. Have there been prosecutions for fraud and corruption? *If there have been successful prosecutions for fraud and corruption, then the risk is "low". If prosecutions seem to focus solely on low grade/junior staff, then the risk is "average". If there is no evidence of any prosecution, then the risk is "extremely high" or "high".*	Yes/No	There have been very few prosecutions for fraud and corruption and the regulations are not being enforced.	High
41. Does the legal/regulatory framework allow for sovereign immunity to agencies for claims against them? *If plaintiffs can sue the government for contractual non-performance, then the risk is "low". If they cannot, then the risk is "extremely high" or "high".*	No	The Decree does not clearly state the regulations about this issue.	unknown
42. Do the regulations allow for the debarment of firms and individuals? *If there is a debarment process that is transparent and equitable, and undertaken by an independent oversight agency, then the risk is "low". If there is a process and it is administered by a single agency, such as the Ministry of Finance, then the risk is "average". If it is administered by the procuring agency, then the risk is "high". If there is no debarment mechanism, then the risk is "extremely high".*	Yes	The regulation allows for negligent firms to be barred after three warnings have been issued for a period of up to three years. This regulation is stipulated in the bidding documents. Powers of debarment are not known but may rest with a single agency such as MOF	Unknown

B. Agency Procurement Risk Assessment Questionnaire

QUESTION	RESPONSE	RISK[1]
A. ORGANIZATIONAL AND STAFF CAPACITY		
PROCUREMENT DEPARTMENT/UNIT		
A.1 Does the agency or Government have a Procurement Committee that is independent from the head of the agency?	Yes, there is a Technical Team within MOH under the supervision of a MOH Procurement Committee that is independent.	Low
A.2 Does the agency have a procurement department/unit, including a permanent office that performs the function of a Secretariat of the Procurement Committee?	The Procurement Unit was established in 2002 and sits within the Department of Planning and International Cooperation (DPIC) within MOH. It is responsible for procurement for ADB-funded projects in the health sector (currently supporting two projects H-SDP and CDC-II)	Low
A.3 If yes, what type of procurement does it undertake?	Equipment including vehicles and office equipment, and Consulting Services.	Low
A.4 How many years' experience does the head of the procurement department/unit have in a direct procurement role?	The head has 12 year experience, since the start of ADB PCU.	Low
A.5 How many staff in the procurement department/unit are: i. full time ii. part time iii. seconded	Three full time staff including the head of unit. One staff also has 12 year experience within the procurement unit and other has about 3 year experience.	Low
A.6 Do the procurement staff have a high level of English language proficiency (verbal and written)?	Yes	Low
A.7 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes, it is sufficient. All staff have a bachelor degree in business and administration from Lao National University.	Low *
A.8 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the	Yes, it is well equipped with a full set of office equipment. However, some equipment, e.g. printers, may soon require replacement.	Low
A.9 Does the agency have, or have ready access to, a procurement training program?	Yes, they rely on training programs provided by ADB during previous years.	Low
A.10 At what level does the department/unit report (to the head of agency, deputy etc.)?	They report to a Technical Team within MOH under the supervision of a MOH Procurement Committee that is independent. Report to the Directors of DPIC, MOH.	Low
A.11 Do the procurement positions in the agency have job descriptions, which outline specific roles, minimum technical requirements and career routes?	Yes, there is a written document that defines the job description of each position	Low
A.12 Is there a procurement process manual for goods and works?	Yes, ADB procurement Guidelines and MOH's Procurement Manual.	Low
A.13 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Yes, it is up to date, and it covers foreign-assisted projects.	Low
A.14 Is there a procurement process manual for consulting services?	Yes	Low
A.15 If there is a manual, is it up to date and	Yes	Low

[1] Questions indicated with * are associated with potentially 'High' or 'Substantial' risks due to the impact being 'High', therefore the strategy for managing those risks should be addressed in the Project Procurement Risk Analysis (Appendix 3).

QUESTION	RESPONSE	RISK[1]
does it cover foreign-assisted projects?		
PROJECT MANAGEMENT UNIT		
A.16 Is there a fully (or almost fully) staffed PMU for this project currently in place?	Yes	Low *
A.17 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes	Low *
A.18 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes, but some are getting near the end of their useful life and require replacement.	Low
A.19 Are there standard documents in use, such as Standard Procurement Documents/Forms, and have they been approved for use on ADB funded projects?	Yes, they use ADB's Standard Bidding Documents.	Low *
A.20 Does the agency follow the national procurement law, procurement processes, guidelines?	Yes	Low *
A.21 Do TORs for consulting services follow a standard format such as background, tasks, inputs, objectives and outputs?	Yes	Low
A.22 Who drafts the procurement specifications?	Staff of the Procurement Unit and the Technical Team, MOH	Low
A.23 Who approves the procurement specifications?	MOH	Low
A.24 Who in the PMU has experience in drafting bidding documents?	Staff of the Procurement Unit, DPIC, MOH	Low *
A.25 Are records of the sale of bidding documents immediately available?	Accounting and Finance Unit, DPIC, MOH Sales manage the sale of BDs for NCB, and the free distribution of bidding documents for local shopping. Records of sales are available	Low *
A.26 Who identifies the need for consulting services requirements?	As defined in the ADB PPTA reports and included in Loan Agreement;	Low
A.27 Who drafts the Terms of Reference (TOR)	Usually the ADB PPTA consultants during project preparation.	Low
A.28 Who prepares the request for proposals (RFPs)	For NCB it is prepared by the Procurement Unit, DPIC, MOH, and for ICB it is prepared by ADB.	Low
B. INFORMATION MANAGEMENT		
B.1 Is there a referencing system for procurement files?	Yes	Low
B.2 Are there adequate resources allocated to record keeping infrastructure, which includes the record keeping system, space, equipment and personnel to administer the procurement records management functions within the agency?	Yes, the records are stored in box files in the Procurement Unit.	Low *
B.3 Does the agency adhere to a document retention policy (i.e. for what period are records kept)?	Yes, 10 years	Low *
B.4 Are copies of bids or proposals retained with the evaluation?	Yes	Low
B.5 Are copies of the original advertisements retained with the pre-contract papers?	Yes, the original advertisements are attached to the pre-contract papers.	Low
B.6 Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes, stored in box files for each contract.	Low

QUESTION	RESPONSE	RISK[1]
B.7 Are copies of invoices included with the contract papers?	Yes	Low
B.8 Is the agency's record keeping function supported by IT?	No (only hard copies were filed and kept)	
C. PROCUREMENT PRACTICES		
Goods and Works		
C.1 Has the agency undertaken procurement of goods or works related to foreign assistance recently (last 12 months or last 36 months)? If yes, indicate the names of the development partner/s and project/s.	Yes, many ADB-funded projects during the last 12 years, such as Health Sector Development Program, and Communicable Diseases Control Project 1 and 2. Another PU within DPIC is responsible for procurement for World Bank-funded projects.	Low *
C.2 If the answer is yes, what were the major challenges faced by the agency?	In some cases there was a delay in delivery of goods by suppliers. The supporting documents required by ADB and MOH are different, usually MOH required more detailed supporting documents, which leads to delays. The time taken for the approval of bidding documents also adds to the delay.	High *
C.3 Is there a systematic process to identify procurement requirements (for a period of one year or more)?	Yes, there is an annual procurement plan for MOH.	Low *
C.4 Is there a minimum period for the preparation of bids and if yes, how long?	Yes, one month	Low *
C.5 Are all queries from bidders replied to in writing?	Yes, usually via email	Low *
C.6 Does the bidding document state the date and time of bid opening?	Yes	Low *
C.7 Are bids opened in public?	Yes, for NCB, but not for local shopping;	High *
C.8 Can late bids be accepted?	No	Low *
C.9 Can bids (except late bids) be rejected at bid opening?	No. (Bids are recorded and any omissions in required documentation noted).	Low *
C.10 Are minutes of the bid opening taken?	Yes	Low *
C.11 Are bidders provided a copy of the minutes?	Yes	Low *
C.12 Are the minutes provided free of charge?	Yes	Low *
C.13 Who undertakes the evaluation of bids (individual(s), permanent committee, ad-hoc committee)?	The Procurement Committee, MOH	Low
C.14 What are the qualifications of the evaluators with respect to procurement and the goods and/or works under evaluation?	The Procurement Unit reviews and prepares a bid summary report for the Procurement Committee allowing 2-3 day time before a committee meeting for members to evaluate the bidding documents.	Low *
C.15 Is the decision of the evaluators final or is the evaluation subject to additional approvals?	The technical team reviews and evaluates the bidding documents and makes a recommendation to the Procurement Committee for their consideration and final decision.	Low *
C.16 Using the three 'worst-case' examples in the last year, how long from the issuance of the invitation for bids can the contract be awarded?	The worst case was 1 *year (lack of qualified suppliers submit bidding documents for specific and sophisticated equipment - it had to advertise 4 times in newspapers; The other two worst cases were about 6 months (delay in evaluation of committee) compared to normal case of 2-3 months.*	Moderate
C.17 Are there processes in place for the collection and clearance of cargo through ports of entry?	No, suppliers are responsible for Customs clearance and must deliver the goods to the project site.	Low
C.18 Are there established goods receiving procedures?	Yes, the MOH Technical Team will verify and sign the receipt of goods delivered to the project sites.	Low

QUESTION	RESPONSE	RISK[1]
C.19 Are all goods that are received recorded as assets or inventory in a register?	The goods are mostly recorded as assets by project sites and also by the Procurement Unit.	Moderate
C.20 Is the agency/procurement department familiar with letters of credit?	Yes	Low
C.21 Does the procurement department register and track warranty and latent defects liability periods?	Yes	Low
Consulting Services		
C.22 Has the agency undertaken foreign-assisted procurement of consulting services recently (last 12 months, or last 36 months)? (If yes, please indicate the names of the development partner/s and the Project/s.)	Yes, under the ADB Health Sector Development Project.	Low *
C.23 If the above answer is yes, what were the major challenges?	No challenges	Low *
C.24 Are assignments and invitations for expressions of interest (EOIs) advertised?	Yes, advertisements placed in local English newspapers and the ADB website.	Low *
C.25 Is a consultants' selection committee formed with appropriate individuals, and what is its composition (if any)?	Committee members from various departments of MOH who select consultants and propose to ADB for approval and Letter of No Objection.	Low
C.26 What criteria is used to evaluate EOIs?	Qualifications, education and experience based on ADB procurement guidelines.	Low
C.27 Historically, what is the most common method used (QCBS, QBS, etc.) to select consultants?	QCBS	Low *
C.28 Do firms have to pay for the RFP document?	No, it is free of charge	Low *
C.29 Does the proposal evaluation criteria follow a pre-determined structure and is it detailed in the RFP?	Yes, its details are in the RFP.	Low *
C.30 Are pre-proposal visits and meetings arranged?	Not usually, but once was done a long time ago under Primary Health Care Expansion Project.	Low
C.31 Are minutes prepared and circulated after pre-proposal meetings?	Yes	Low *
C.32 To whom are the minutes distributed?	To ADB and MOH	Low *
C.33 Are all queries from consultants answered/addressed in writing?	Yes	Low *
C.34 Are the technical and financial proposals required to be in separate envelopes and remain sealed until the technical evaluation is completed?	Yes, two separate envelopes	Low *
C.35 Are proposal securities required?	Not for Consulting Services, but for goods only.	Low *
C.36 Are technical proposals opened in public?	Yes	Low *
C.37 Are minutes of the technical opening distributed?	No	High *
C.39 Who determines the final technical ranking and how?	The Procurement Unit scores and ranks candidates according to ADB guidelines and recommends to MOH.	Low *
C.40 Are the technical scores sent to all firms?	Yes	Low *
C.41 Are the financial proposal opened in public?	Yes, according to ADB guidelines.	Low *
C.42 Are minutes of the financial opening distributed?	Yes	Low *
C.43 How is the financial evaluation completed?	Based on ADB guidelines	Low *
C.44 Are face to face contract negotiations held?	Yes, usually	Low *

QUESTION	RESPONSE	RISK[1]
C.45 How long after financial evaluation is negotiation held with the selected firm?	Normally one week but it depends on the time taken by ADB to approve.	Low
C.46 What is the usual basis for negotiation?	Budget and the Scope of Works	Low
C.47 Are minutes of negotiation taken and signed?	Yes	Low *
C.48 How long after negotiation is the contract signed, on average?	1-2 weeks	Low
C.49 Is there an evaluation system for measuring the outputs of consultants?	Yes, evaluation is made by the Procurement Unit.	Low
Payments		
C.50 Are advance payments made?	No	Low
C.51 What is the standard period for payment included in contracts?	1 month	Low
C.52 On average, how long is it between receiving a firm's invoice and making payment?	1 month	Low
C.53 When late payment is made, are the beneficiaries paid interest?	No	Moderate
D. EFFECTIVENESS		
D.1 Is contractual performance systematically monitored and reported?	No	High
D.2 Does the agency monitor and track its contractual payment obligations?	No	High
D.3 Is a complaints resolution mechanism described in national procurement documents?	No	High
D.4 Is there a formal non-judicial mechanism for dealing with complaints?	No	High
D.5 Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	No (never had any contractual disputes).	High *
E. ACCOUNTABILITY MEASURES		
E.1 Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	None apart for the Code of Ethics for government employees.	High *
E.2 Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes, but not closely monitored.	High *
E.3 Is the commencement of procurement dependent on external approvals (formal or de-facto) that are outside of the budgeting process?	Yes, the Minister and ADB must give their approval before proceeding to procurement;	High
E.4 Who approves procurement transactions, and do they have procurement experience and	Yes, after ADB no-objection the summary of bid documents is submitted to MOH and MPI for approval.	High*
E.5 Which of the following actions require approvals outside the procurement unit or the evaluation committee, as the case may be, and who grants the approval?		
a) Bidding document, invitation to pre-qualify or RFP	ADB	High
b) Advertisement of an invitation for bids, pre-qualification or call for EOIs	ADB	High
c) Evaluation reports	ADB	Low *
d) Notice of award	Procurement Unit and signed by DPIC;	Low *
e) Invitation to consultants to negotiate	MOH with a no-objection from ADB;	Low *

QUESTION		RESPONSE	RISK[1]
f)	Contracts	MOH with a no-objection from ADB;	Low *
E.6	Is the same official responsible for: (i) authorizing procurement transactions, procurement invitations, documents, evaluations and contracts; (ii) authorizing payments; (iii) recording procurement transactions and events; and (iv) the custody of assets?	No	Low *
E.7	Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes	Low *

Appendix 2

DRAFT PROCUREMENT PLAN

Basic Data

Project Name: Health Security Project	
Project Number: ?	**Approval Number**: ?
Country: Lao PDR	**Executing Agency**: Ministry of Health
Project Financing Amount: **ADB Financing:** **Non-ADB Financing:**	**Implementing Agency: Project Management Unit**
Date of First Procurement Plan {loan (grant) approval date}:	**Date of this Procurement Plan**: {dd / mm / year}

A. Methods, Thresholds, Review and 18-Month Procurement Plan

1. Procurement and Consulting Methods and Thresholds

Except as the Asian Development Bank (ADB) may otherwise agree, the following process thresholds shall
apply to procurement of goods and works.

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
International Competitive Bidding (ICB) for Works	$3,000,000	Prior
International Competitive Bidding for Goods	$1,000,000	Prior
National Competitive Bidding (NCB) for Works	Beneath that stated for ICB, Works	
National Competitive Bidding for Goods	Beneath that stated for ICB, Goods	
Shopping for Works	Below $100,000	
Shopping for Goods	Below $100,000	

Consulting Services	
Method	**Comments**
Quality and Cost Based Selection (QCBS)	Prior
Quality Based Selection	Prior
Consultants' Qualifications Selection	Prior
Least-Cost Selection	Account and Audit firm
Fixed Budget Selection	

2. Goods and Works Contracts Estimated to Cost $1 Million or More

The following table lists goods and works contracts for which the procurement activity is either ongoing or
expected to commence within the next 18 months.

Package Number	General Description	Estimated Value	Procurement Method	Review (Prior / Post)	Bidding Procedure	Advertisement Date (quarter/year)	Comments
	Hospital equipment	1,136,400	ICB	Prior	1S1E		**Break**

3. Consulting Services Contracts Estimated to Cost $100,000 or More

The following table lists consulting services contracts for which the recruitment activity is either ongoing or expected
to commence within the next 18 months.

Package Number	General Description	Estimated Value	Recruitment Method	Review (Prior / Post)	Advertisement Date (quarter/year)	Type of Proposal	Comments
	National	761,200	**CQS**	Prior			
	International Consultants	402,000	**CQS**	Prior			

4. Goods and Works Contracts Estimated to Cost Less than $1 Million and Consulting Services Contracts Less than $100,000 (Smaller Value Contracts)

The following table groups smaller-value goods, works and consulting services contracts for which the activity
is either ongoing or expected to commence within the next 18 months.

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Procurement Method**	**Review** (Prior / Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
11	IT equipment	171,000		NCB	Prior	1S1E		
	Outbreak equipment	102,000		Shopping	Prior	1S1E		Break
	Laboratory high tech	193,200		Shopping	Prior	1S1E		Break
	Laboratory standard	246,400		Shopping	Prior	1S1E		Break
	Laboratory small	520,000		Shopping	Prior	1S1E		Break
8	Motorcycles	26,000		Shopping	Prior	1S1E		
9	Vehicles	460,000		UNOPs	Prior	1S1E		
1	Biosafety supplies	215,800		NCB	Prior	1S1E		Break
4	Lab consumables /reagents	788,000		Shopping	Prior	1S1E		Break
7	Furniture and fixtures	10,000		Shopping	Prior	1S1E		Break
10	Malaria/Dengue control equipment and insecticides	6,000						(check budget)
10	Emergency Vector control Kits and equipment	13,590						(check budget)

Consulting Services								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Recruitment Method**	**Review** (Prior / Post)	**Advertisement Date** (quarter/ year)	**Type of Proposal**	**Comments**

B. Indicative List of Packages Required Under the Project

The following table provides an indicative list of goods, works and consulting services contracts over the life
of the project, other than those mentioned in previous sections (i.e., those expected beyond the current period).

Goods and Works							
Package Number	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Procurement Method**	**Review** (Prior / Post)	**Bidding Procedure**	**Comments**

Consulting Services							
Package Number	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Recruitment Method**	**Review** (Prior / Post)	**Type of Proposal**	**Comments**

C. List of Awarded and On-going, and Completed Contracts

The following tables list the awarded and on-going contracts, and completed contracts.

1. Awarded and Ongoing Contracts

Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Procurement Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**	**Comments**

Package Number	General Description	Estimated Value	Contract Value	Recruitment Method	Advertisement Date (quarter/year)	Date of ADB Approval of Contract Award	Comments

2. Completed Contracts

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Procurement Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**	**Date of Completion**	**Comments**

Consulting Services								
Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Recruitment Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**	**Date of Completion**	**Comments**

D. Non-ADB Financing

The following table lists goods, works and consulting services contracts over the life of the project, financed by
Non-ADB sources.

Goods and Works				
General Description	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Procurement Method**	**Comments**

Consulting Services				
General Description	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Recruitment Method**	**Comments**

5. National Competitive Bidding

1. General

The procedures to be followed for National Competitive Bidding (NCB) shall be those set forth for "Public Bidding" in Prime Minister's Decree No. 03/PM of the Lao People's Democratic Republic, effective 09 January 2004, and Implementing Rules and Regulations effective 12 March 2004, with the clarifications and modifications described in the following paragraphs required for compliance with the provisions of the Procurement Guidelines.

2. Application

Contract packages subject to NCB procedures will be those identified as such in the project Procurement Plan. Any changes to the mode of procurement from those provided in the Procurement Plan shall be made through updating of the Procurement Plan, and only with prior approval of ADB.

3. Eligibility

The eligibility of bidders shall be as defined under Section 1 of the Procurement Guidelines; accordingly, no bidder or potential bidder should be declared ineligible for reasons other than those provided in Section 1 of the Guidelines, as amended from time to time.

4. Advertising

Bidding of NCB contracts estimated at $500,000 or more for goods and related services or $1,000,000 or more for civil works shall be advertised on ADB's website via the posting of the Procurement Plan.

5. Procurement Documents

The standard procurement documents provided with Ministry of Finance, Procurement Monitoring Office shall be used to the extent possible. The first draft English language version of the procurement documents shall be submitted for ADB review and approval, regardless of the estimated contract amount, in accordance with agreed review procedures (post and prior review). The ADB-approved procurement documents will then be used as a model for all procurement financed by ADB for the project, and need not be subjected to further review unless specified in the procurement plan.

6. Preferences

(i) No preference of any kind shall be given to domestic bidders or for domestically manufactured goods.

(ii) Suppliers and contractors shall not be required to purchase local goods or supplies or materials.

7. Rejection of all Bids and Rebidding

Bids shall not be rejected and new bids solicited without ADB's prior concurrence.

8. National Sanctions List

National sanctions lists may be applied only with prior approval of ADB.

9. Corruption Policy

A bidder declared ineligible by ADB, based on a determination by ADB that the bidder has engaged in corrupt, fraudulent, collusive, or coercive practices in competing for or in executing an ADB-financed contract shall be ineligible to be awarded ADB-financed contract during the period of time determined by ADB

10. Disclosure of Decisions on Contract Awards

At the same time that notification on award of contract is given to the successful bidder, the results of the bid evaluation shall be published in a local newspaper or well-known freely accessible website identifying the bid and lot numbers and providing information on (i) name of each Bidder who submitted a Bid, (ii) bid prices as read out at bid opening, (iii) name of bidders whose bids were rejected and the reasons for their rejection, (iv) name of the winning Bidder, and the price it offered, as well as the duration and summary scope of the contract awarded. The executing agency/implementing agency shall respond in writing to unsuccessful bidders who seek explanations on the grounds on which their bids are not selected.

Project Procurement Risk Assessment Report, Myanmar

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS
(as of 7 April 2016)

Currency unit	–	kyat (MMK)
MMK1.00	=	$0.00085
$1.00	=	MMK1,170

NOTES

(i) The fiscal year (FY) of the Government of Myanmar and its agencies ends on 31 March. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 March 2017.

(ii) In this report, "$" refers to US dollars.

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ACRONYMS

ADB	Asian Development Bank
EA	executing agency
CMSD	Central Medical Store Depot
DIH	Department of International Health
HSGP	health sector government program
ICS	individual consultant selection
IA	implementing agency
MOH	Ministry of Health
NGO	nongovernmental organization
PMU	project management unit
P-RAMP	Procurement Risk Assessment and Management Plan

EXECUTIVE SUMMARY

The Governments of Cambodia, Lao PDR, Myanmar and Viet Nam have requested the Asian Development Bank (ADB) to support the Greater Mekong Subregion (GMS) Health Security Project (the Project). The Project is to strengthen health security systems in terms of regional cooperation, CDC in border areas, surveillance and response, laboratory services, and hospital infection prevention and control.

The total project cost in Myanmar is $12.6 million for implementation in 12 townships in 5 states and one region. The Ministry of Health (MOH) is the Executing Agency and the Department of Public Health and the Department of Medical Services will represent MOH and establish a project management unit (PMU). Almost half of the project costs in Myanmar is to procure laboratory, hospital and outreach equipment, and vehicles.

Procurement experts conducted a project procurement risk assessment (PRA) in each country to determine the procurement risk of the proposed project, establish appropriate measures to mitigate these risks, and prepare the procurement plan for the proposed project with an appropriate procurement method as well as the type of ADB review (prior or post). The overall project procurement risk was assessed as high.

The overall procurement environment in Myanmar is characterized by limited legislation and considerable delegation of powers of procurement to national and state/regional directors. A substantial part of investment was donor financed and often procured by external or non-government agencies.

MOH has no experience with ADB procurement but has experience with Government procurement and has done a good job recently in major procurement of laboratory equipment. Sufficient staff need to be engaged for the PMU to able to carry out procurement.

Project procurement weaknesses and risks include limited government procurement legislation and guidelines, lack of clarity on procurement arrangements and procedures, limited staff capacity and unfamiliarity with donor procedures, and lack of consistency and transparency while fraud and corruption appear less of a problem.

In terms of procurement risk mitigation, it is recommended to centralize project procurement, establish proper procurement arrangements, provide procurement training for the PMU, and provide technical support through international and national consultants. Procurement will be monitored to ensure that it is in compliance with government and ADB procedures. Procurement processing steps will be carefully monitored.

Systematic national procurement guidelines will be established soon (within one to three months) with the support of USAID. During project implementation, this will facilitate the adoption of systematic project procurement processes between National Procurement Guidelines and ADB procurement guidelines.

I. INTRODUCTION

1. The Asian Development Bank (ADB) plans to support the Greater Mekong Subregion (GMS) Health Security Project (the Project) covering Cambodia, Lao PDR, Myanmar, and Viet Nam. In accordance with ADB's Guidelines for Assessing Country, Sector and Project Procurement Risks, a Procurement Risk Assessment (PRA), including a Procurement Risk and Management Plan (P-RAMP) and a procurement plan, was prepared in each country. The purpose of the PRA is to determine the overall procurement risk of the project, establish appropriate measures to mitigate these risks, and prepare the procurement plan. The PRA was prepared in accordance with ADB's *Guidelines for Assessing Country, Sector and Project Procurement Risks*.

2. The Project aims to contribute to regional health security by strengthening the health security system and communicable diseases control (CDC) coverage with 3 outputs: i) improved regional cooperation and CDC in border areas, ii) strengthened national disease surveillance and response capacity; iii) improved laboratory capacity and infection prevention and control in hospitals.

3. The Project is estimated to cost $135 million including $12.6 million for Myanmar. MOH Myanmar is the executing agency, represented by the Department of Public Health and the Department of Medical Services. Implementing agencies are the National Health Laboratory, five State Health Departments, and one Regional Health Department. Major procurement packages are for i) outbreak control and outreach vehicles, ii) regional and district laboratory equipment, iii) equipment for international quarantine centers and border posts, iv) equipment for hospitals, v) consulting services, and vi) repair of laboratories and wards.

4. Procurement for the Project is complex as it concerns a large number of items for many locations, including for laboratory equipment that needs to be of high quality and standardized as much as possible. In Myanmar, MOH has limited procurement experience. Most procurement is currently done by government agencies other than MOH, and directly by international agencies. However, with support of the World Bank and USAID, MOH will strengthen its procurement capacity.

5. National and international consultants conducted a PRA intermittently during the period January to June 2016, including the following activities:

- Review MOH procurement organization and system (legal framework, agencies, roles and responsibilities), compare with ADB procurement guidelines, and identify discrepancies;
- Obtain MOH and provincial views on procurement environment and practices;
- Conduct PRA of executing agencies (EAs) and implementing agencies (IAs) based on questionnaires and assess procurement practices, capacity and risks, including for procurement monitoring and record keeping;
- Identify initiatives to improve procurement, e-procurement and audit;
- Propose capacity building, mentoring and supervision arrangements; and
- Propose procurement plan and prepare master bidding documents.

6. The PRA examines five aspects including i) organizational and staff capacity; ii) information management; iii) procurement practices; iv) effectiveness, and v) accountability

measures; examines strengths and weaknesses, presents a procurement risk assessment and management plan (P-RAMP), identifies procurement thresholds, and proposes a procurement plan. A PRA questionnaire prepared by the international expert was applied to the executing agency and implementing agencies. The completed questionnaires are in Appendix 1. The procurement plan is in Appendix 2.

II. PROJECT PROCUREMENT RISK ASSESSMENT

A. Overview

i. Organization and Staff Capacity

Procurement Legislative and Regulatory Framework:

7. While the Government of Myanmar is modernizing its public administration and expecting more aid, there is no comprehensive written legal framework for public procurement processes and there is much less exposure to international procurement rules. As part of its economic reforms, the Government is to set up a modern public procurement system, and has taken a series of actions including the issuance of two Presidential Instructions and two directives on Public Procurement to establish the basis for an open and competitive public procurement system (World Bank Governance Blog on Twitter). Myanmar is committed to increasing openness, which is illustrated in the awarding of tenders to foreign businesses (ICS 2015). Myanmar is also committed to improving efficiency of public administration. For example, the Ministry of Commerce has implemented the Multi systems Gateway Project, among others to improve e-procurement [1]. Concomitantly, the Government is making efforts to improve governance. The Myanmar Anti-Corruption Law 23 took effect in 2013, among others to deal with the risks of corruption in public procurement such as diversion of public funds, favoritism and irregular payments (GCR 2015-2016).

8. The Myanmar Government has been partnering with the World Bank in the Modernization of Public Finance Management ("PFM") Project, which supplements Myanmar's efforts in developing a stronger public financial management system including a modern national public procurement system. The World Bank is working with the line ministries to strengthen their procurement practices and address current problems in public procurement that are hindering efficient public service delivery.

9. Each EA/IA (ministry and/or local authority) is largely responsible for its own procurement policies and guidelines, while there is a document detailing the consensus reached among the Ministry of Construction (lead ministry for public procurement) and other ministries. MOH, like other executing agencies, has not created its own manual/procedure for its own procurement processes. However, procurement guidelines for MOH are expected to be established very soon (estimated within three months), with the support of the World Bank and USAID. Therefore new procurement guidelines will have been defined by the time ADB project is implemented.

10. Procurement financed by foreign aid is typically done directly by international agencies outside MOH. For example, UNOPS is providing consulting procurement services to the MDG Fund following their own procurement manual.

[1] Economic and Social Commission for Asia and the Pacific, Asian Development Bank Institute, Public Procurement Service of the Republic of Korea, E-procurement. 2006 Thailand.

Procurement Organization

11. MOH lacks a centralized procurement unit. Procurement in MOH is currently delegated to the departments, including the Departments of Public Health, Medical Services, Professional Resource Development and Management, Medical Research, Traditional Medicine, and Food and Drug Administration. The Departments of Public Health and Medical Services are the main departments concerned with this GMS Project.

12. The Procurement and Supply Division is under the control of the Department of Public Health and the Central Medical Store Depot (CMSD) is under the direct control of the Department of Medical Services. Currently, 6 full time staff are working in the procurement section of CMSD which was established five years ago, and 15 persons work at the Procurement and Supply Division created last year.

13. The procurement units of the IAs (departments) conduct all document preparations, invitations, evaluations, contract preparations and distributions. Specifications of required equipment are identified by specialists such as from the laboratory or from hospitals. Since all the procurement units in each department were established very recently except CMSD procurement, systematic procurement guidelines will need to be established very soon.

14. MOH as the EA has a Tender Selection Committee. The Committee is composed of the Deputy Minister, the Permanent Secretary, Departmental Directors, and Directors of Procurement Units. The Deputy Minister is the chairman of the Committee and he has the authority to take decisions on internal specific problems and conflicts.

15. The MOH Internal Inspection Department checks all departmental operations including procurement work, but its functioning needs to be strengthened.

Procurement Management Capacity

16. According to ADB's Interim Country Partnership Strategy 2015-2016[2], Myanmar public procurement system has several major weaknesses. As stated, *it does not effectively promote transparency, accountability, and competition in the procurement of goods and services. Management capabilities in public procurement are also weak. It will be important over the longer term to implement procurement reforms to improve transparency and accountability in public procurement, inject competition into the procurement of goods and services, and build institutional capacity and internal audit and control systems within government agencies.*

17. There are no guidelines for international competitive bidding, but there are for national competitive bidding and for national shopping. Myanmar lacked exposure to international procurement rules and has developed its own system. There are numerous public procurement practices that are contrary to international procurement policies including those of ADB, such as establishing minimum and maximum tender estimates below and above which proposals can be rejected, restrictions on foreign competition, limitation of consultants' fees, etc.

18. Staff capacity in procurement is not clear. While MOH has considerable technical administrative know-how, it is understood that there is a serious shortage of staff competent in procurement. This needs to be examined further. At state level, based on observations in three out of seven states, staff capacity in procurement is very limited.

[2] ADB. 2012. *Myanmar Interim Country Partnership Strategy 2012-2016*. Manila.

ii. Information Management

19. Administration of all externally funded projects is monitored by the Department of International Health. DIH has an overall role in monitoring project progress, but not specifically in procurement monitoring, which is the responsibility of the concerned procurement units in the departments. Project monitoring is being computerized but not in a systematic way. Manual monitoring sheets are regularly updated by the responsible staff in the Procurement Unit of the Department.

20. There is no central referencing system for procurement files. Original documentation is retained by the Procurement Unit in the Department, which, for a project, may have a PMU. Copies of advertisements, invitations, proposals, bids, evaluation reports, contracts, and all subsequent contractual correspondence and invoiced are retained. All documents are kept for at least 10 years. Procurement documents are always well recorded in the procurement unit and therefore it is easy to find them and track the status of the process of all procurement tenders.

21. The procurement unit under the Central Medical Store Department was established five years ago. The physical space to store tender documents is not sufficient. This lack of space will create difficulties for the record keeping system. The procurement unit in the Department of Public Health was established last year and hence there are no space constraints in record keeping.

iii. Procurement Practices

Procurement Processes of Goods and Works

22. The Procurement Unit is responsible for drafting bidding documents and managing the transaction or sharing of documents in cooperation with the Financial Management Unit. In case of any queries regarding bidding documents or requests for clarification from bidders, response to them is made in writing to all concerned bidders.

23. The minimum period for preparation of NCB (national competitive bidding) is about one month and preparation for national shopping is about two weeks. Bidding documents clearly state the date and time for opening. The date and time for opening is usually just after the deadline for bid submission. The bid opening is in public. Late bids are not accepted and bids can be rejected at the opening especially in case the bidder is absent at the bid opening ceremony. Minutes of bid opening are taken by one procurement staff during the opening time but the meeting minutes are available only upon official request for the representative bidders.

24. Transportation and collection services of cargo through ports of entry depend on the conditions in contract agreement but the departments have their own trucks to provide transportation services. In most processes, suppliers are required to deliver goods procured at the final project sites. All goods received are recorded properly as assets or inventory. Documents concerning the warranty and latent defects liability period are well recorded in the procurement units. The procurement units are already familiar with letters of credit.

Procurement Processes of Consulting Services

25. Since this is the first experience with ADB project, MOH and any PMU to be formed will not have any experience with ADB loan projects. MOH also has no experience with the selection of firms, NGOs, and individual consultants using ADB procurement methods including consultants' qualification selection (CQS), quality and cost-based selection (QCBS), and single source selection (SSS) for domestic and international consultants. All heads of procurement units in each department are professional medical doctors and not trained in procurement, but in

general evaluation processes are done efficiently. Terms of References (ToR) are drafted by IAs in consultation with the Procurement Unit, and they follow the standard format such as background, objectives, outputs, tasks, and inputs. The Procurement Unit is responsible for advertising Requests for Expressions of Interest, and for preparing Requests for Proposals.

E-procurement

26. With the support of USAID, the Supply Chain Management System project of Management Sciences for Health is now testing the use of a data inventory software (M-Supply software) in three regions; Magwe, Bago and Ayeyarwaddy. The Procurement and Supply Division under the Public Health Department has seven computers in its department and CMSD has three computers in its overall inadequate facilities. There is currently no public e-procurement being piloted in MOH, although, as mentioned above, pilots are underway in other ministries in Myanmar. MOH has its own internet website but all procurement activities are carried out offline. Knowledge of e-procurement among procurement practitioners is very limited. The procurement staff and the administrator of the project's website would require training in e-procurement.

iv. Effectiveness

27. Contractual performance is routinely monitored and reported. The Project team is responsible for tracking contractual payment obligations. On average it takes from 1 to 2 months between receiving a firm's invoice and making payment. Arrangements for late payment are mentioned in the contract. While beneficiaries may be entitled to interest payment, this is not claimed. Payments are approved by the Project Director who also approves the invitation documents, evaluations, and contracts.

v. Accountability Measures

28. All key procurement documents are signed by the designated authority. There is always a written auditable trail of procurement decisions attributable to individuals and committees, and procurement decisions and disputes are always supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment, etc.

29. There is no single website created by MOH for publishing public procurement data. Information on public procurement may be publicly available on websites for some projects.

30. The Anti-Corruption Law 23 of 2013 stipulates staff conduct. The inspection department monitors conduct of all departments in MOH including for procurement. Internal audits are however seldom conducted. A complaints resolution mechanism is described in national procurement documents, but there is no formal non-judicial mechanism for dealing with complaints.

B. Strengths

31. There is only one legal and regulatory framework, although lacking specific guidelines, covering all sectors. It may be less appropriate for MOH to develop its own procurement guidelines except where this is to address issues unique for MOH. MOH is seeking to align Myanmar procurement standards and practices with international standards with support of USAID and the World Bank.

32. All procurement activities for externally funded projects of MOH are managed by the concerned department, which has considerable authority to manage the procurement process.

A PMU can be established for project implementation, including provision of consulting services to address gaps in staff capacity.

C. Weaknesses

33. The major procurement weakness is the lack of standard procurement guidelines covering all ministries. A related problem is that procurement guidelines are not according to international standards. These are under preparation under the leadership of the Ministry of Construction with support of the World Bank and USAID, and are likely to be available by the time of project commencement.

34. A second problem is insufficient procurement capacity in MOH, including (i) lack of a central procurement unit and insufficient procurement coordination and support; (ii) limited staff engaged in procurement and limited facilities, in particular at the CMS; and (iii) insufficient understanding of procurement by the procurement unit and the procurement tender selection committee.

35. A new challenge is the introduction of e-procurement processes including advertisement, bidding documentation, monitoring, accountability, transparency, and complaint mechanisms.

D. Procurement Risk Assessment and Management Plan

36. According to the results of the risk assessment, the P-RAMP for the procurement environment, MOH and IAs may be summarized in terms of two risks:

- Lack of standard government procurement guidelines for any type of procurement.
- Lack of internationally accepted procurement procedures.
- Lack of procurement capacity in MOH.

37. Mitigation measures recommended are:

- Providing technical training for EA and IA to be familiar with international project procurement procedures.
- If there is a delay in the development of public procurement guidelines, including those being prepared with support of the World Bank and USAID, MOH may, as interim arrangement, adopt ADB procurement guidelines.

Table 1: Summary Ratings General Procurement Environment Risk Assessment

Criterion	Risk
A. Legal and Regulatory Framework	High
B. Institutional Framework	High
C. Procurement Market and Operations	High
D. Integrity of the Procurement System	Moderate
Overall Risk Rating	**High**

Table 2: Summary Ratings Agency Procurement Risk Assessment

Criterion	Risk
A. Organization and Staff Capacity	High
B. Information Management	Moderate
C. Procurement Practices	High
D. Effectiveness	Moderate
E. Accountability Measures	Moderate

Overall Risk Rating	Moderate

38. The Project Procurement Risk Assessment and Management Plan (P-RAMP) is showed in the table 3 below based on the assessment.

Table 3: Project Procurement Risk Assessment and Management Plan (P-RAMP)

Risk Description	Risk Assessment	Mitigation Measures or Risk Management Plan
General Procurement Environment Risk Assessment		
A. Legal and Regulatory Framework		
Insufficient international procurement legislation and guidelines, no guidelines for ICB	High	- Government is preparing this with support of development partners
B. Institutional Framework		
Insufficient procurement structures and institutional core capacities	High	- There are no short term solutions, except through interim arrangements of strong PMUs that coordinate well with central agencies such as the Ministry of Finance
C. Procurement Market Operations		
Still highly underdeveloped post military rule	High	- Development of e-procurement may broaden civil engagement and should be encouraged and groomed in MOH
D. Integrity of the Procurement System		
Need to implement the anti-Corruption Law 23 od 2013	Moderate	- Need for capacity building and staff inspection and sanctions in MOH
Agency Procurement Risk Assessment		
A. Organization and Staff Capacity		
Insufficient MOH procurement framework and staff capacity	High	- World Bank and USAID are assisting MOH in procurement structure. Project staff will need to be provided with general and ADB specific procurement training
B. Information Management		
Insufficient computerization	Moderate	- Support computerization
C. Procurement Practices		
Insufficient experience with ADB procurement practices	High	- Consultants to assess procurement practices, develop a manual and provide training
D. Effectiveness		
Shortcomings in contract management	Moderate	- Consultants to provide training and introduce e-procurement
E. Accountability Measures		
Shortcomings in public disclosure and complaint mechanisms Governance weaknesses	Moderate	- Consultants to provide training and introduce e-procurement - Provide training in staff conduct
Overall Risk Rating	**High**	

III. PROJECT SPECIFIC PROCUREMENT THRESHOLDS

39. Procurement thresholds are generally defined in the National Procurement Guidance Manual. Calls for tenders must be issued if the amount is superior to 5 million Kyats ($4,200) and if the amount is not within that limit, the procurement department can purchase by following its own process. But this must be done by decision made by the board of the department. The departments do not have their own ICB (international competitive bidding) format and hopefully they will have a good ICB format after the elaboration of the Procurement Guidelines Manual by USAID.

40. The comparison of applicable thresholds is indicated in table 4 below. The Government has only one threshold for bidding for goods, works and services. ADB ceilings are higher, so the lower government ceilings are allowed by ADB. Table 4 also indicates prior ADB reviews. ADB's concern stems from shopping without advertising, and no ceiling and arrangements for international competitive bidding. In general, ADB encourages advertising even for small procurements. ADB and government ceilings for direct purchase and community participation are to be determined. Table 5 summarizes consultant selection thresholds.

Table 4: Comparison of Government and ADB Thresholds

	Procurement of Goods and Works			
	Method	**Government Threshold**	**ADB Threshold**	**Comments**
Goods	International Competitive Bidding	No provision in MOH	Above $1,000,000 for goods, Above $5,000,000 for works	Prior ADB review shall be applied for all contracts for all IAs Evaluation and approval by tender board/committee
	National Competitive Bidding	No threshold	Up to $1,000,000	Prior ADB review shall be applied for first contract of each IA Evaluation and approval by tender board/committee
	Shopping with or without advertising	Up to $4,200	Up to $100,000	Prior ADB review shall be applied for first contract of each IA. MOH decides on procedure to be followed.

Table 5: Procurement Method Thresholds of Consulting Services

Consulting Services	
Method	**Comments**
Consultant Qualification Selection	Prior Review shall be applied for: • **Firms**: the first contract for each method regardless of value and all contracts equal or above $0.5 m; all TORs and cost estimates; shortlist for audit contracts. • **Individuals**: all contracts equal or above $50,000; single source selection (SSS); all TORs and cost estimates;
Least-Cost Selection	
Individual Consultants Selection	

IV. PROCUREMENT PLAN

41. The proposed project procurement plan is included in Appendix 2. A total of 19 packages have been identified. Subject to confirmation of the budget estimates, a total of one package of goods above $1 million and two consulting services above $100,000 have been identified. No advance action is foreseen. Initial consulting services are expected to be provided through an ADB technical assistance to initiate the procurement process.

V. CONCLUSION

42. The experience of ADB in Myanmar is very limited in comparison with other countries in the Subregion. The procurement risk was assessed as "*high*", in particular due to a weak procurement environment. Procurement is essentially delegated to ministries without much guidance and control.

43. While major procurement and governance reforms are being undertaken by the Government with the assistance of development partners, MOH has demonstrated some good procurement activities. The overall procurement capacity of MOH is considered "*moderate*" due mainly to internationally unacceptable procurement processes. The procurement capacity of MOH has a potential to be improved following adoption of procurement guidelines that are being prepared with the assistance of partners. Thereafter the overall project risk may be reclassified as moderate. MOH also needs to improve its in-house procurement capacity and preferably move to e-procurement. Information and contract management and accountability measures also need to be improved.

44. Specifically for the project, MOH has a limited number of employees to undertake additional procurement tasks for the proposed ADB project. It will be necessary to have a PMU before project implementation stage, and obtain international procurement technical assistance. Delegation of procurement to the states is not considered appropriate for the proposed GMS Health Security Project. But if it is the case, procurement capacity building for the procurement teams will be required.

45. MOH and ADB may also consider the following measures:

- MOH doesn't use ICB. International bidders cannot participate in NCB. MOH needs to adopt guidelines to allow this.
- All procurement staff and the Tender Selection Committee should be trained.
- Advertisement for calls for tenders and publication should be done in the website of MOH (https://www.moh.gov.mm) for all the national and international bidders.
- The Supply Chain Management System is testing the use of data inventory software (M-Supply software) in some regions.
- The e-procurement system is weak and needs to be prioritized.
- The quality checking system and supply system of warehouse represents a high risk. CMSD has two old trucks for the transportation of equipment and medicine but most of the time the trucks are not working.
- The risks of the procurement sector can be reduced by applying ADB procurement guidelines during the project implementation period.

Appendix 1 – Procurement Risk Assessment

A. General Procurement Environment Assessment Questionnaire
Procurement and Supply Division, Department of Public Health

		Risk Assessment
1. Is there a procurement law?	Not established yet. Under processing to establish the procurement guidelines.	Hgh
2. Are the laws and regulations clear and concise?	Not established yet. Under processing to establish the procurement guidelines.	High
3. What does the law (or regulations applicable to procurement) cover?	Not established yet. Under processing to establish the procurement guidelines.	High
4. Does the law cover the procurement of consulting services?	Not established yet. Under processing to establish the procurement guidelines.	High
5. Does the law differentiate between processes for consulting services and Goods/Works?	Not established yet. Under processing to establish the procurement guidelines.	High
6. Does the law require advertisement of all procurement opportunities?	Not established yet. Under processing to establish the procurement guidelines.	High
7. Are contract awards advertised?	Yes. Contract awards are advertised on the white board of the procurement office.	Low
8. Are there restrictions on goods works and services on the basis of origin?	No restriction. Only depends on the quotation.	Low
9. Does the law or relevant legislation and regulations provide acceptable provision for the participation of state owned enterprises?	Not established yet. Under processing to establish the procurement guidelines.	High
10. Are there restrictions on the nationality of bidders and consulting firms invited	Yes. But we have only National Competitive Bidders.	High
11. Are there foreign bidders and consultants forced to offer through or with local partners	No.	Low
12. Is there a domestic preference scheme?	There is a domestic preference scheme.	High
13. Is there a national standard mandated for use for quality control purposes?	No	High
14. Are any agencies exempt from the law?	No	Low
15. Is the default method for procurement open competition?	Yes	Low
16. Is open procurement easily avoided?	No	Low
17. Do the rules and regulations require pre-qualification?	No	Low
18. Do the rules and regulations require registration?	No	High
19. Are there systematic procurement process audits?	Yes. There is a government audits team.	Low
20. Is there a national procurement manual or guide?	We have only departmental procurement manual.	Moderate
21. Do the laws and regulations mandate the use of standard documents?	No	High
22. Have these standard bidding documents has been approved for use on ADB projects	This is the first time experience with ADB project.	Moderate
23. Do the regulations require the collection of nationwide statistics on procurement?	There is no regulation yet.	High
24. Is consolidated historical procurement data available to the public?	Not available.	High
25. Do the procurement laws and regulations contain provisions for dealing with misconduct?	There is no procurement law and regulation so far.	High
26. Is fraud and corruption in procurement	There is a special law for that case.	Moderate

regarded as a criminal act?		
27. Have there been prosecutions for fraud and corruption?	It used to have in another department under MOH.	Moderate
28. Is there an alternative disputes resolution process independent of government and courts	Giving warning by the Deputy Minister MOH who is also a chairman of Tender Selection Committee	Low
29. Does the law allow for sovereign immunity to the EA for claims against it?	No	Low
30. Do the regulations allow for blacklisting (disbarment) of firms and individuals and if they do	Yes, we used to do this.	Low
31. Which body oversees procurement?	Tender Selection Committee	Low
32. What powers does the oversight body have?	Deputy Minister of Health makes the decision for the internal specific cases and he is also the board of Tender Selection Committee	Low
33. Is there a nationwide procurement training plan	No	High
34. Is there a procurement accreditation or professionalization program?	No	High
35. Are major projects identified within an agency's appropriation or budget?	Yes	Low
36. Is the procurement cycle tied to an annual budgeting cycle? i.e. can procurement activity only commence once a budget is approved	Yes	Low
37. Once an appropriation or budget is approved will funds be placed with the EA or can the EA draw them down at will	Yes.	Low
38. Can an EA draw directly from a loan or imprest account or will it spend budgeted funds with the borrower claiming reimbursement?	Yes.	Low
39. When an EA is implementing a project using funds from the national budget has a delay in funding significantly delayed procurement?	Yes, we usually have a delay in this process.	Moderate

Since the procurement law and guidelines will be established soon, the risks of the assessment especially for the procurement law and guidelines are regarded as moderate.

B - IA Procurement Capacity Assessment - Procurement Capacity Assessment Questionnaire - Provincial Department of Health - Procurement and Supply Division, Department of Public Health

Part A. General Agency Resource Assessment	
A.1. Is there a procurement department?	Yes. We have a procurement unit in each department.
A.2. What procurement does it undertake?	Medicine and equipment for Department of Public Health
A.3. Are the staff provided with written job descriptions?	Yes.
A.4. How many years experienced does the head of the procurement unit have in a direct procurement role?	Only 10 months experienced.
A.5.How many staff in the procurement department are:	
i. Full-time?	15 staffs
ii. Part-time?	
iii. Seconded?	
A.6. At what level does the department report (to the head of agency, deputy, etc.)?	To the Director of Public Health Department and then to the MOH.
A.7. Do the staff that will be involved with the procurement have English language skills sufficient to undertake international procurement?	Yes. But not all the staffs.
A.8. Is the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	No. It will be better if the project can support a technical training.
A.9. Does the unit have adequate facilities such as PCs, internet connections, photocopy facilities, printers, etc. to undertake the expected procurement?	No. The facilities are not sufficient.
A.10. Is there a procurement training program	No
Part B. Agency Procurement Processes, Goods and Works	
B.1. Has the agency undertaken foreign assisted procurement of goods or works recently (last 12 months, or last 36 months)? (If yes, funded by whom and name of the project)	Last (12) months ago with the World Bank project.
B.2. If the above is yes, what were the major challenges?	The lack of International Procurement Bidding.
B.3. Is there a procurement process manual for goods and works?	There is no Procurement manual.
B.4. If there is a manual, is it up to date, and does it cover foreign-assisted procurement?	There is no Procurement manual.
B.5. Is there a systematic process to identify procurement requirements (1 year or more)	Yes
B.6. Who drafts the specifications?	The Medical Specialists.
B.7. Who approves the specification?	Procurement unit
B.8. Are there standard bidding documents in use and have they been approved for use on ADB funded projects?	Yes. There is Standard Bidding Document. But that is only for the national bidders.
B.9. Who drafts the bidding documents?	Procurement Department
B.10. Who manages the sale of the document?	Financial Department
B.11. Are all queries from bidders replied to in writing?	Bidders are replied by phone.
B.12. Is there a minimum period for preparation of bids and if yes how long?	At least one month
B.13. Does the bidding document state the date and time of opening and how close is it to the Deadline for submission?	Yes. It takes about two weeks to one

	month.
B.14. Is the opening public?	Yes
B.15. Can late bids be accepted?	No
B.16. Can bids be rejected at bid opening?	Yes, when they are absence.
B.17. Are minutes taken?	Yes
B.18. Who may have a copy of the minutes?	Only DOPH.
B.19. Are the minutes free of charge?	Yes
B.20. Who undertakes the evaluation (individual(s), permanent committee, ad-hoc committee)?	Procurement Department
B.21. What are the qualifications of the evaluators in respect to procurement and the goods and works under evaluation?	All the committee members are directors of each department. They are technical experts and qualified enough.
B.22. Is the decision of the evaluators final or is the evaluation subject to additional approvals?	Yes, the approval of the committee is the final.
B.23. Using at least three real examples how long between the issue of the invitation for bids and Contact effectiveness?	About three months.
B.24. Are there processes in place for the collection and clearance of cargo through ports of Entry?	Yes
B.25. Are there established goods receiving procedures?	Yes
B.26. Are all goods received recorded as assets or inventory in a register or similar?	Yes
B.27. Is the agency/procurement department familiar with letters of credit?	No
B.28. Does the procurement department register and track warranty and latent defects liability Periods?	Yes
Part C. Agency Procurement Processes, Consulting Services	
C.1. Has the agency undertaken foreign assisted procurement of consulting services recently (last 12 months, or last 36 months)?	No There are no consulting services. Therefore remainder of this section is not filled in.
C.2. If the above is yes what where the major challenges?	
C.3. Is there a procurement process manual for consulting services procurement?	
C.4. Is the manual up to date and does it cover foreign assisted projects?	
C.5. Who identifies the need for consulting services requirements?	
C.6. Who drafts the TOR?	
C.7. Do the TOR followed a standard format such as background, tasks, inputs, objectives and Outputs?	
C.8. Who prepares the request for proposals?	
C.9. Are assignments advertised and expressions of interest called for?	
C.10. Is a consultants' selection committee formed with appropriate individuals in terms of Procurement and technical expertise?	
C.11. What criteria is used to evaluate EOIs?	
C.12. Historically what is the most common method used (QCBS, QBS etc.)	
C.13. Do firms have to pay for the proposal document?	
C.14. Does the evaluative criteria follow a pre-determined structure and is it detailed in the RFP?	
C.15. Are pre-proposal visits and meetings arranged?	
C.16. Are minutes prepared and circulated after pre-proposal meetings?	
C.17. To whom are minutes distributed?	
C.18. Are all queries from consultants answered to in writing?	
C.19. Are the financial and technical proposals in separate envelopes?	
C.20. Are proposal securities required?	

C.21. Are technical proposals opened in public?	
C.22. Do the financial proposals remain sealed until technical evaluation is completed?	
C.23. Are minutes of technical opening distributed?	
C.24. Who determines the final technical ranking and how?	
C.25. Are the technical scores published and sent to all firms?	
C.26. Is the financial proposal opening public?	
C.27. Are there minutes taken and distributed of financial proposal opening?	
C.28. How is the financial evaluation completed?	
C.29. Are face to face contract negotiations held?	
C.30. How long after financial evaluation is the selected firm to negotiate?	
C.31. What is the usual basis for negotiation?	
C.32. Are minutes of negotiation taken and signed?	
C.33. How long after negotiations until the contract is signed?	
C.34. Are advance payments made?	
Part D. Process Oversight and Control	
D.1. Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes
D.2. Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes
D.3. Is the commencement of procurement dependent on external approvals (formal or de-facto) outside of the budgeting process?	Not Beyond the project.
D.4. Who approves procurement transactions and do they have procurement experience and qualifications?	By the Committee and they have procurement experience.
D.5. Which of the following actions require approval outside of the procurement unit or a permanent evaluation committee and who grants the approval?	
(i) Bidding document, invitation to pre-qualify or request for proposal	Bidder
(ii) Advertisement of an invitation for bids, pre-qualification or call for expressions of interest	Head of procurement unit.
(iii) Evaluation reports	Bidder
(iv) Notice of award	Head of procurement unit.
(v) Invitation to consultants to negotiate	Head of procurement unit.
(vi) Contracts	Head of procurement unit.
D.6. Is contractual performance systematically monitored and reported upon?	Yes
D.7. Does the agency monitor and track its contractual payment obligations?	Yes
D.8. On average how long is it between receiving a firm's invoice and making payment?	5 days after submitting to the financial department
D.9. What is the standard period for payment included in contracts?	Within one week.
D.10. When payment is made late are the beneficiaries paid interest?	No interest is needed to be paid.
D.11. Are payments authorized by the same individuals empowered to approve invitation documents, evaluations and contracts	Payment by Financial Department and Invitation, documents, evaluations and contracts by procurement department.
D.12. Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes. There is a detecting checking program by inspection department.
D.13. Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes
D.14. Is there a formal non-judicial mechanism for dealing with complaints?	Yes
D.15. Is a complaints resolution mechanism described in national procurement documents?	Yes

Part E. Records Keeping	
E.1. Is there a referencing system for procurement files?	Yes
E.2. Are original contracts secured in a fire and theft proof location?	Yes
E.3. Are copies of bids or proposals retained with the evaluation?	Yes
E.4. Are copies of the original advertisements retained with the pre-contract files	Yes
E.5. Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes
E.6. Are copies of invoices included with contract papers?	Yes
E.7. For what period are records kept?	Yes, more than five years

C. General Procurement Environment Assessment Questionnaire - Procurement Department, Central Medical Store Depot

		Risk Assessment
1. Is there a procurement law?	The procurement law is not established yet. Just under processing to establish the procurement guidelines.	Moderate
2. Are the laws and regulations clear and concise?	The procurement law is not established yet. Just under processing to establish the procurement guidelines.	Moderate
3. What does the law (or regulations applicable to procurement) cover?	The procurement law is not established yet. Just under processing to establish the procurement guidelines.	Moderate
4. Does the law cover the procurement of consulting services?	The procurement law is not established yet. Just under processing to establish the procurement guidelines.	Moderate
5. Does the law differentiate between processes for consulting services and Goods/Works?	The procurement law is not established yet. Just under processing to establish the procurement guidelines.	Moderate
6. Does the law require advertisement of all procurement opportunities?	The procurement law is not established yet. Just under processing to establish the procurement guidelines.	Moderate
7. Are contract awards advertised?	Yes. Contract awards are advertised on the white board of the procurement office.	Low
8. Are there restrictions on goods works and services on the basis of origin?	No restriction. Only depends on the quotation.	High
9. Does the law or relevant legislation and regulations provide acceptable provision for the participation of state owned enterprises?	The procurement law is not established yet. Just under processing to establish the procurement guidelines.	Moderate
10. Are there restrictions on the nationality of bidders and consulting firms invited	Only national bidders in CMSD.	High
11. Are there foreign bidders and consultants forced to offer through or with local partners	Only national bidders in CMSD.	Moderate
12. Is there a domestic preference scheme?	No	High
13. Is there a national standard mandated for use for quality control purposes?	FDA approval is necessary.	Low
14. Are any agencies exempt from the law?	No	Moderate
15. Is the default method for procurement open competition?	Yes	Low
16. Is open procurement easily avoided?	Yes	Moderate
17. Do the rules and regulations require pre-qualification?	There is no rules and regulation for now.	Moderate
18. Do the rules and regulations require registration?	There is no rules and regulation for now.	Moderate
19. Are there systematic procurement process audits?	Yes, There is a government audit team.	Low
20. Is there a national procurement manual or guide?	Procurement guideline is still under processing and will be established soon.	Moderate
21. Do the laws and regulations mandate the use of standard documents?	No	Moderate
22. Have these standard bidding documents has been approved for use on ADB projects	This is the first time experience with ADB project.	Moderate
23. Do the regulations require the collection of nationwide statistics on procurement?	There is no rules and regulation for now.	Moderate
24. Is consolidated historical procurement data available to the public?	Yes, with the official request and official approval from the higher level.	Moderate
25. Do the procurement laws and regulations contain provisions for dealing with misconduct?	No.	Moderate
26. Is fraud and corruption in procurement regarded as a criminal act?	There is no special law for that case. Bur we can add this kind of case to the blank list.	Moderate
27. Have there been prosecutions for fraud	No. Not yet.	Low

and corruption?		
28. Is there an alternative disputes resolution process independent of government and courts	Giving warning by the Deputy Minister MOH who is also a chairman of Tender Selection Committee.	Low
29. Does the law allow for sovereign immunity to the EA for claims against it?	EA is just a board for this procurement session and there is no procurement law for now.	High
30. Do the regulations allow for blacklisting (disbarment) of firms and individuals and if they do	Yes, we used to do this.	Low
31. Which body oversees procurement?	Tender Selection Committee	Low
32. What powers does the oversight body have?	Deputy Minister of Health makes the decision for the internal specific cases and he is also the member of the board of Tender Selection Committee	Low
33. Is there a nationwide procurement training plan	No	High
34. Is there a procurement accreditation or professionalization program?	No	High
35. Are major projects identified within an agency's appropriation or budget?	Yes	Low
36. Is the procurement cycle tied to an annual budgeting cycle? i.e. can procurement activity only commence once a budget is approved	Yes	Moderate
37. Once an appropriation or budget is approved will funds be placed with the EA or can the EA draw them down at will	No. Only IA serves for that case	Moderate
38. Can an EA draw directly from a loan or imprest account or will it spend budgeted funds with the borrower claiming reimbursement?	No. This is the first time with loan project.	Moderate
39. When an EA is implementing a project using funds from the national budget has a delay in funding significantly delayed procurement?	Yes, we usually have a delay in this process.	Moderate

Since the procurement law and guidelines will be established soon, the risks of the assessment especially for the procurement law and guidelines are regarded as moderate.

D. Agency Capacity Risk Assessment - Provincial Department of Health Procurement Unit, Central Medical Store Department

Part A. General Agency Resource Assessment	
A.1. Is there a procurement department?	Yes.
A.2. What procurement does it undertake?	Medical Equipment, especially drugs
A.3. Are the staff provided with written job descriptions?	No, all are coordinating together
A.4. How many year experienced does the head of the procurement unit have in a direct procurement role?	5 years
A.5.How many staff in the procurement department are:	
i. Full-time?	6 staffs
ii. Part-time?	
iii. Seconded?	
A.6. At what level does the department report (to the head of agency, deputy, etc.)?	Department of Medical Services.
A.7. Do the staff that will be involved with the procurement have English language skills sufficient to undertake international procurement?	Moderate
A.8. Is the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes
A.9. Does the unit have adequate facilities such as PCs, internet connections, photocopy facilities, printers, etc. to undertake the expected procurement?	No, office facilities are not sufficient.
A.10. Is there a procurement training program	No
Part B. Agency Procurement Processes, Goods and Works	
B.1. Has the agency undertaken foreign assisted procurement of goods or works recently (last 12 months, or last 36 months)? (If yes, funded by whom and name of the project)	No
B.2. If the above is yes, what were the major challenges?	
B.3. Is there a procurement process manual for goods and works?	Yes
B.4. If there is a manual, is it up to date, and does it cover foreign-assisted procurement?	No
B.5. Is there a systematic process to identify procurement requirements (1 year or more)	Yes. Since one year ago.
B.6. Who drafts the specifications?	By specialists.
B.7. Who approves the specification?	Procurement department
B.8. Are there standard bidding documents in use and have they been approved for use on ADB funded projects?	Yes, we have only for national bidding document.
B.9. Who drafts the bidding documents?	Procurement department
B.10. Who manages the sale of the document?	Procurement department
B.11. Are all queries from bidders replied to in writing?	Answer by phone
B.12. Is there a minimum period for preparation of bids and if yes how long?	At least one month. Depends on the quantity of items.
B.13. Does the bidding document state the date and time of opening and how close is it to the Deadline for submission?	Yes
B.14. Is the opening public?	Yes
B.15. Can late bids be accepted?	No
B.16. Can bids be rejected at bid opening?	Yes

B.17. Are minutes taken?	Yes
B.18. Who may have a copy of the minutes?	Procurement department
B.19. Are the minutes free of charge?	Yes, but the meeting minutes are only official (No available by the private sector)
B.20. Who undertakes the evaluation (individual(s), permanent committee, ad-hoc committee)?	Procurement department
B.21. What are the qualifications of the evaluators in respect to procurement and the goods and works under evaluation?	Some of the evaluator are qualified.
B.22. Is the decision of the evaluators final or is the evaluation subject to additional approvals?	The approval of the board is final.
B.23. Using at least three real examples how long between the issue of the invitation for bids and Contact effectiveness?	Minimum at least one and half month
B.24. Are there processes in place for the collection and clearance of cargo through ports of Entry?	Yes. By bidders, if we buy by dollars, CMSD have to serve for the cargo transportation of the cargo.
B.25. Are there established goods receiving procedures?	Yes
B.26. Are all goods received recorded as assets or inventory in a register or similar?	Yes, with the specific records.
B.27. Is the agency/procurement department familiar with letters of credit?	Yes
B.28. Does the procurement department register and track warranty and latent defects liability Periods?	Yes, at least one year warranty maintenance must be supported by the company.
Part C. Agency Procurement Processes, Consulting Services	
C.1. Has the agency undertaken foreign assisted procurement of consulting services recently (last 12 months, or last 36 months)?	No There are no consulting services. Therefore remainder of this section is not filled in.
C.2. If the above is yes what where the major challenges?	
C.3. Is there a procurement process manual for consulting services procurement?	
C.4. Is the manual up to date and does it cover foreign assisted projects?	
C.5. Who identifies the need for consulting services requirements?	
C.6. Who drafts the TOR?	
C.7. Do the ToR followed a standard format such as background, tasks, inputs, objectives and Outputs?	
C.8. Who prepares the request for proposals?	
C.9. Are assignments advertised and expressions of interest called for?	
C.10. Is a consultants' selection committee formed with appropriate individuals in terms of Procurement and technical expertise?	
C.11. What criteria is used to evaluate EOIs?	
C.12. Historically what is the most common method used (QCBS, QBS etc.)	
C.13. Do firms have to pay for the proposal document?	
C.14. Does the evaluative criteria follow a pre-determined structure and is it detailed in the RFP?	
C.15. Are pre-proposal visits and meetings arranged?	
C.16. Are minutes prepared and circulated after pre-proposal meetings?	
C.17. To whom are minutes distributed?	
C.18. Are all queries from consultants answered to in writing?	
C.19. Are the financial and technical proposals in separate envelopes?	
C.20. Are proposal securities required?	
C.21. Are technical proposals opened in public?	

C.22. Do the financial proposals remain sealed until technical evaluation is completed?	
C.23. Are minutes of technical opening distributed?	
C.24. Who determines the final technical ranking and how?	
C.25. Are the technical scores published and sent to all firms?	
C.26. Is the financial proposal opening public?	
C.27. Are there minutes taken and distributed of financial proposal opening?	
C.28. How is the financial evaluation completed?	
C.29. Are face to face contract negotiations held?	
C.30. How long after financial evaluation is the selected firm to negotiate?	
C.31. What is the usual basis for negotiation?	
C.32. Are minutes of negotiation taken and signed?	
C.33. How long after negotiations until the contract is signed?	
C.34. Are advance payments made?	
Part D. Process Oversight and Control	
D.1. Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes
D.2. Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes
D.3. Is the commencement of procurement dependent on external approvals (formal or de-facto) outside of the budgeting process?	Yes
D.4. Who approves procurement transactions and do they have procurement experience and qualifications?	By the Committee and they have procurement experience.
D.5. Which of the following actions require approval outside of the procurement unit or a permanent evaluation committee and who grants the approval?	Technical Expertise from vertical program
(i) Bidding document, invitation to pre-qualify or request for proposal	Procurement department
(ii) Advertisement of an invitation for bids, pre-qualification or call for expressions of interest	Procurement department
(iii) Evaluation reports	Evaluation by specialists. Report by Procurement session.
(iv) Notice of award	Procurement department
(v) Invitation to consultants to negotiate	Procurement department
(vi) Contracts	Procurement department
D.6. Is contractual performance systematically monitored and reported upon?	Yes
D.7. Does the agency monitor and track its contractual payment obligations?	Yes. The payment can be done only after checking.
D.8. On average how long is it between receiving a firm's invoice and making payment?	5days, after submitting to the financial department.
D.9. What is the standard period for payment included in contracts?	Within one week.
D.10. When payment is made late are the beneficiaries paid interest?	No need to pay for interest.
D.11. Are payments authorized by the same individuals empowered to approve invitation, documents, evaluations and contracts	Payment by financial department and invitation, document evaluation and contracts by procurement session.
D.12. Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes,
D.13. Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes. There is a detecting checking program by inspection department.
D.14. Is there a formal non-judicial mechanism for dealing with complaints?	No mechanism for complaint.
D.15. Is a complaints resolution mechanism described in national procurement documents?	Yes, but still need to integrate it.
Part E. Records Keeping	

E.1. Is there a referencing system for procurement files?	Yes.
E.2. Are original contracts secured in a fire and theft proof location?	Yes
E.3. Are copies of bids or proposals retained with the evaluation?	Yes
E.4. Are copies of the original advertisements retained with the pre-contract files	Yes
E.5. Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes
E.6. Are copies of invoices included with contract papers?	Yes
E.7. For what period are records kept?	Five years. But there is no limitation for this instance.

APPENDIX 2: DRAFT PROCUREMENT PLAN

{All text in red and footnotes should be removed from a completed procurement plan.}

Basic Data

Project Name:	
Project Number:	**Approval Number**:
Country: MYANMAR	**Executing Agency**: **Ministry of Health**
Project Procurement Classification:	**Implementing Agency: Procurement and Supply Division**
Procurement Risk: Moderate	
Project Financing Amount: **ADB Financing:** **Cofinancing (ADB Administered):** **Non-ADB Financing:**	**Project Closing Date:**
Date of First Procurement Plan:	**Date of this Procurement Plan**:

A. Methods, Thresholds, Review and 18-Month Procurement Plan

1. Procurement and Consulting Methods and Thresholds

Except as the Asian Development Bank (ADB) may otherwise agree, the following process thresholds shall apply to procurement of goods and works. {delete the methods that do not apply}

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
International Competitive Bidding (ICB) for Works	$5,000,000[1]	
International Competitive Bidding for Goods	$1,000,000[1]	
National Competitive Bidding (NCB) for Works[2]	Beneath that stated for ICB, Works	Prior
National Competitive Bidding for Goods[2]	Beneath that stated for ICB, Goods	Prior
Shopping for Works	Below $100,000	Prior
Shopping for Goods	Below $100,000	Prior
{List here any other methods of procurement approved for use (see Section III of the Procurement Guidelines)}	{To be agreed with ADB during project processing}	

[1] Please insert a specific threshold amount

[2] Refer to Para. 3 of PAI 3.05 for National Competitive Bidding

Consulting Services	
Method	**Comments**
Quality and Cost Based Selection (QCBS)	Prior
Quality Based Selection	
Consultants' Qualifications Selection[3]	
Least-Cost Selection[4]	
Fixed Budget Selection	
{List here any other methods of recruitment approved for use (see Section II of the Consulting Guidelines)}	{To be agreed with ADB during project processing}

[3] Refer to Para. 29 of PAI 2.02 for Consultants' Qualification Selection

[4] Refer to Para. 26 of PAI 2.02 for Least-Cost Selection

2.

3. Goods and Works Contracts Estimated to Cost $1 Million or More

The following table lists goods and works contracts for which the procurement activity is either ongoing or expected to commence within the next 18 months.

Package Number[5]	**General Description**	**Estimated Value ($ million)**	**Procurement Method**	**Review** [Prior / Post/Post (Sampling)]	**Bidding Procedure**[6]	**Advertisement Date** (quarter/year)	**Comments**[7]
1	IT equipment	1.15	NCB	Prior	1S2E	II/2017	**Goods**

[5] If the package contains multiple lots, please provide the following information for each lot – lot number, lot description and lot estimated value.

[6] Type of Bidding Procedures: 1S1E / 1S2E / 2S / 2S2E.

[7] Indicate whether prequalification of bidders and domestic preference is applicable. Specify the type of bidding documents to be used: Small Works / Large Works / Plant / Goods.

4. Consulting Services Contracts Estimated to Cost $100,000 or More

The following table lists consulting services contracts for which the recruitment activity is either ongoing or expected to commence within the next 18 months.

Package Number	General Description	Estimated Value $ million	Recruitment Method	Review (Prior / Post)	Advertisement Date (quarter/year)	Type of Proposal[8]	Comments[9]
2	CTA 27 pm	0.30	CQS	Prior	I/2017	BTP	International Public Health
3	Deputy CTA 53 pm	0.11	CQS	Prior	I/2017	BTP	National Public Health

[8] See PAI 2.02G: full, simplified or bio data technical proposal.

[9] Indicate the type of assignment: International or National. Specify the Quality-Cost Ratio for QCBS method. Indicate the type of expertise for Individual Consultant Selection.

5. Goods and Works Contracts Estimated to Cost Less than $1 Million and Consulting Services Contracts Less than $100,000 (Smaller Value Contracts)

The following table groups smaller-value goods, works and consulting services contracts for which the activity is either ongoing or expected to commence within the next 18 months.

Goods and Works								
Package Number[5]	General Description	Estimated Value	Number of Contracts	Procurement Method	Review [Prior / Post/Post (Sampling)]	Bidding Procedure[6]	Advertise-ment Date (quarter/ year)	Comments[7]
4	High End lab	0.55	1	NCB	Prior	1S2E	I/2018	
5	Medium and small lab equipment	0.26	1	NCB	Post	1S2E	III/2017	
6	Hospital Equipment	0.97	1	NCB	Prior	1S2E	III/2017	
7	Vehicles	0.66	1	NCB	Prior	1S2E	II/2017	
8	Motorcycles	0.12	1	NS	Post	1S2E	II/2017	
9	A-V equipment	0.30	1	NS	Post	1S2E	III/2017	
10	Outbreak equipment	0.43	1	NS	Post	1S2E	III/2017	
11	Lab Reagents	0.11	1	NS	Post	1S2E	II/2017	

Consulting Services								
Package Number	**General Description**	**Estimated Value $**	**Number of Contracts**	**Recruitment Method**	**Review** (Prior / Post)	**Advertisement Date** (quarter/ year)	**Type of Proposal**[8]	**Comments**[9]
12	IPC expert 3 pm	39,000	1	**CQS**	Prior	I/2017	BTP	International, IPC
13	IPC expert 6 pm	18,000	1	**CQS**	Prior	I/2017	BTP	National, public health
14	Laboratory Studies 1 pm	13000	1	**CQS**	Prior	I/2017	BTP	International lab
15	Gender and Social Development	0	1	**CQS**	Prior	I/2017	BTP	National, SD
16	PME 53 pm	46500	1	**CQS**	Prior	I/2017	BTP	National, PME
17	IT 50 pm	75000	1	**CQS**	Prior	I/2017	BTP	National, IT
18	Procurement		1	**CQS**	Prior	I/2017	BTP	International, procurement
19	Procurement		1	**CQS**	Prior	I/2017	BTP	National, administration

B. Indicative List of Packages Required Under the Project

The following table provides an indicative list of goods, works and consulting services contracts over the life of the project, other than those mentioned in previous sections (i.e., those expected beyond the current period).

Goods and Works							
Package Number[5]	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Procurement Method**	**Review** [Prior / Post/Post (Sampling)]	**Bidding Procedure**[6]	**Comments**[7]

Consulting Services							
Package Number	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Recruitment Method**	**Review** (Prior / Post)	**Type of Proposal**[8]	**Comments**[9]

C. List of Awarded and On-going, and Completed Contracts

The following tables list the awarded and on-going contracts, and completed contracts.

1. Awarded and On-going Contracts

Goods and Works							
Package Number	**General Description**	**Estimated Value**	**Awarded Contract Value**	**Procurement Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**[10]	**Comments**[11]

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.

[11] Indicate the Contractor's name and the contract signing date.

Consulting Services							
Package Number	**General Description**	**Estimated Value**	**Awarded Contract Value**	**Recruitment Method**	**Advertisement Date** (quarter/year)	**Date of ADB Approval of Contract Award**[10]	**Comments**[12]

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.

12 Indicate the Consulting Firm's name and the contract signing date.

2. Completed Contracts

Goods and Works								
Package Number	**General Descrip-tion**	**Estimated Value**	**Contract Value**	**Procure-ment Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**[10]	**Date of Completion**[13]	**Comments**

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.

[13] The Date of Completion is the physical completion date of the contract.

Consulting Services								
Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Recruitment Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**[10]	**Date of Completion**[13]	**Comments**

[10] Date of ADB Approval of Contract Award is the date of No-Objection letter to the EA/IA.

[13] The Date of Completion is the physical completion date of the contract.

D. Non-ADB Financing

The following table lists goods, works and consulting services contracts over the life of the project, financed by Non-ADB sources.

Goods and Works				
General Description	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Procurement Method**	**Comments**

Consulting Services				
General Description	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Recruitment Method**	**Comments**

National Competitive Bidding

A. Regulation and Reference Documents

1. The procedures to be followed for national competitive bidding shall be those set forth in ADB's standard bidding documents, with the clarifications and modifications described in the following paragraphs required for compliance with the provisions of ADB's Procurement Guidelines (2015, as amended from time to time).

B. Procurement Procedures

1. Application

2. Contract packages subject to national competitive bidding procedures will be those identified as such in the project procurement plan. Any changes to the method of procurement from those provided in the procurement plan shall be made through updating of the procurement plan, and only with prior approval of ADB.

2. Eligibility

3. The eligibility of bidders shall be as defined under section I of the Procurement Guidelines; accordingly, no bidder or potential bidder should be declared ineligible for reasons other than those provided in section I of the Guidelines, **as amended from time to time**.

3. Sanctioning

4. Bidders shall not be declared ineligible or prohibited from bidding on the basis of barring procedures or sanction lists, except individuals and firms sanctioned by ADB, without prior approval of ADB.

4. Advertising

5. The posting of NCB specific notices for contracts valued at less than $1 million on ADB's website is not required but is highly recommended

5. Rejection of all Bids and Rebidding

6. Bids shall not be rejected and new bids solicited without ADB's prior concurrence.

C. Bidding Documents

6. ADB Policy Clauses

7. A provision shall be included in all NCB works and goods contracts financed by ADB requiring suppliers and contractors to permit ADB to inspect their accounts and records and other documents relating to the bid submission and the performance of the contract, and to have them audited by auditors appointed by ADB.

8. A provision shall be included in all bidding documents for NCB works and goods contracts financed by ADB stating that the Borrower shall reject a proposal for award if it determines that the bidder recommended for award has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive or obstructive practices in competing for the contract in question.

9. A provision shall be included in all bidding documents for NCB works and goods contracts financed by ADB stating that ADB will declare a firm or individual ineligible, either indefinitely or for a stated period, to be awarded a contract financed by ADB, if it at any time determines that the firm or individual has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive or obstructive practices or any integrity violation in competing for, or in executing, ADB-financed contract.

Appendix 3: Master Bidding Documents

A. Step by step QCBS method

Activities/Steps for recruitment of consultant firms by QCBS method
(Prior Review Contract)

1. Prepare Term of Reference (TOR) and Request for Expression of Interest (REOI)
2. Sending TOR and REOI to WB for NO Objection Request
3. Get “No objection” from WB, publication of REOI in local newspaper and UNDB online & WB external website (WB will post in UNDB online and WB external website after receiving the final REOI from project)
4. Publication of REOI
5. Sending TOR to interested consultant upon request
6. Receiving the EOI and evaluate EOI, prepare 6 shortlist firms
7. Sending the shortlist evaluation report and RFP (request for proposal) to WB for “No Objection”
8. Obtain “No objection” from WB and Issuing the RFP document to the shortlisted consultant
9. Receipt of proposals from consultants
10. Evaluation of technical proposals and prepare technical evaluation Report
11. Sending technical evaluation report (TER) to WB for “No objection”
12. Obtain “No objection” from WB
13. Opening of Financial Proposals and evaluation of financial proposal
14. Combined Teach-Financial Evaluation and send combine Tech + fin evaluation report to WB for information only
15. Inviting the highest ranking consultant to negotiate the contract
16. Preparation of the draft negotiated contract
17. Sending the initialed draft negotiated contract to WB for “No objection”
18. Obtaining “No objection” from WB;
19. Signing the finalized contract;
20. Sending the final signed contract to WB for record

Activities/ steps for recruitment of Individual Consultant
(Prior Review Contract)

1. Prepare Term of Reference (TOR) and Request for Expression of Interest (REOI)
2. Sending TOR and REOI to WB for No Objection Request
3. Get “No objection” from WB, publication of REOI in local newspaper and UNDB online & WB external website (WB will post in UNDB online and WB external website (WB) will post in UNDB online and WB external website after receiving the final REOI from project).

Note: This document is from the Procurement and supply division, DOPH and this is a document from the World Bank project.

B. Past Practice Tender document for medical equipment

THE GOVERNMENT OF THE REPUBLIC OF THE UNION OF MYANMAR

MINISTRY OF HEALTH

TENDER DOCUMENT

FOR

MEDICAL EQUIPMENT

GROUP (M)

TENDER NO-1 CMS 2015 (L)

The Government of the Republic of the Union of Myanmar
Ministry of Health
Department of Medical Services
Central Medical Stores Depot
57, Zakawa Road, Yangon

Local Quotation No - 1 CMS 2015 (L)
Dated - 27.5.2015
Closing Date - 26.6.2015, 2:00 PM

Firm quotations in local kyats are invited for the supply of medical equipment appended herewith so as to reach in time to the above address.

GENERAL INSTRUCTIONS

(1) The tenderer should prepare two envelopes – envelope A and envelope B.

(2) The envelope A should contain the price quotation.

(2.1) Price quotation should specify the unit price in local kyats exclusively net CMSD, Yangon or respective hospitals. The unit price shall cover all kinds of charges including necessary installation or assembling at work site by the technician of the supplier.

(2.2) The price quoted must be firm and remain valid for six calendar months from the closing date of tender.

(2.3) Quotation should specify the model, the manufacturer and the Country of Origin and where there are more than one Country of Origin, it should be clearly stated against each item concerned.

(3) The envelope B should contain the document specifying the model, the manufacturer, the Country of Origin and the terms and conditions such as price validity, delivery, payment, warranty, availability of spare parts and training. And the Soft copy of summary table without price must be included in envelope B.
(CD of template for summary table has already attached in tender document)

(3.7) The document in the envelope B should specify the items to be delivered promptly and the definite period of delivery for the remaining items.

(3.8) The envelope B should also contain relevant catalogs and detail specifications for each item. All must be written in English.

(4) The envelope B should not contain the price quotation.

(4.1) Both envelope must clearly be marked on top with either A or B (A for envelope A, B for envelope B), the quotation number, bidder's name and address and closing date as mentioned above and properly sealed.

(4.2) The envelope A should be dropped directly into the tender box which will be kept ready at the office of Deputy Director (Medical Stores), Central Medical Stores Depot, No. 57, Zakawa Road, Dagon Township Yangon, not later than the closing time for submission of tender.

(4.3) The envelope B should be submitted in person to Deputy Director (Medical Stores), Central Medical Stores Depot.

(4.4) Both envelops sent by telex, telegraph, fax, e-mail or mail will not be accepted.

(4.5) The tenderer should warrant that the equipment are brand new, the most recent model of the manufacturer, free from any material defect and free from inadequate workmanship in accordance with the international code of Good Manufacturing Practices.

(4.6) The tenderer should also warrant the definite duration for availability of spare parts, replacement of materials, if any, upon the request and on the cost of purchaser.

(4.7) A tenderer is neither allowed to modify nor withdraw his tender after the closing time and also no bid shall be allowed to drop into the tender box beyond the closing time.

GENERAL CONDITIONS

(1) A Sales contract is compulsory to make between the buyer and the successful bidder for the portion being awarded. The sale contract must be conducted accordingly such as use of Revenue Stamp.

(2) The successful bidder shall establish a performance bank guarantee of a sum equal to five percent of the total contracted value of Myanma Economics Bank, Nay Pyi Taw and one of original challan is to be produced to the Department of Medical Services This condition is exempted if the delivery is to be made promptly. The Supplier falls to deposit as performance bank guarantee within ten working days, the Supplier shall pay as Liquidated damage, a sum equal to 0.5 percent per week of the amount of performance guarantee.

(3) The performance bank guarantee shall be released without interest one month after the date of complete delivery of the medical equipment. However, the supplier shall forfeit the performance bank guarantee in case of default in his obligation to implement the contract.

(4) Under all circumstances other than forced majeure, delivery must be made within the time scheduled or the supplier shall pay to the buyer liquidated damages, a sum equal to 0.5 percent per week of the value of equipment not delivered in time. The total amount of liquidated damages however shall not exceed ten percent of the value of non-delivered medical equipment.

(5) It is a condition that the tenderers shall deposit as tender premium specified in the schedule to the branch 5, Myanma Economics Bank, Yangon, one of the original Payment Order is to be attached with the envelope B. The tender premium shall be forfeited in the event of failure to proceed with what he is awarded, and the same amount shall immediately be released if when no portion of tender is awarded to him.

(6) An inspection on the medical equipment shall be carried out at the time of delivery and the buyer shall reject whole lot or part thereof which differs from specifications and the supplier must replace as soon as possible without extra charges.

(7) In case of purchasing large amount of quantity, storage facility shall be provided by the supplier of necessary.
(8) For some commodities which need to be delivered directly to respective Hospitals or Health center, the suppliers must use his best endeavor to deliver them.

PAYMENT

(1) Payment will be made in local kyats by cheque, within one week after complete delivery as well as compliance of supplier's obligations stipulated in the sales contract.
(2) It is essential to be noted, according to the existing regulations issued by the tax authority, that there will be a deduction of two percent as withholding tax.

(Dr. Aung Gyi Maung)
Deputy Director (Medical Stores)
Central Medical Stores Depot
Department of Medical Services

C. Past Practice Tender Documents for Laboratory Reagents

THE GOVERNMENT OF THE REPUBLIC OF THE UNION OF MYANMAR

MINISTRY OF HEALTH

DEPARTMENT OF PUBLIC HEALTH

TENDER DOCUMENT

FOR

LABORATORY REAGENTS

GROUP F

TENDER NO – PH – PS – (1) – F - 2015

The Government of the Republic of the Union of Myanmar
Ministry of Health
Department of Public Health
Office No. 47. Nay Pyi Taw

Local Quotation No - PH – PS – (1) – F – 2015
Dated - 22 – 6 - 2015
Closing Date - 21.7.2015, 2:00 PM

Firm quotations in local kyats are invited for the supply of laboratory equipment appended herewith so as to reach in time to the above address.

GENERAL INSTRUCTIONS

(3) The tenderer should prepare two envelopes – envelope A and envelope B.

(4) The envelope A should contain the price quotation.

(2.1) Price quotation should specify the unit price in kyats exclusively net the above address covering all kinds of charges.

(2.2) The price quoted must be firm and remain valid for six calendar months from the closing date of tender.

(2.3) Quotation should specify the batch number, the manufacturer and the Country of Origin and where there are more than one Country of Origin, it should be clearly stated against each item concerned.

(3) The envelope B should contain the document specifying the batch number, the manufacturer, the Country of Origin and the terms and conditions such as price validity, delivery, payment.

(3.1) The document in the envelope B should specify the items to be delivered promptly and the definite period of delivery for the remaining items.

(4) The envelope B should not contain the price quotation.

(5) Both envelope must clearly be marked on top with either A or B (A for envelope A, B for envelope B), the quotation number, bidder's name and address and closing date as mentioned above and properly sealed.

(6) The envelope A should be dropped directly into the tender box which will be kept ready at the office of Director (Procurement and Supply), Department of Public Health office No. (47) Naypyitaw, not later than the closing time for submission of tender.

(7) The envelope B should be submitted in person to Director (Procurement and Supply), Department of Public Health

(8) Both envelopes sent by telex, telegraph, fax, e-mail or mail will not be accepted.

(9) A tenderer is neither allowed to modify nor withdraw his tender after the closing time and also no bid shall be allowed to drop into the tender boxy beyond the closing time.

GENERAL CONDITIONS

(9) The successful bidder shall establish a performance guarantee of a sum equal to five percent of the total contracted value of Myanmar Economic Bank, Nay Pyi Taw and one of original challan is to be produced to the Director (Procurement and Supply), Department of Public Health. This condition is exempted if the delivery is to be made promptly.

The Supplier falls to deposit as performance bank guarantee within one week, the Supplier shall pay as liquidated damage, a sum equal to (0.5) percent per week of the amount of performance guarantee.

(10) The performance guarantee shall be released without interest one week after the date of complete delivery of the medical stores awarded. However, the supplier shall forfeit the performance guarantee in case of default in his obligations to implement the contract.

(11) Under all circumstances other than forced majeure, delivery must be made within the time scheduled or the supplier shall pay to the buyer liquidated damages, a sum equal to half percent per week of the value of medical stores not delivered in time. The total amount of liquidated damages however shall not exceed ten percent of the value of non-delivered medical stores.

(12) At the time of inspection at the buyer’s warehouse, the buyer shall reject whole lot or part thereof which differs from samples, or found to be defective in material and workmanship or damage, rusted and corrosive and the supplier must replace as soon as possible without extra charges.

(13) The bidder must produce sample specified in the schedule for each quoted item without which no quotation shall be entitled to be considered.

(14) The Procurement and Supply Section (if it is a drug) offered by the bidders must be manufactured in accordance with the Good Manufacturing Practice (G.M.P) standard established by the World Health Organization (WHO) and also the drug formulation must be conform to the latest edition of internationally recognized pharmacopoeia.

(15) Each item of drug must accompanied with a copy of DRC certificate recently obtained from FDA, Myanmar or the tender is liable to be rejected.

(16) No drug will be accepted having an expiry date of less than (2) years on delivery except those of which the shelf life normally does not exceed (2) years. Preference will be given to those bidders who offer the shelf life longer than (2) years.

(17) The label of each container of medicines must be written in English, describing the followings:-

(a) Trade name,
(b) Generic name
(c) Composition
(d) Strength, Weight, Volume etc.
(e) Manufacturer’s name
(f) Content per Container

(g) Manufacture Date
(h) Expiry Date
(i) Batch No.

(18) Every packing / container should have the medical leaflet explaining on the under mentioned headlines.
(a) Indication
(b) Dosage
(c) Warning
(d) Storage instruction
(e) Contraindication
(f) Drug action
And else other details which need to know by the users.

(19) It is a condition that the tenderers shall deposit tender premium specified in the schedule by Bank Guarantee Payment from Myanma Economic Bank, Nay Pyi Taw, one of the original challan is to be attached with the Envelope B. The tender premium shall be forfeited in the event of failure to proceed with what he is awarded, and the same amount shall immediately be released if when no portion of tender is awarded to hm.

(20) A sales contract is compulsory to make between the buyer and the successful bidder for the portion being awarded.

PAYMENT

(3) Payment will be made in local kyats by means of a cross cheque, within one week after complete delivery as well as compliance of supplier's obligations stipulated in the sales contract.

(4) It is essential to be noted, according to the existing regulations there will be a deduction of two percent as withholding tax.

(Dr. Kyaw Kan Kaung)
Director (Procurement and Supply)

Project Procurement Risk Assessment Report, Viet Nam

Project number: 48118-REG
July 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

CURRENCY EQUIVALENTS

(as of 31 May 2016)

Currency Unit	–	Viet Nam dong (VND)
VND1.00	=	$0.0000445
US$1.00	=	VND22,145

NOTES

(i) The fiscal year (FY) of the Government of Viet Nam and its agencies ends on 31 December (from 2016 onwards). "FY" before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

This project procurement risk assessment report is a document of the borrower. The views expressed herein do not necessarily represent those of ADB's Board of Directors, Management, or staff, and may be preliminary in nature.

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ACRONYMS

ADB	Asian Development Bank
GDPM	General Department of Preventive Medicine
GMS	Greater Mekong Subregion
MOH	Ministry of Health
MPI	Ministry of Planning and Investment
NCB	national competitive bidding
PHO	Provincial Health Office (or Bureau)
PMU	project management unit
PPC	provincial people committee
PRA	procurement risk assessment

Executive Summary

The Governments of Cambodia, Lao PDR, Myanmar and Viet Nam have requested the Asian Development Bank (ADB) to support the Greater Mekong Subregion (GMS) Health Security Project (the project). The project is to strengthen health security systems in terms of regional cooperation, CDC in border areas, surveillance and response, laboratory services, and hospital infection prevention and control. The total project cost in Viet Nam is $84 million for implementation in 250 districts in 36 provinces. Almost half of the project costs is to procure laboratory, hospital and outreach equipment, and vehicles. The Ministry of Health (MOH) is the Executing Agency, represented by the General Department of Preventive Medicine, which will establish the project management unit (PMU) and carry out all procurement.

In each country, a Procurement Risk Assessment (PRA) was prepared to determine the overall procurement risk of the Project, establish appropriate measures to mitigate these risks, and prepare the procurement plan for the proposed project with the proposed packages and procurement methods. For MOH, Viet Nam, the overall project procurement risk was assessed as *moderate*. This PRA reports on the findings in Viet Nam.

The four main risks identified for the project in Viet Nam are (i) limited project management unit (PMU) capacity for procurement, (ii) complex procurement procedures that change frequently, (iii) discrepancies between Vietnamese and the Asian Development Bank (ADB) procurement regulations, and (iv) procurement of substandard equipment. The current PMU for a similar ADB-financed project is expected to continue supporting this project, but has capacity constraints in terms of government staff and qualified contractual staff and consultants. Even so, procurement procedures are being followed. For externally funded projects, both Vietnamese and donor procurement procedures need to be followed but these are sometimes contradictory. While Viet Nam requires donor procedures to prevail, in practice both government and ADB procedures are followed, which is cumbersome. Another important issue is that standard competitive bidding processes may result in equipment being procured that complies with all specifications but is not suitable, durable, or otherwise defective.

The proposed measures to mitigate procurement risks are to: (i) strengthen the CDC2 PMU with competent, mid-career professionals working on full-time basis, preferably prior to project effectiveness; (ii) provide procurement training to reinforce understanding and compliance with ADB's Guidelines; (iii) develop guidelines to reconcile differences in ADB and Viet Nam procurement procedures; (iv) engage international and national procurement and laboratory equipment specialists; (v) add additional technical requirements and contract conditions for equipment, and (vi) conduct prior ADB review of major procurements.

I. INTRODUCTION

1. The procurement risk assessment (PRA) for the Viet Nam part of the proposed Greater Mekong Subregion (GMS) Health Security Project (the project) was prepared in accordance with ADB's Guidelines for Assessing Country, Sector and Project Procurement Risks. Intermittently from October 2015 to February 2016 for a period of 3 months, a national procurement specialist conducted the PRA with guidance of an international procurement specialist and ADB. The PRA assessed five aspects including: (i) organizational and staff capacity; (ii) information management; (iii) procurement practices; (iv) effectiveness, and (v) accountability measures. To facilitate the assessment of implementing agencies, the PRA questionnaire was issued to expected implementing agencies including the General Department of Preventive Medicine (GDPM) of the Ministry of Health (MOH) and four out of 36 provincial health offices (PHOs) in Ha Giang, Tay Ninh, Dien Bien and Gia Lai provinces. The completed questionnaires are shown in Appendix 1. Other PRA activities included reviewing Government and ADB procurement documents and reports; and discussions with government counterparts, ADB staff, and other stakeholders.

2. The project aims to contribute to regional health security by strengthening the health security system and communicable diseases control (CDC) coverage with 3 outputs: (i) improved regional cooperation and CDC in border areas, (ii) strengthened national disease surveillance and response capacity; (iii) improved laboratory capacity and infection prevention and control in hospitals.

3. The project is estimated to cost $84 million including $80 million ADB loan and $4 million in counterpart funds. The project will be implemented by GDPM, 4 regional laboratory centers, 36 provinces and 250 districts. Major procurement packages are for: (i) outbreak control and outreach vehicles, (ii) regional and district laboratory equipment, (iii) equipment for international quarantine centers and border posts, (iv) equipment for hospitals, (v) consulting services, and (vi) repair of laboratories and wards.

II. PROJECT PROCUREMENT RISK ASSESSMENT

A. Overview

i. Organization and Staff Capacity

4. The public procurement system in Viet Nam is governed by the Law on Procurement and related legal documents. The latest Law on Procurement 43/2013/QH13 (Law 43) came into effect on 1 July 2014. Decree 63/2014/NĐ-CP detailing the implementation of Law 43 regarding selection of bidders, and Decree 30/2015/NĐ-CP detailing provisions of Law 43 regarding selection of investors were issued to serve as a procurement manual where procurement requirements are translated into detailed procedures.

5. Law 43 aims to cover procurement by public bodies at central and local levels of consulting services, non-consulting services, goods and civil works to capital investments projects using state funds of 30% or more of the total investment capital in a project.

6. Competitive procurement is the default method of public procurement. National competitive bidding (NCB) is the most popular method of procurement applied for goods and civil works and non-consulting services packages and is only for local bidders. International

competitive bidding (ICB) is not a popular method of procurement and recommended to be used only in cases when local contractors are not capable regardless of package price.

7. The new law on procurement provides clear instructions on how and when to apply the other procurement methods (i.e. limited bidding, shopping, repeat order, force account, direct contracting). Direct contracting is allowed for all packages costing less than US$ 25,000.

8. In accordance with the procurement law, the Ministry of Planning and Investment (MPI) has issued standard procurement documents such as standard bidding documents, sample shopping documents, and sample evaluation reports. The standard procurement document has been used for both NCB and ICB. It has been allowed also for the international assistance projects if the donor has accepted this. In addition, a harmonized version of NCB sample bidding document jointly prepared by the World Bank (WB) and ADB has been issued and applied for ADB and WB-funded projects.

9. For Overseas Development Aid (ODA) projects, MOH is to apply donor procurement procedures as stipulated in the project documents such as loan agreement, guidelines, and project administration manual.

10. The Government's regulations and guidelines show some differences with ADB's Guidelines for procurement and consulting services. Important ones are:

- NCB is only for local bidders. Foreign bidders are not permitted to participate in national bidding.
- Consulting services to be provided by a firm may be selected without shortlisting.
- Small NCB package (less than US$ 250,000) is only open to small enterprises.
- Preference is given to firms using labor of women and the invalids or being small enterprises.
- Prior review is applied for all procurement stages including bidding documents and contract award regardless of package value.
- All awards of contracts of the procurement committee need to be verified and approved by the approval committee.

11. The role of overseeing procurement activities of the government is assigned to the Public Procurement Agency (PPA) under Ministry of Planning and Investment (MPI). This Agency is organizing periodic meetings with line ministries to review and discuss procurement procedures and issues.

12. Procurement in specific line ministries is to be decided by the Minister and undertaken by the project owner (implementing agency). The project owner may establish a project management unit (PMU) for project administration. In that case, the PMU conducts day-to-day project management and administration including all procurement activities required by the project.

13. It is noted that MOH Viet Nam has extensive experience in ODA projects including those funded by ADB. MOH staff of ODA-project PMUs is familiar with procurement procedures of the donors like the WB, ADB and JICA. They have participated in many training courses on procurement organized by the donors like WB and ADB.

14. The MOH procurement committee is established in accordance with government procurement regulation. The committee consists of staff of various departments in MOH, and is

chaired by the Director General or Deputy Director General of Planning and Finance or other Departmental head in MOH. Procurement committee meetings are sometimes delayed as members of the procurement committee are busy with other work.

General Department of Preventive Medicine (GDPM)

15. The General Department of Preventive Medicine (GDPM) is experienced in implementing ODA funded projects including those funded by ADB such as the Preventive Health System Support Project[1], the GMS Regional Communicable Diseases Control Project,[2] and the on-going Second Greater Mekong Subregion Regional Communicable Diseases Control (CDC2) Project that has been extended in 2015 with a grant for malaria control and CDC until 2017.[3]

16. In GDPM, the Planning and Financing Division is in charge of procurement and performs the function of secretariat of the procurement committee. The procurement carried out includes common procurement of goods and services for preventive medicine using government funds and procurement under specific projects, most of them ODA funded projects. For the procurement using government fund, the NCB is the common method of procurement. Force Account has been used at times when the Law on Procurement allowed. The procurement of ODA funded projects has to follow procurement regulations of the project's donor.

17. GDPM has a number of officers with experience in procurement including for ADB funded projects. Staff of GDPM is familiar with both Government procurement regulation as well as ADB procurement procedures. Procurement-related staff has participated in training courses on Vietnamese and ODA procurement procedures including those organized by ADB. Most staff have basic to adequate knowledge of English required for the execution of internationally assisted projects. However, GDPM is facing capacity constraints, as many staff are working on part-time basis for projects.

18. The supporting facilities of GDPM are considered sufficient. The department has been equipped by previous projects.

19. The CDC2 PMU in GDPM is expected to continue supporting the project. The CDC2 PMU currently has two part-time government staff assignment to project procurement, four contracted junior staff, and no consultants or experts. Despite these constraints, through years of experience the staff has improved their capacity and knowledge to carry out procurement, although with delay in some cases.

20. The CDC2 PMU in GDPM manages the procurement process and carries out or causes to carry out specific procurement activities including preparing specifications, preparing bidding documents, proceeding with bidding from bid invitation to evaluation of bids, negotiation and signing contracts, and monitoring contract implementation. Bid evaluation is subject to interdepartmental committees' approval.

[1] ADB. 2005. Strengthening of Preventive Health System Project. Manila
[2] ADB. 2009. GMS Regional Communicable Diseases Control Project. Manila
[3] ADB. 2010. Second GMS Regional Communicable Diseases Control Project. Manila

Provincial Departments of Health

21. The project is to centralize all procurement with GDPM, so provincial health offices health (PHOs) will not carry out any procurement as per design. However, as this was uncertain at the time of this PRA, PHOs have still been assessed and the report is provided herewith.

22. All assessed PHOs have certain experience in implementing ODA funded projects including those mentioned above and other ADB and WB projects.

23. In PHOs, as in GDPM, the Planning and Financing Division is in charge of procurement in coordination with other divisions in the Department. The procurement carried out includes medicines using government fund and other procurement under specific projects.

24. Procurement-related staff has participated in training courses in government and ADB procurement systems. The capacity constraints stay with still limited knowledge and capacity to apply the regulations, as well as the fact that officers work as part-time staff for project, and some of them have no or insufficient English-language capacity to work with.

25. PHOs have enough supporting facilities being equipped by previous projects.

i. Information Management

26. Under the current CDC2 project, all procurement related documents are safely kept including submitted bids and proposals, evaluation reports, signed contracts, invoices and other related documents. Procurement documents are also archived electronically by the project. There is not yet a project information management system is. No electronic copies are maintained at higher levels.

27. The time of keeping documents is ten years since the date of contract clearance in accordance with government regulation.

ii Procurement Practices

Procurement Experience of Goods and Works:

28. GDPM has extensive experience in the procurement of goods. The procurement includes laboratory equipment, vehicles, and office equipment. The methods of procurement that have been used include international competitive bidding (ICB), national competitive bidding (NCB) and shopping. GDPM also has some experience with procurement of civil works, although this is normally done by PHOs. The common methods of procurement are NCB and shopping. Force account is sometimes used when allowed based on procurement rules.

29. Assessed PHOs have certain experience in implementing procurement for ODA funded projects including ADB funded projects mentioned above. The common methods of procurement are NCB and shopping. Force Account is sometimes used when allowed based on procurement rules.

30. GDPM also has experience with selection of consulting services as a regular feature of ODA funded projects. Consultants have been engaged for a wide range of technical consulting in the health sector, financial audit, surveys, studies, and project evaluation. The common used selection methods include Consultants Qualification Selection (CQS) and Individual Consultant

Selection (ICS). The selection has been following the procurement procedures stipulated in the Loan Agreement and ADB Guidelines for selection of consultant. GDPM has difficulties attracting mid-career, well qualified national and international consultants as offered salaries are not competitive. This may result in MOH engaging consultants who are either too young or too old. Once engaged, consultants have found work conditions satisfactory.

31. PHOs have almost no experience in consulting services. For previous ADB projects, this activity was always undertaken by GDPM as consultant services are engaged at national level for the entire project.

32. E-procurement procedure was mentioned in Procurement law 61/2005/QH11 dated 19 November 2005 and in Procure 43 in Chapter 7. MPI and donors such as the WB have organized training courses on e-procurement. On 8 September 2015, MPI and the Ministry of Finance issued Circular No. 07/2015/TTLB-BKHDT-BTC on detail requirement of provision and posting information on e-bidding, for procurement of consulting services, goods and works using NCB, and national shopping, using the one stage one envelope method.

33. It is said that E-procurement was applied for some packages of public procurement for a WB funded project. There are challenges for applying e-procurement. Issued standard bidding documents do not include clauses for e-procurement. Other challenges are limited capacity of staff and facilities of implementing agencies (IAs). The Governments intend to apply e-procurement nation-wide for the purpose of transparency in public procurement. The MPI is in the process of finalizing a new procurement document for the use of e-procurement.

34. E-procurement was not yet applied in the surveyed IAs. But with the new government directive on promoting E-procurement, it may be applied when the system is well developed.

iii. Effectiveness

35. There is a clear procurement process that follows government public procurement procedures with well-defined functional entities involved in evaluation, appraisal and approval of procurement documents and dissemination of evaluation results to ensure adequate transparency. The procurement progress is reported to the government authority on a quarterly basis. But the report of the procurement progress is not always on time as required.

36. The complaints resolution mechanism has been determined in the procurement law. The claim procedure is also included in bidding documents. Firms make use of this mechanism and government and ADB are generally responsive.

37. Procurement decisions and disputes are typically supported by all related documents.

iv. Accountability Measures

38. The procurement law and bidding documents state that parties involved in public procurement are required to observe standards of ethics as well as declare any potential conflict of interest during procurement process. A procedure of handling violation of procurement procedures is stipulated in chapter xiii of the Law on Procurement.

39. Procurement responsibilities at central level are shared between MOH and GDPM. Minister of Health is playing the role of decision maker and responsible for appraisal and final approval of procurement plans of all packages to be procured. Playing the role of project owner,

GDPM is responsible for appraisal and approval of all procurement documents including bidding document and request for proposal (RFP), evaluation result, contract award, and any amendment thereafter.

40. Similarly, at the provincial level, Provincial People Committee (PPC) is playing the role of project decision maker. PHO is the project owner and implementing agency, if so designated, and may have a provincial PMU, if so designed. PPC is responsible for appraisal and approval of the project procurement plan. PHO is responsible for appraisal and approval of all procurement documents, evaluation result and contract award.

B. Strengths

41. GDPM and PHOs have previous experience in procurement for ADB-funded projects. The staff involved in procurement management are experienced with donor-funded projects including the ADB's projects.

42. The procurement system and procedures are broadly harmonized with international best practices. Established rules and regulations are in place within these IAs for handling all stages of procurement including bidding document preparation, bidding process, bids evaluation, contract award and contract administration during the procurement process. There are harmonized standard bidding documents approved by ADB and WB for ADB-financed projects.

C. Weaknesses

43. The project procurement must follow both procedures of the ADB and the government of Viet Nam. Both procedures are to be followed, which causes more work and delays. There are cases where government procurement procedures contradict ADB procedures, in which ADB procedures prevail.

44. Many IA's staff responsible for procurement work on a basic of part-time for the project. Also, members of the procurement committee are often too busy to be convened for meetings, and causes delays. In addition, most of PHOs' staff have insufficient capacity to use English as working language.

45. A common problem is that Vietnamese and ADB procedures applied routinely carry the risk of procurement of substandard equipment. Equipment specifications are often inadequate to distinguish between quality and substandard products in the bidding process.

D. Procurement Risk Assessment and Management Plan

46. Procurement for this Project is assessed as simple in term of small independent items being procured, but complex in that it concerns a large number of items for many locations, and that it includes laboratory equipment that needs to be of high quality and standardized as much as possible. Combining procurement of the same items from various locations into one package helps to reduce number of packages to be procured, but may also result in certain delays in packaging and preparing bidding documents.

47. The overall risk rating concluded from the results of the general procurement environment risk assessment and the agency procurement risk assessment is Moderate. The summary is presented in Table 1 and 2. The assessments questionnaires are in Appendix 1. Assessments of other institutional agencies are not included as these will not conduct any substantive procurement.

Table 1: Summary Ratings Central Procurement Agency

Criterion	Risk
A. Organization and Staff Capacity	Moderate
B. Information Management	Low
C. Procurement Practices	Moderate
D. Effectiveness	Low
E. Accountability Measures	Low
Overall Risk Rating	**Moderate**

Table 2: Summary Ratings Provincial Procurement Agencies

Criterion	Risk
A. Organization and Staff Capacity	Moderate
B. Information Management	Low
C. Procurement Practices	Moderate
D. Effectiveness	Low
E. Accountability Measures	Low
Overall Risk Rating	**Moderate**

48. The Project Procurement Risk Assessment and Management Plan (P-RAMP) is shown in table 3.

Table 3: Project Procurement Risk Assessment and Management Plan (P-RAMP)

Risk Description	Risk Assessment	Mitigation Measures or Risk Management Plan
- No PMU for this project is currently in place. - The existing CDC2 PMU is to become the project PMU but has capacity problems. - Government procurement staff is working on part-time basis - Risk of not retaining experienced PMU staff and engaging junior staff - Members of Procurement committee and appraisal committee are often too busy to meet.	Substantial	- The project PMU will be established before starting the project. - Staff capacity for PMU needs to be agreed to and adhered to. - More senior procurement staff will be made available. - Experienced procurement staff will be retained. - Part-time staff must arrange enough time for project procurement activities to ensure the procurement progress. - Members of committees must arrange enough time for project procurement activities to ensure the procurement progress.
- Complex procurement procedures that change frequently	Moderate	- National procurement specialist should be assigned to work full time for at least 2 years - International procurement specialist should be engaged to support and advice on the complex procurement and technical issues. - It is envisage that training on procurement will be necessary to reinforce understanding and compliance with ADB's Guidelines - Project shall be required (in financing agreement & PAM) to fully apply ADB procurement document

Risk Description	Risk Assessment	Mitigation Measures or Risk Management Plan
		- There is a need for 'external monitoring' of compliance with the spirit of professionalism, openness and fairness in procurement in accordance with ADB's Guidelines. This will be in the form of 'Prior Review' by ADB in accordance with the agreed Procurement Plan, i.e. prior review be applied for all ICB contracts and the first NCB & shopping contract for goods for each IA, and post review for other procurement modes.
- There are differences in Vietnamese and ADB procurement procedures, procurement must follow both government and donors' procedures, but this causes delay and these are sometimes contradictory.	Moderate	- Suitable project procurement guidelines must be developed for procurement areas where Vietnamese and ADB procedures differ, and conflict areas must be resolved by combining procedures or allowing or condoning some required procedures to prevail.
- Risk of procurement of substandard equipment with current bidding procedures	Substantial	- Review of procurement procedures by experts to determine how procurement process can be improved - Engagement of laboratory equipment experts to improve specifications - Selection of expert committee for selection of equipment specifications

III. PROJECT SPECIFIC PROCUREMENT THRESHOLDS

49. The applicable thresholds are indicated in the table below:

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
International Competitive Bidding for Goods	$5,000,000	Prior review shall be applied for all packages
National Competitive Bidding for Goods	Beneath that stated for ICB, Goods	Prior review shall be applied for first procurement
Shopping for Goods	$100,000 and below	
Shopping for Civil Works	$30,000 and below	NA
Consulting Services		
Method	**Comments**	
Consultant Qualification Selection	Prior Review shall be applied for all packages:	
Least-Cost Selection		
Individual Consultants Selection		
Fixed Budget Selection (FBS)		

IV. PROCUREMENT PLAN

50. **Scope of procurement**: the proposed project procurement will include goods including vehicles, laboratory equipment, hospital equipment, outbreak equipment and IT equipment. Consulting services recruitment will be for individual international and national consultants. There will be no new civil works, but there will be small repairs of laboratories and hospital wards.

51. **Packaging**: The procurement plan includes the following. One package for vehicles for $7,525,000 will be procured through ICB. Laboratory high-tech equipment packages for $17,290,000, laboratory standard equipment packages for $7,480,000 and hospital equipment packages for $2,985,000 will be procured through NCB. Laboratory small equipment packages for $230,000, outbreak equipment packages for $230,000, IT and office equipment and small civil packages for $3,343,999 will be procured through the shopping method. Consulting services to be provided by a firm will be selected through least cost selection method, and individual consultant selection shall be applied for individual consultants.

52. **Advance action and retroactive financing:** Advance action will be used for recruitment of international consultants who are needed for project implementation from the early stage of project.

53. The proposed project procurement plan is attached in Appendix 2.

V. CONCLUSION

54. Four types of procurement risks have been identified, regarding staff procurement capacity, complex procurement procedures, differences in ADB and government procedures, and procurement of substandard equipment. Capacity in provincial health offices for complex procurement procedures is much less. Also considering the nature of the Project, centralized procurement by GDPM is preferred but based on careful provincial assessment of requirements.

55. Overall risks are assessed as moderate. While GDPM has substantial experience in ADB project procurement, it needs to assure sufficient capacity to mitigate these risks, among others through timely engagement of an international and a national procurement consultant. A procurement risk assessment and management plan have been prepared with appropriate mitigation measures. Procurement monitoring during project implementation will help identify procurement issues to be addressed, as well as compliance with ADB's procurement guidelines.

APPENDIX 1: PROJECT PROCUREMENT RISK ASSESSMENT QUESTIONNAIRE

A. General Department of Preventive Medicine

QUESTION		RESPONSE	RISK[4]
A.	**ORGANIZATIONAL AND STAFF CAPACITY**		
PROCUREMENT DEPARTMENT/UNIT			
A.1	Does the agency or Government have a Procurement Committee that is independent from the head of the agency?	There is Procurement Committee chaired by the vice director of GDPM. The members are staff from related departments	Low
A.2	Does the agency have a procurement department/unit, including a permanent office that performs the function of a Secretariat of the Procurement Committee?	No specific procurement department. Planning & Financing Department is responsible for procurement including a permanent office with coordination of staff of other departments	Substantial
A.3	If yes, what type of procurement does it undertake?	Goods and consulting services	Low
A.4	How many years' experience does the head of the procurement department/unit have in a direct procurement role?	6 years	Moderate
A.5	How many staff in the procurement department/unit are: i. full time ii. part time iii. seconded	All staff are full time But work for project on a part-time basis	Moderate
A.6	Do the procurement staff have a high level of English language proficiency (verbal and written)?	Yes. They are fluency in English	Low
A.7	Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes.	Low
A.8	Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes. Equipped by previous project	Low
A.9	Does the agency have, or have ready access to, a procurement training program?	Yes. Including training program provided by donors such as WB and ADB	Low

[4] Questions indicated with * are associated with potentially 'High' or 'Substantial' risks due to the impact being 'High', therefore the strategy for managing those risks should be addressed in the Project Procurement Risk Analysis (table 3).

QUESTION	RESPONSE	RISK[4]
A.10 At what level does the department/unit report (to the head of agency, deputy etc.)?	To the head of agency	Low
A.11 Do the procurement positions in the agency have job descriptions, which outline specific roles, minimum technical requirements and career routes?	No	Moderate
A.12 Is there a procurement process manual for goods and works?	No. A issued Decree guiding on use of procurement law is served as manual	Moderate
A.13 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016 and allows for foreign-assisted projects	Moderate
A.14 Is there a procurement process manual for consulting services?	No. A issued Decree guiding on use of procurement law is served as manual	Moderate
A.15 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016 and allows for foreign-assisted projects	Moderate
PROJECT MANAGEMENT UNIT		
A.16 Is there a fully (or almost fully) staffed PMU for this project currently in place?	No. A PMU for specific project will be established when the project is approved. At present, there is CDC2 PMU that is manages ADB funded CDC2 project expected to be finished at the end of 2017.	Substantial
A.17 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	No. But experienced staff of GDPM are available	Substantial
A.18 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes. Fully equipped	Low
A.19 Are there standard documents in use, such as Standard Procurement Documents/Forms, and have they been approved for use on ADB funded projects?	Yes. MPI issues standard bidding documents and allowed to be used for foreign--assisted projects. There is also harmonized SBD using for WB and ADB projects. But there is some inconsistence with ADB guidelines CDC2 project uses ADB standard procurement documents	Substantial
A.20 Does the agency follow the national procurement law, procurement processes, and guidelines?	Yes. Procurement law allow to follow donor procedure if there are inconsistencies with donor procedure	Low
A.21 Do TORs for consulting services follow a standard format such as background, tasks, inputs, objectives and outputs?	Yes	Low

QUESTION	RESPONSE	RISK[4]
A.22 Who drafts the procurement specifications?	Member of procurement committee in corporation with staff in other departments and specialists	Low
A.23 Who approves the procurement specifications?	Director of GDMP	Low
A.24 Who in the PMU has experience in drafting bidding documents?	Procurement staff recruited to the PMU	Substantial
A.25 Are records of the sale of bidding documents immediately available?	Yes	Low
A.26 Who identifies the need for consulting services requirements?	Director of GDMP	Low
A.27 Who drafts the Terms of Reference (TOR)	Member of procurement committee in corporation with staff in other departments and specialists (if any)	Low
A.28 Who prepares the request for proposals (RFPs)	Procurement staff recruited to the PMU	Low
B. INFORMATION MANAGEMENT		
B.1 Is there a referencing system for procurement files?	Yes	Low
B.2 Are there adequate resources allocated to record keeping infrastructure, which includes the record keeping system, space, equipment and personnel to administer the procurement records management functions within the agency?	Yes. But no information management system	Moderate
B.3 Does the agency adhere to a document retention policy (i.e. for what period are records kept)?	5 years after project completion as required by government regulations	Low
B.4 Are copies of bids or proposals retained with the evaluation?	Yes	Low
B.5 Are copies of the original advertisements retained with the pre-contract papers?	Yes. Included in evaluation report	Low
B.6 Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes	Low
B.7 Are copies of invoices included with the contract papers?	Yes	Low
B.8 Is the agency's record keeping function supported by IT?	Procurement document are also in the form of electronic file saved in computer	Moderate
C. PROCUREMENT PRACTICES		

QUESTION	RESPONSE	RISK[4]
Goods and Works		
C.1 Has the agency undertaken procurement of goods or works related to foreign assistance recently (last 12 months or last 36 months)? If yes, indicate the names of the development partner/s and project/s.	Yes. ADB funded projects: Preventive Health System Support Project (from March 2006 to June 2014) and on-going Second Greater Mekong Subregion Regional Communicable Diseases Control (CDC2) Project	Low
C.2 If the answer is yes, what were the major challenges faced by the agency?	Following both ADB and government procedure at the same time	Substantial
C.3 Is there a systematic process to identify procurement requirements (for a period of one year or more)?	Yes. The procurement requirement of the project is determined in project budget allocation and procurement plan	Low
C.4 Is there a minimum period for the preparation of bids and if yes, how long?	Yes. NCB: 20 days; ICB: 40 days	Low
C.5 Are all queries from bidders replied to in writing?	Yes	Low
C.6 Does the bidding document state the date and time of bid opening?	Yes	Low
C.7 Are bids opened in public?	Yes	Low
C.8 Can late bids be accepted?	No	Low
C.9 Can bids (except late bids) be rejected at bid opening?	No	Low
C.10 Are minutes of the bid opening taken?	Yes	Low
C.11 Are bidders provided a copy of the minutes?	Yes	Low
C.12 Are the minutes provided free of charge?	Yes	Low
C.13 Who undertakes the evaluation of bids (individual(s), permanent committee, ad-hoc committee)?	Procurement committee	Moderate
C.14 What are the qualifications of the evaluators with respect to procurement and the goods and/or works under evaluation?	Evaluators have certificate on procurement training. Procurement committee includes expert in the field of goods to be procured.	Moderate
C.15 Is the decision of the evaluators final or is the evaluation subject to additional approvals?	No. It needs the approval of GDPM's director after reviewing by appraisal committee	Low
C.16 Using the three 'worst-case' examples in the last year, how long from the issuance of the invitation for		

QUESTION	RESPONSE	RISK[4]
bids can the contract be awarded?		
C.17 Are there processes in place for the collection and clearance of cargo through ports of entry?	Yes. But goods delivered to a final destination	Substantial
C.18 Are there established goods receiving procedures?	Yes	Low
C.19 Are all goods that are received recorded as assets or inventory in a register?	Yes. As requested by the government regulations	Low
C.20 Is the agency/procurement department familiar with letters of credit?	No. But most procurement are locally available	Moderate
C.21 Does the procurement department register and track warranty and latent defects liability periods?	Yes. Excluded goods which were handed-over to beneficent	Low
Consulting Services		
C.22 Has the agency undertaken foreign-assisted procurement of consulting services recently (last 12 months, or last 36 months)? (If yes, please indicate the names of the development partner/s and the Project/s.)	Yes. ADB funded projects: Preventive Health System Support Project (from March 2006 to June 2014) and on-going Second Greater Mekong Subregion Regional Communicable Diseases Control (CDC2) Project	Low
C.23 If the above answer is yes, what were the major challenges?	Follow both ADB and government procedure	Substantial
C.24 Are assignments and invitations for expressions of interest (EOIs) advertised?	Yes	Low
C.25 Is a consultants' selection committee formed with appropriate individuals, and what is its composition (if any)?	Yes. It is procurement committee with specialists of related department	Moderate
C.26 What criteria are used to evaluate EOIs?	Qualification and experience of consultant	Moderate
C.27 Historically, what is the most common method used (QCBS, QBS, etc.) to select consultants?	LCS, ICS	Moderate
C.28 Do firms have to pay for the RFP document?	No	Low
C.29 Does the proposal evaluation criteria follow a pre-determined structure and is it detailed in the RFP?	Yes	Low
C.30 Are pre-proposal visits and meetings arranged?	No	Low
C.31 Are minutes prepared and circulated		N/A

QUESTION	RESPONSE	RISK[4]
after pre-proposal meetings?		
C.32 To whom are the minutes distributed?		N/A
C.33 Are all queries from consultants answered/addressed in writing?	Yes	Low
C.34 Are the technical and financial proposals required to be in separate envelopes and remain sealed until the technical evaluation is completed?	Yes	Low
C.35 Are proposal securities required?	No	
C.36 Are technical proposals opened in public?	Yes	Low
C.37 Are minutes of the technical opening distributed?	Yes	Low
C.39 Who determines the final technical ranking and how?	Procurement committee based on technical score calculating as average of score of evaluators	Low
C.40 Are the technical scores sent to all firms?	Yes	Low
C.41 Are the financial proposal opened in public?	Yes	Low
C.42 Are minutes of the financial opening distributed?	Yes	Low
C.43 How is the financial evaluation completed?	According to criteria stipulated in RFP	Low
C.44 Are face to face contract negotiations held?	Yes	Low
C.45 How long after financial evaluation is negotiation held with the selected firm?	Depends on the approval financial evaluation of project owner. According to new procurement law, this time may be shorter as the approval financial proposal is not required anymore	Moderate
C.46 What is the usual basis for negotiation?	RFP and proposal	Low
C.47 Are minutes of negotiation taken and signed?	Yes	Low
C.48 How long after negotiation is the contract signed, on average?	Depends on the approval of project owner and the donors (if any)	Substantial
C.49 Is there an evaluation system for measuring the outputs of consultants?	No	Moderate

QUESTION	RESPONSE	RISK[4]
Payments		
C.50 Are advance payments made?	Yes. Against the bank guarantee	Low
C.51 What is the standard period for payment included in contracts?	56 days	Low
C.52 On average, how long is it between receiving a firm's invoice and making payment?	10 working days	Low
C.53 When late payment is made, are the beneficiaries paid interest?	No	Moderate
D. EFFECTIVENESS		
D.1 Is contractual performance systematically monitored and reported?	Yes	Low
D.2 Does the agency monitor and track its contractual payment obligations?	Yes	Low
D.3 Is a complaints resolution mechanism described in national procurement documents?	Yes. (Degree 63, Art. 118)	Low
D.4 Is there a formal non-judicial mechanism for dealing with complaints?	Yes. Via Vietnam Arbitration Centre	Low
D.5 Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes	Low
E. ACCOUNTABILITY MEASURES		
E.1 Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes	Low
E.2 Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes	Low
E.3 Is the commencement of procurement dependent on external approvals (formal or de-facto) that are outside of the budgeting process?	No	Low
E.4 Who approves procurement transactions, and do they have procurement experience and	MOH approved procurement plan Director of MOH approve other procurement documents	Moderate

QUESTION		RESPONSE	RISK[4]
	qualifications?		
E.5	Which of the following actions require approvals outside the procurement unit or the evaluation committee, as the case may be, and who grants the approval?		
	a) Bidding document, invitation to pre-qualify or RFP	Director of GDPM supporting by appraisal committee	Low
	b) Advertisement of an invitation for bids, pre-qualification or call for EOIs	Head of PMU	Low
	c) Evaluation reports	Director of GDPM supporting by appraisal committee	Moderate
	d) Notice of award	Director of GDPM	Low
	e) Invitation to consultants to negotiate	Head of PMU	Low
	f) Contracts	Director of GDPM	Low
E.6	Is the same official responsible for: (i) authorizing procurement transactions, procurement invitations, documents, evaluations and contracts; (ii) authorizing payments; (iii) recording procurement transactions and events; and (iv) the custody of assets?	Procurement staff is responsible for (i) and (iii); accountant is responsible for (ii) and (iv)	Low
E.7	Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes	Low

Appendix 1: Project Procurement Risk Assessment Questionnaire

B. Ha Giang Province Department of Health

QUESTION		RESPONSE	RISK[5]
A.	**ORGANIZATIONAL AND STAFF CAPACITY**		
PROCUREMENT DEPARTMENT/UNIT			
A.1	Does the agency or Government have a Procurement Committee that is independent from the head of the agency?	No	Substantial
A.2	Does the agency have a procurement department/unit, including a permanent office that performs the function of a Secretariat of the Procurement Committee?	No specific procurement department. Planning & Financing Department is responsible for procurement	Substantial
A.3	If yes, what type of procurement does it undertake?	Office equipment and works. Works and equipment for medicine waste treatment in hospital (carried out by Health sector PMU)	Low
A.4	How many years' experience does the head of the procurement department/unit have in a direct procurement role?	5 years	Moderate
A.5	How many staff in the procurement department/unit are: i. full time ii. part time iii. seconded	All staff are full time	Moderate
A.6	Do the procurement staff have a high level of English language proficiency (verbal and written)?	No	Moderate
A.7	Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	No.	Substantial
A.8	Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes.	Low
A.9	Does the agency have, or have ready access to, a procurement	Yes. Short term (3 days) as required by procurement law	Substantial

5 Questions indicated with * are associated with potentially 'High' or 'Substantial' risks due to the impact being 'High', therefore the strategy for managing those risks should be addressed in the Project Procurement Risk Analysis (table 3).

QUESTION	RESPONSE	RISK[5]
training program?		
A.10 At what level does the department/unit report (to the head of agency, deputy etc.)?	To the director of PHO	Low
A.11 Do the procurement positions in the agency have job descriptions, which outline specific roles, minimum technical requirements and career routes?	No	Moderate
A.12 Is there a procurement process manual for goods and works?	No. A issued Decree guiding on use of procurement law is served as manual	Moderate
A.13 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016 and allows for foreign-assisted projects	Moderate
A.14 Is there a procurement process manual for consulting services?	No. A issued Decree No 63/2014/NĐ-CP guiding on use of procurement law is served as manual	Moderate
A.15 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016 and allows for foreign-assisted projects	Moderate
PROJECT MANAGEMENT UNIT		
A.16 Is there a fully (or almost fully) staffed PMU for this project currently in place?	No. A PMU for specific project will be established when the project is approved.	High
A.17 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	No PMU for proposed project yet	High
A.18 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes.	Low
A.19 Are there standard documents in use, such as Standard Procurement Documents/Forms, and have they been approved for use on ADB funded projects?	Yes.	Substantial
A.20 Does the agency follow the national procurement law, procurement processes, and guidelines?	Yes	Substantial
A.21 Do TORs for consulting services follow a standard format such as background, tasks, inputs, objectives and outputs?	No experience on consulting services selection	Substantial
A.22 Who drafts the procurement	Professional specialists	Low

QUESTION	RESPONSE	RISK[5]
specifications?		
A.23 Who approves the procurement specifications?	Director of PHO	Low
A.24 Who in the PMU has experience in drafting bidding documents?	Procurement staff	Substantial
A.25 Are records of the sale of bidding documents immediately available?	Yes	Low
A.26 Who identifies the need for consulting services requirements?	No experience on consulting services selection	
A.27 Who drafts the Terms of Reference (TOR)	No experience on consulting services selection	
A.28 Who prepares the request for proposals (RFPs)	No experience on consulting services selection	
B. INFORMATION MANAGEMENT		
B.1 Is there a referencing system for procurement files?	Yes	Low
B.2 Are there adequate resources allocated to record keeping infrastructure, which includes the record keeping system, space, equipment and personnel to administer the procurement records management functions within the agency?	Yes	Moderate
B.3 Does the agency adhere to a document retention policy (i.e. for what period are records kept)?	10 years	Low
B.4 Are copies of bids or proposals retained with the evaluation?	Yes	Low
B.5 Are copies of the original advertisements retained with the pre-contract papers?	Yes. Included in evaluation report	Low
B.6 Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes	Moderate
B.7 Are copies of invoices included with the contract papers?	Yes	Low
B.8 Is the agency's record keeping function supported by IT?	No	Moderate
C. PROCUREMENT PRACTICES		
Goods and Works		
C.1 Has the agency undertaken procurement of goods or works	Yes. WB and ADB projects: - Hospital Waste Management Support	Low

QUESTION	RESPONSE	RISK[5]
related to foreign assistance recently (last 12 months or last 36 months)? If yes, indicate the names of the development partner/s and project/s.	Project funded by WB (Health sector PMU) - Preventive Health System Support Project (ADB funded)	
C.2 If the answer is yes, what were the major challenges faced by the agency?	Following two procedures	Substantial
C.3 Is there a systematic process to identify procurement requirements (for a period of one year or more)?	Annual plan	Moderate
C.4 Is there a minimum period for the preparation of bids and if yes, how long?	According to procurement law	Low
C.5 Are all queries from bidders replied to in writing?	Yes	Low
C.6 Does the bidding document state the date and time of bid opening?	Yes	Low
C.7 Are bids opened in public?	Yes	Low
C.8 Can late bids be accepted?	No	Low
C.9 Can bids (except late bids) be rejected at bid opening?	No	Low
C.10 Are minutes of the bid opening taken?	Yes	Low
C.11 Are bidders provided a copy of the minutes?	Yes	Low
C.12 Are the minutes provided free of charge?	Yes	Low
C.13 Who undertakes the evaluation of bids (individual(s), permanent committee, ad-hoc committee)?	Procurement committee	Moderate
C.14 What are the qualifications of the evaluators with respect to procurement and the goods and/or works under evaluation?	Evaluators have certificate on procurement training.	Substantial
C.15 Is the decision of the evaluators final or is the evaluation subject to additional approvals?	No. It needs the approval of PHO’s director	Low
C.16 Using the three ‘worst-case’ examples in the last year, how long from the issuance of the invitation for bids can the contract be awarded?		
C.17 Are there processes in place for the collection and clearance of cargo through ports of entry?	Yes	Substantial

QUESTION	RESPONSE	RISK[5]
C.18 Are there established goods receiving procedures?	Yes	Low
C.19 Are all goods that are received recorded as assets or inventory in a register?	Yes. As requested by the government regulations	Low
C.20 Is the agency/procurement department familiar with letters of credit?	No	Substantial
C.21 Does the procurement department register and track warranty and latent defects liability periods?	No	Substantial
Consulting Services		
C.22 Has the agency undertaken foreign-assisted procurement of consulting services recently (last 12 months, or last 36 months)? (If yes, please indicate the names of the development partner/s and the Project/s.)	No. Consulting services were selected by CPMU	
C.23 If the above answer is yes, what were the major challenges?		*
C.24 Are assignments and invitations for expressions of interest (EOIs) advertised?		*
C.25 Is a consultants' selection committee formed with appropriate individuals, and what is its composition (if any)?		
C.26 What criteria are used to evaluate EOIs?		
C.27 Historically, what is the most common method used (QCBS, QBS, etc.) to select consultants?		*
C.28 Do firms have to pay for the RFP document?		*
C.29 Does the proposal evaluation criteria follow a pre-determined structure and is it detailed in the RFP?		*
C.30 Are pre-proposal visits and meetings arranged?		
C.31 Are minutes prepared and circulated after pre-proposal meetings?		*
C.32 To whom are the minutes distributed?		*
C.33 Are all queries from consultants answered/addressed in writing?		*

QUESTION	RESPONSE	RISK[5]
C.34 Are the technical and financial proposals required to be in separate envelopes and remain sealed until the technical evaluation is completed?		*
C.35 Are proposal securities required?		*
C.36 Are technical proposals opened in public?		*
C.37 Are minutes of the technical opening distributed?		*
C.39 Who determines the final technical ranking and how?		*
C.40 Are the technical scores sent to all firms?		*
C.41 Are the financial proposal opened in public?		*
C.42 Are minutes of the financial opening distributed?		*
C.43 How is the financial evaluation completed?		*
C.44 Are face to face contract negotiations held?		*
C.45 How long after financial evaluation is negotiation held with the selected firm?		
C.46 What is the usual basis for negotiation?		
C.47 Are minutes of negotiation taken and signed?		*
C.48 How long after negotiation is the contract signed, on average?		
C.49 Is there an evaluation system for measuring the outputs of consultants?		
Payments		
C.50 Are advance payments made?	As stipulated in contract	Low
C.51 What is the standard period for payment included in contracts?	30 days	Low
C.52 On average, how long is it between receiving a firm’s invoice and making payment?	15 days	Low

QUESTION	RESPONSE	RISK[5]
C.53 When late payment is made, are the beneficiaries paid interest?	No	Moderate
D. EFFECTIVENESS		
D.1 Is contractual performance systematically monitored and reported?	Yes	Low
D.2 Does the agency monitor and track its contractual payment obligations?	Yes	Low
D.3 Is a complaints resolution mechanism described in national procurement documents?	Yes. (Procurement Law 43, Art. 91-92)	Low
D.4 Is there a formal non-judicial mechanism for dealing with complaints?	Yes. Via Vietnam Arbitration Centre	Low
D.5 Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes	Low
E. ACCOUNTABILITY MEASURES		
E.1 Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes.	Low
E.2 Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes	Low
E.3 Is the commencement of procurement dependent on external approvals (formal or de-facto) that are outside of the budgeting process?	No	Low
E.4 Who approves procurement transactions, and do they have procurement experience and qualifications?	Procurement Plan: PPC Director of PHO: other procurement documents	Moderate
E.5 Which of the following actions require approvals outside the procurement unit or the evaluation committee, as the case may be, and who grants the approval?		
g) Bidding document, invitation to pre-qualify or RFP	Director of PHO	Low

QUESTION	RESPONSE	RISK[5]
h) Advertisement of an invitation for bids, pre-qualification or call for EOIs	Director of PHO	Low
i) Evaluation reports	Director of PHO	Moderate
j) Notice of award	Director of PHO	Low
k) Invitation to consultants to negotiate	Director of PHO	Low
l) Contracts	Director of PHO	Low
E.6 Is the same official responsible for: (i) authorizing procurement transactions, procurement invitations, documents, evaluations and contracts; (ii) authorizing payments; (iii) recording procurement transactions and events; and (iv) the custody of assets?	No	Low
E.7 Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes	Low

Appendix 1: Project Procurement Risk Assessment Questionnaire

C. Tay Ninh Province Department of Health

	QUESTION	RESPONSE	RISK[6]
A.	**ORGANIZATIONAL AND STAFF CAPACITY**		
PROCUREMENT DEPARTMENT/UNIT			
A.1	Does the agency or Government have a Procurement Committee that is independent from the head of the agency?	No	Substantial
A.2	Does the agency have a procurement department/unit, including a permanent office that performs the function of a Secretariat of the Procurement Committee?	No	Substantial
A.3	If yes, what type of procurement does it undertake?	Drugs Medicine equipment	Low
A.4	How many years' experience does the head of the procurement department/unit have in a direct procurement role?	10 years	Low
A.5	How many staff in the procurement department/unit are: i. full time ii. part time iii. seconded	All staff are full time	Moderate
A.6	Do the procurement staff have a high level of English language proficiency (verbal and written)?	No	Moderate
A.7	Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	No	Substantial
A.8	Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes	Low
A.9	Does the agency have, or have ready access to, a procurement	All staff involved in procurement tasks have attended procurement course according to	*

[6] Questions indicated with * are associated with potentially 'High' or 'Substantial' risks due to the impact being 'High', therefore the strategy for managing those risks should be addressed in the Project Procurement Risk Analysis (table 3).

QUESTION	RESPONSE	RISK[6]
training program?	Government procurement regulations	Substantial
A.10 At what level does the department/unit report (to the head of agency, deputy etc.)?	To the director of PHO	Low
A.11 Do the procurement positions in the agency have job descriptions, which outline specific roles, minimum technical requirements and career routes?	No	Moderate
A.12 Is there a procurement process manual for goods and works?	No. A issued Decree guiding on use of procurement law is served as manual	Moderate
A.13 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016. and allows for foreign-assisted projects	Moderate
A.14 Is there a procurement process manual for consulting services?	No. A issued Decree No 63/2014/NĐ-CP guiding on use of procurement law is served as manual	Moderate
A.15 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016 and allows for foreign-assisted projects	Moderate
Procurement Management Unit		
A.16 Is there a fully (or almost fully) staffed PMU for this project currently in place?	No PMU will be established	High
A.17 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	No	High
A.18 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes	Low
A.19 Are there standard documents in use, such as Standard Procurement Documents/Forms, and have they been approved for use on ADB funded projects?	Yes	Substantial
A.20 Does the agency follow the national procurement law, procurement processes, and guidelines?	Yes	Substantial
A.21 Do ToRs for consulting services follow a standard format such as background, tasks, inputs, objectives and outputs?	No experience on consulting services selection	Substantial
A.22 Who drafts the procurement	Member of procurement committee	Low

QUESTION	RESPONSE	RISK[6]
specifications?		
A.23 Who approves the procurement specifications?	Director of PHO	Low
A.24 Who in the PMU has experience in drafting bidding documents?	Procurement staff	Substantial
A.25 Are records of the sale of bidding documents immediately available?	Yes	Low
A.26 Who identifies the need for consulting services requirements?	No experience on consulting services selection	
A.27 Who drafts the Terms of Reference (TOR)	No experience on consulting services selection	
A.28 Who prepares the request for proposals (RFPs)	No experience on consulting services selection	
B. INFORMATION MANAGEMENT		
B.1 Is there a referencing system for procurement files?	Yes	Low
B.2 Are there adequate resources allocated to record keeping infrastructure, which includes the record keeping system, space, equipment and personnel to administer the procurement records management functions within the agency?	Yes	Moderate
B.3 Does the agency adhere to a document retention policy (i.e. for what period are records kept)?	10 years	Low
B.4 Are copies of bids or proposals retained with the evaluation?	Original bid retained	Low
B.5 Are copies of the original advertisements retained with the pre-contract papers?	Yes. Included in evaluation report	Low
B.6 Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Not yet met requirements	Moderate
B.7 Are copies of invoices included with the contract papers?	Yes	Low
B.8 Is the agency's record keeping function supported by IT?	No	Moderate
C. PROCUREMENT PRACTICES		
Goods and Works		
C.1 Has the agency undertaken procurement of goods or works	No	Substantial

QUESTION	RESPONSE	RISK[6]
related to foreign assistance recently (last 12 months or last 36 months)? If yes, indicate the names of the development partner/s and project/s.		
C.2 If the answer is yes, what were the major challenges faced by the agency?		*
C.3 Is there a systematic process to identify procurement requirements (for a period of one year or more)?	No	Moderate
C.4 Is there a minimum period for the preparation of bids and if yes, how long?	Yes. From 5 to 40 days according to procurement method as stipulated in procurement law 43(article 12)	Low
C.5 Are all queries from bidders replied to in writing?	Yes	Low
C.6 Does the bidding document state the date and time of bid opening?	Yes	Low
C.7 Are bids opened in public?	Yes	Low
C.8 Can late bids be accepted?	No	Low
C.9 Can bids (except late bids) be rejected at bid opening?	No	Low
C.10 Are minutes of the bid opening taken?	Yes	Low
C.11 Are bidders provided a copy of the minutes?	Yes	Low
C.12 Are the minutes provided free of charge?	Yes	Low
C.13 Who undertakes the evaluation of bids (individual(s), permanent committee, ad-hoc committee)?	Procurement committee	Moderate
C.14 What are the qualifications of the evaluators with respect to procurement and the goods and/or works under evaluation?	Evaluators have certificate on procurement training.	Substantial
C.15 Is the decision of the evaluators final or is the evaluation subject to additional approvals?	No. It needs the approval of PHO’s director after appraisal	Low
C.16 Using the three ‘worst-case’ examples in the last year, how long from the issuance of the invitation for bids can the contract be awarded?		
C.17 Are there processes in place for the collection and clearance of cargo through ports of entry?	No. Not receive goods at port, only at final destination	Substantial

QUESTION	RESPONSE	RISK[6]
C.18 Are there established goods receiving procedures?	Yes	Low
C.19 Are all goods that are received recorded as assets or inventory in a register?	Yes. As requested by the government regulations	Low
C.20 Is the agency/procurement department familiar with letters of credit?	No	Substantial
C.21 Does the procurement department register and track warranty and latent defects liability periods?	Yes	Substantial
Consulting Services		
C.22 Has the agency undertaken foreign-assisted procurement of consulting services recently (last 12 months, or last 36 months)? (If yes, please indicate the names of the development partner/s and the Project/s.)	No. Consulting services were selected by CPMU	*
C.23 If the above answer is yes, what were the major challenges?		*
C.24 Are assignments and invitations for expressions of interest (EOIs) advertised?		*
C.25 Is a consultants' selection committee formed with appropriate individuals, and what is its composition (if any)?		
C.26 What criteria are used to evaluate EOIs?		
C.27 Historically, what is the most common method used (QCBS, QBS, etc.) to select consultants?		*
C.28 Do firms have to pay for the RFP document?		*
C.29 Does the proposal evaluation criteria follow a pre-determined structure and is it detailed in the RFP?		*
C.30 Are pre-proposal visits and meetings arranged?		
C.31 Are minutes prepared and circulated after pre-proposal meetings?		*
C.32 To whom are the minutes distributed?		*
C.33 Are all queries from consultants answered/addressed in writing?		*

QUESTION	RESPONSE	RISK[6]
C.34 Are the technical and financial proposals required to be in separate envelopes and remain sealed until the technical evaluation is completed?		*
C.35 Are proposal securities required?		*
C.36 Are technical proposals opened in public?		*
C.37 Are minutes of the technical opening distributed?		*
C.39 Who determines the final technical ranking and how?		*
C.40 Are the technical scores sent to all firms?		*
C.41 Are the financial proposal opened in public?		*
C.42 Are minutes of the financial opening distributed?		*
C.43 How is the financial evaluation completed?		*
C.44 Are face to face contract negotiations held?		*
C.45 How long after financial evaluation is negotiation held with the selected firm?		
C.46 What is the usual basis for negotiation?		
C.47 Are minutes of negotiation taken and signed?		*
C.48 How long after negotiation is the contract signed, on average?		
C.49 Is there an evaluation system for measuring the outputs of consultants?		
Payments		
C.50 Are advance payments made?	Dependents on specific contract	Low
C.51 What is the standard period for payment included in contracts?	30 days	Low
C.52 On average, how long is it between receiving a firm's invoice and making payment?	15 days	Low

QUESTION	RESPONSE	RISK[6]
C.53 When late payment is made, are the beneficiaries paid interest?	Not applicable	Low
D. EFFECTIVENESS		
D.1 Is contractual performance systematically monitored and reported?	Yes	Low
D.2 Does the agency monitor and track its contractual payment obligations?	Yes	Low
D.3 Is a complaints resolution mechanism described in national procurement documents?	Yes. (Degree 63, Art. 118)	Low
D.4 Is there a formal non-judicial mechanism for dealing with complaints?	Yes. Via Vietnam Arbitration Centre	Low
D.5 Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes	Low
E. ACCOUNTABILITY MEASURES		
E.1 Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes	Low
E.2 Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes	Low
E.3 Is the commencement of procurement dependent on external approvals (formal or de-facto) that are outside of the budgeting process?	Yes	Low
E.4 Who approves procurement transactions, and do they have procurement experience and qualifications?	Provincial People Committee based on appraisal of Department of Finance	Moderate
E.5 Which of the following actions require approvals outside the procurement unit or the evaluation committee, as the case may be, and who grants the approval?		
a) Bidding document, invitation to pre-qualify or RFP	Director of PHO	Low

QUESTION		RESPONSE	RISK[6]
	b) Advertisement of an invitation for bids, pre-qualification or call for EOIs	Director of PHO	Low
	c) Evaluation reports	Director of PHO	Moderate
	d) Notice of award	Director of PHO	Low
	e) Invitation to consultants to negotiate	Director of PHO	Low
	f) Contracts	Director of PHO	Low
E.6	Is the same official responsible for: (i) authorizing procurement transactions, procurement invitations, documents, evaluations and contracts; (ii) authorizing payments; (iii) recording procurement transactions and events; and (iv) the custody of assets?	No	Low
E.7	Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes	Low

Appendix 1: Project Procurement Risk Assessment Questionnaire

D. Dien Bien Province Department of Health

QUESTION		RESPONSE	RISK[7]
A.	**ORGANIZATIONAL AND STAFF CAPACITY**		
PROCUREMENT DEPARTMENT/UNIT			
A.1	Does the agency or Government have a Procurement Committee that is independent from the head of the agency?	No	Substantial
A.2	Does the agency have a procurement department/unit, including a permanent office that performs the function of a Secretariat of the Procurement Committee?	No Division of Planning & Financing is in charge of procurement of drug and office equipment. Health sector PMU for investment construction projects	Substantial
A.3	If yes, what type of procurement does it undertake?	office equipment; Drug Works and equipment for medicine waste treatment in hospital (Health professional PMU)	Low
A.4	How many years' experience does the head of the procurement department/unit have in a direct procurement role?	Over 5 years	Moderate
A.5	How many staff in the procurement department/unit are: i. full time ii. part time iii. seconded	All staff are full time	Moderate
A.6	Do the procurement staff have a high level of English language proficiency (verbal and written)?	Have basic level	Substantial
A.7	Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes. But they work for projects only on part-time basis	Substantial
A.8	Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes	Low
A.9	Does the agency have, or have	Yes. Short term (3 days) required by	Low

[7] Questions indicated with * are associated with potentially 'High' or 'Substantial' risks due to the impact being 'High', therefore the strategy for managing those risks should be addressed in the Project Procurement Risk Analysis (table 3).

QUESTION	RESPONSE	RISK[7]
ready access to, a procurement training program?	procurement law; short terms course on WB and ADB procurement procedures organized by CPMU	
A.10 At what level does the department/unit report (to the head of agency, deputy etc.)?	To the director of PHO	Low
A.11 Do the procurement positions in the agency have job descriptions, which outline specific roles, minimum technical requirements and career routes?	No	Moderate
A.12 Is there a procurement process manual for goods and works?	No. Decree guiding on use of procurement law is served as manual	Moderate
A.13 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016. and allows for foreign-assisted projects	Moderate
A.14 Is there a procurement process manual for consulting services?	No. Decree No 63/2014/NĐ-CP guiding on use of procurement law is served as manual	Moderate
A.15 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016 allows using for foreign-assisted projects	Moderate
PROJECT MANAGEMENT UNIT		
A.16 Is there a fully (or almost fully) staffed PMU for this project currently in place?	No. A PMU for specific project will be established when the project is approved. The Health professional PMU is only for investment construction projects	High
A.17 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	PMU not yet established	High
A.18 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes.	Low
A.19 Are there standard documents in use, such as Standard Procurement Documents/Forms, and have they been approved for use on ADB funded projects?	Yes. But there are discrepancies in comparison with those of ADB	Substantial
A.20 Does the agency follow the national procurement law, procurement processes, and guidelines?	Yes. But have some inconsistences from ADB guidelines	Substantial
A.21 Do ToRs for consulting services follow a standard format such as background, tasks, inputs, objectives and outputs?	No experience on consulting services selection	Substantial

QUESTION	RESPONSE	RISK[7]
A.22 Who drafts the procurement specifications?	Professional specialists	Low
A.23 Who approves the procurement specifications?	Director of PHO	Low
A.24 Who in the PMU has experience in drafting bidding documents?	Procurement staff	Substantial
A.25 Are records of the sale of bidding documents immediately available?	Yes	Low
A.26 Who identifies the need for consulting services requirements?	No experience on consulting services selection	
A.27 Who drafts the Terms of Reference (TOR)	No experience on consulting services selection	
A.28 Who prepares the request for proposals (RFPs)	No experience on consulting services selection	
B. INFORMATION MANAGEMENT		
B.1 Is there a referencing system for procurement files?	Yes	Low
B.2 Are there adequate resources allocated to record keeping infrastructure, which includes the record keeping system, space, equipment and personnel to administer the procurement records management functions within the agency?	Yes. But in more than departments	Moderate
B.3 Does the agency adhere to a document retention policy (i.e. for what period are records kept)?	At least 05 years according to applicable regulation	Low
B.4 Are copies of bids or proposals retained with the evaluation?	Yes	Low
B.5 Are copies of the original advertisements retained with the pre-contract papers?	Yes. Included in evaluation report	Low
B.6 Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes	Low
B.7 Are copies of invoices included with the contract papers?	Yes	Low
B.8 Is the agency's record keeping function supported by IT?	No	Low
C. PROCUREMENT PRACTICES		
Goods and Works		

QUESTION	RESPONSE	RISK[7]
C.1 Has the agency undertaken procurement of goods or works related to foreign assistance recently (last 12 months or last 36 months)? If yes, indicate the names of the development partner/s and project/s.	Yes. WB and ADB projects: - Hospital Waste Management Support Project (WB funded) - Northern Uplands Health Support Project (WB funded) - Preventive Health System Support Project (ADB funded) - Greater Mekong Subregion Regional Communicable Diseases Control Project	Low
C.2 If the answer is yes, what were the major challenges faced by the agency?	Combine donor's procedure and government procedure	Substantial
C.3 Is there a systematic process to identify procurement requirements (for a period of one year or more)?	For drug	Low
C.4 Is there a minimum period for the preparation of bids and if yes, how long?	Yes. From 5 to 40 days according to procurement method as stipulated in procurement law (article 12)	Low
C.5 Are all queries from bidders replied to in writing?	Yes	Low
C.6 Does the bidding document state the date and time of bid opening?	Yes	Low
C.7 Are bids opened in public?	Yes	Low
C.8 Can late bids be accepted?	No	Low
C.9 Can bids (except late bids) be rejected at bid opening?	No	Low
C.10 Are minutes of the bid opening taken?	Yes	Low
C.11 Are bidders provided a copy of the minutes?	Yes	Low
C.12 Are the minutes provided free of charge?	Yes	Low
C.13 Who undertakes the evaluation of bids (individual(s), permanent committee, ad-hoc committee)?	Ad-hoc committee	Moderate
C.14 What are the qualifications of the evaluators with respect to procurement and the goods and/or works under evaluation?	Procurement committee members including related specialist all have certificate on procurement training as required by procurement regulations	Moderate
C.15 Is the decision of the evaluators final or is the evaluation subject to additional approvals?	No. It needs the approval of PHO's director	Low
C.16 Using the three 'worst-case' examples in the last year, how long from the issuance of the invitation for		

QUESTION	RESPONSE	RISK[7]
bids can the contract be awarded?		
C.17 Are there processes in place for the collection and clearance of cargo through ports of entry?	No. But do not receive goods at port, only at final destination	Substantial
C.18 Are there established goods receiving procedures?	Yes	Low
C.19 Are all goods that are received recorded as assets or inventory in a register?	Yes. As requested by the government regulations	Low
C.20 Is the agency/procurement department familiar with letters of credit?	No	Substantial
C.21 Does the procurement department register and track warranty and latent defects liability periods?	No	Substantial
Consulting Services		
C.22 Has the agency undertaken foreign-assisted procurement of consulting services recently (last 12 months, or last 36 months)? (If yes, please indicate the names of the development partner/s and the Project/s.)	No. Consulting services were selected by CPMU	*
C.23 If the above answer is yes, what were the major challenges?		*
C.24 Are assignments and invitations for expressions of interest (EOIs) advertised?		*
C.25 Is a consultants' selection committee formed with appropriate individuals, and what is its composition (if any)?		
C.26 What criteria are used to evaluate EOIs?		
C.27 Historically, what is the most common method used (QCBS, QBS, etc.) to select consultants?		*
C.28 Do firms have to pay for the RFP document?		*
C.29 Does the proposal evaluation criteria follow a pre-determined structure and is it detailed in the RFP?		*
C.30 Are pre-proposal visits and meetings arranged?		
C.31 Are minutes prepared and circulated after pre-proposal meetings?		*

QUESTION	RESPONSE	RISK[7]
C.32 To whom are the minutes distributed?		*
C.33 Are all queries from consultants answered/addressed in writing?		*
C.34 Are the technical and financial proposals required to be in separate envelopes and remain sealed until the technical evaluation is completed?		*
C.35 Are proposal securities required?		*
C.36 Are technical proposals opened in public?		*
C.37 Are minutes of the technical opening distributed?		*
C.39 Who determines the final technical ranking and how?		*
C.40 Are the technical scores sent to all firms?		*
C.41 Are the financial proposal opened in public?		*
C.42 Are minutes of the financial opening distributed?		*
C.43 How is the financial evaluation completed?		*
C.44 Are face to face contract negotiations held?		*
C.45 How long after financial evaluation is negotiation held with the selected firm?		
C.46 What is the usual basis for negotiation?		
C.47 Are minutes of negotiation taken and signed?		*
C.48 How long after negotiation is the contract signed, on average?		
C.49 Is there an evaluation system for measuring the outputs of consultants?		
Payments		
C.50 Are advance payments made?		
C.51 What is the standard period for	14 days	Low

QUESTION		RESPONSE	RISK[7]
	payment included in contracts?		
C.52	On average, how long is it between receiving a firm's invoice and making payment?	14 days	Low
C.53	When late payment is made, are the beneficiaries paid interest?	No	Moderate
D. EFFECTIVENESS			
D.1	Is contractual performance systematically monitored and reported?	Yes	Low
D.2	Does the agency monitor and track its contractual payment obligations?	Yes	Low
D.3	Is a complaints resolution mechanism described in national procurement documents?	Yes. (Procurement Law 43, Art. 91-92)	Low
D.4	Is there a formal non-judicial mechanism for dealing with complaints?	Yes. Via Vietnam Arbitration Centre	Low
D.5	Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes	Low
E. ACCOUNTABILITY MEASURES			
E.1	Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes.	Low
E.2	Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes	Low
E.3	Is the commencement of procurement dependent on external approvals (formal or de-facto) that are outside of the budgeting process?	Yes. Some needs the approval of PPC	Substantial
E.4	Who approves procurement transactions, and do they have procurement experience and qualifications?	PPC with supporting of appraisal of Department of Finance. In some case PHO was authorized.	Moderate
E.5	Which of the following actions require approvals outside the procurement unit or the evaluation		

QUESTION		RESPONSE	RISK[7]
	committee, as the case may be, and who grants the approval?		
	m) Bidding document, invitation to pre-qualify or RFP	Director of PHO	Low
	n) Advertisement of an invitation for bids, pre-qualification or call for EOIs	Head of PMU	Low
	o) Evaluation reports	Director of PHO	Moderate
	p) Notice of award	Director of PHO	Low
	q) Invitation to consultants to negotiate	Head of PMU	Low
	r) Contracts	Director of PHO	Low
E.6	Is the same official responsible for: (i) authorizing procurement transactions, procurement invitations, documents, evaluations and contracts; (ii) authorizing payments; (iii) recording procurement transactions and events; and (iv) the custody of assets?	No. Procurement official responsible for procurement related activities, financial responsible for financial related activities	Low
E.7	Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes	Low

Appendix 1: Project Procurement Risk Assessment Questionnaire

E. Gia Lai Province Department of Health

QUESTION	RESPONSE	RISK[8]
A. ORGANIZATIONAL AND STAFF CAPACITY		
PROCUREMENT DEPARTMENT/UNIT		
A.1 Does the agency or Government have a Procurement Committee that is independent from the head of the agency?	No	Substantial
A.2 Does the agency have a procurement department/unit, including a permanent office that performs the function of a Secretariat of the Procurement Committee?	No Division of Planning & Financing is in charge of procurement of drug and office equipment. Health professional PMU for investment construction projects	Substantial
A.3 If yes, what type of procurement does it undertake?	Drug Works and equipment for medicine waste treatment in hospital (Health professional PMU)	Low
A.4 How many years' experience does the head of the procurement department/unit have in a direct procurement role?	8 years	Low
A.5 How many staff in the procurement department/unit are: i. full time ii. part time iii. seconded	All staff are full time	Moderate
A.6 Do the procurement staff have a high level of English language proficiency (verbal and written)?	No	Moderate
A.7 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	Yes	Substantial
A.8 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes. Equipped by previous projects	Low
A.9 Does the agency have, or have	Yes. Short term in accordance with	Low

[8] Questions indicated with * are associated with potentially 'High' or 'Substantial' risks due to the impact being 'High', therefore the strategy for managing those risks should be addressed in the Project Procurement Risk Analysis (table 3).

QUESTION	RESPONSE	RISK[8]
ready access to, a procurement training program?	government regulations; short terms course on WB and ADB procurement procedures organized by CPMU, donors	
A.10 At what level does the department/unit report (to the head of agency, deputy etc.)?	To the director of PHO	Low
A.11 Do the procurement positions in the agency have job descriptions, which outline specific roles, minimum technical requirements and career routes?	No	Moderate
A.12 Is there a procurement process manual for goods and works?	No. Decree guiding on use of procurement law is served as manual.	Moderate
A.13 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree 63/2014/NĐ-CP is used. It allows to use for foreign-assisted projects	Moderate
A.14 Is there a procurement process manual for consulting services?	No. Decree No 63/2014/NĐ-CP guiding on use of procurement law is served as manual	Moderate
A.15 If there is a manual, is it up to date and does it cover foreign-assisted projects?	Degree No 63/2014/NĐ-CP issued on 26 June 2016 allows using for foreign-assisted projects	Moderate
PROJECT MANAGEMENT UNIT		
A.16 Is there a fully (or almost fully) staffed PMU for this project currently in place?	No. A PMU for specific project will be established when the project is approved. The Health professional PMU is in charged only for investment construction projects	High
A.17 Are the number and qualifications of the staff sufficient to undertake the additional procurement that will be required under the proposed project?	PMU not yet established	High
A.18 Does the unit have adequate facilities, such as PCs, internet connection, photocopy facilities, printers etc. to undertake the planned procurement?	Yes.	Low
A.19 Are there standard documents in use, such as Standard Procurement Documents/Forms, and have they been approved for use on ADB funded projects?	Yes. Issued by MPI with some differences from the ADB documents	Substantial
A.20 Does the agency follow the national procurement law, procurement processes, and guidelines?	Yes.	Substantial
A.21 Do ToRs for consulting services follow a standard format such as background, tasks, inputs, objectives and outputs?	No experience on consulting services selection	Substantial

QUESTION	RESPONSE	RISK[8]
A.22 Who drafts the procurement specifications?	Benefit organization	Low
A.23 Who approves the procurement specifications?	Director of PHO	Low
A.24 Who in the PMU has experience in drafting bidding documents?	Procurement staff	Substantial
A.25 Are records of the sale of bidding documents immediately available?	Yes	Low
A.26 Who identifies the need for consulting services requirements?	No experience on consulting services selection	
A.27 Who drafts the Terms of Reference (TOR)	No experience on consulting services selection	
A.28 Who prepares the request for proposals (RFPs)	No experience on consulting services selection	
B. INFORMATION MANAGEMENT		
B.1 Is there a referencing system for procurement files?	Yes	Low
B.2 Are there adequate resources allocated to record keeping infrastructure, which includes the record keeping system, space, equipment and personnel to administer the procurement records management functions within the agency?	Yes	Moderate
B.3 Does the agency adhere to a document retention policy (i.e. for what period are records kept)?	10 years	Low
B.4 Are copies of bids or proposals retained with the evaluation?	Yes	Low
B.5 Are copies of the original advertisements retained with the pre-contract papers?	Yes.	Low
B.6 Is there a single contract file with a copy of the contract and all subsequent contractual correspondence?	Yes. In Planning & financial department	Low
B.7 Are copies of invoices included with the contract papers?	Yes	Low
B.8 Is the agency's record keeping function supported by IT?	Procurement documents store in computers	Low
C. PROCUREMENT PRACTICES		
Goods and Works		

QUESTION	RESPONSE	RISK[8]
C.1 Has the agency undertaken procurement of goods or works related to foreign assistance recently (last 12 months or last 36 months)? If yes, indicate the names of the development partner/s and project/s.	Yes. WB and ADB projects: - Healthcare Support to the Poor of the Northern Upland and Central Highlands Project (WB funded) - Greater Mekong Subregion Regional Communicable Diseases Control Project (ADB funded) - Second Health Care in the Central Highlands Project (ADB funded) -	Low
C.2 If the answer is yes, what were the major challenges faced by the agency?	Government regulations is changing from time to time	Substantial
C.3 Is there a systematic process to identify procurement requirements (for a period of one year or more)?	Procurement plan	Low
C.4 Is there a minimum period for the preparation of bids and if yes, how long?	Yes. NCB minimum 20 days; Shopping 7 days	Low
C.5 Are all queries from bidders replied to in writing?	Yes	Low
C.6 Does the bidding document state the date and time of bid opening?	Yes	Low
C.7 Are bids opened in public?	Yes	Low
C.8 Can late bids be accepted?	No	Low
C.9 Can bids (except late bids) be rejected at bid opening?	No	Low
C.10 Are minutes of the bid opening taken?	Yes	Low
C.11 Are bidders provided a copy of the minutes?	Yes	Low
C.12 Are the minutes provided free of charge?	Yes	Low
C.13 Who undertakes the evaluation of bids (individual(s), permanent committee, ad-hoc committee)?	Ad-hoc committee	Moderate
C.14 What are the qualifications of the evaluators with respect to procurement and the goods and/or works under evaluation?	Procurement committee members including related specialists	Moderate
C.15 Is the decision of the evaluators final or is the evaluation subject to additional approvals?	No. It needs the approval of PHO after appraisal by appraisal committee	Low
C.16 Using the three 'worst-case'		

QUESTION	RESPONSE	RISK[8]
examples in the last year, how long from the issuance of the invitation for bids can the contract be awarded?		
C.17 Are there processes in place for the collection and clearance of cargo through ports of entry?	No. Not receive goods at port, only at final destination	Substantial
C.18 Are there established goods receiving procedures?	Yes. In accordance with contracts	Low
C.19 Are all goods that are received recorded as assets or inventory in a register?	Yes. As requested by the government regulations	Low
C.20 Is the agency/procurement department familiar with letters of credit?	No	Substantial
C.21 Does the procurement department register and track warranty and latent defects liability periods?	Yes	Substantial
Consulting Services		
C.22 Has the agency undertaken foreign-assisted procurement of consulting services recently (last 12 months, or last 36 months)? (If yes, please indicate the names of the development partner/s and the Project/s.)	No. Consulting services were selected by CPMU.	*
C.23 If the above answer is yes, what were the major challenges?		*
C.24 Are assignments and invitations for expressions of interest (EOIs) advertised?		*
C.25 Is a consultants' selection committee formed with appropriate individuals, and what is its composition (if any)?		
C.26 What criteria are used to evaluate EOIs?		
C.27 Historically, what is the most common method used (QCBS, QBS, etc.) to select consultants?		*
C.28 Do firms have to pay for the RFP document?		*
C.29 Does the proposal evaluation criteria follow a pre-determined structure and is it detailed in the RFP?		*
C.30 Are pre-proposal visits and meetings arranged?		

QUESTION	RESPONSE	RISK[8]
C.31 Are minutes prepared and circulated after pre-proposal meetings?		*
C.32 To whom are the minutes distributed?		*
C.33 Are all queries from consultants answered/addressed in writing?		*
C.34 Are the technical and financial proposals required to be in separate envelopes and remain sealed until the technical evaluation is completed?		*
C.35 Are proposal securities required?		*
C.36 Are technical proposals opened in public?		*
C.37 Are minutes of the technical opening distributed?		*
C.39 Who determines the final technical ranking and how?		*
C.40 Are the technical scores sent to all firms?		*
C.41 Are the financial proposal opened in public?		*
C.42 Are minutes of the financial opening distributed?		*
C.43 How is the financial evaluation completed?		*
C.44 Are face to face contract negotiations held?		*
C.45 How long after financial evaluation is negotiation held with the selected firm?		
C.46 What is the usual basis for negotiation?		
C.47 Are minutes of negotiation taken and signed?		*
C.48 How long after negotiation is the contract signed, on average?		
C.49 Is there an evaluation system for measuring the outputs of consultants?		
Payments		

QUESTION	RESPONSE	RISK[8]
C.50 Are advance payments made?	According to specific contract	Low
C.51 What is the standard period for payment included in contracts?	14 days	Low
C.52 On average, how long is it between receiving a firm's invoice and making payment?	14 days	Low
C.53 When late payment is made, are the beneficiaries paid interest?	no	Low
D. EFFECTIVENESS		
D.1 Is contractual performance systematically monitored and reported?	Yes. Progress Report submitted quarterly	Low
D.2 Does the agency monitor and track its contractual payment obligations?	Yes	Low
D.3 Is a complaints resolution mechanism described in national procurement documents?	Yes. (Procurement Law 43, Art. 91-92)	Low
D.4 Is there a formal non-judicial mechanism for dealing with complaints?	Yes. Via Viet Nam Arbitration Center	Low
D.5 Are procurement decisions and disputes supported by written narratives such as minutes of evaluation, minutes of negotiation, notices of default/withheld payment?	Yes	Low
E. ACCOUNTABILITY MEASURES		
E.1 Is there a standard statement of ethics and are those involved in procurement required to formally commit to it?	Yes. Stated in procurement law and bidding document	Low
E.2 Are those involved with procurement required to declare any potential conflict of interest and remove themselves from the procurement process?	Yes	Low
E.3 Is the commencement of procurement dependent on external approvals (formal or de-facto) that are outside of the budgeting process?	No	Low
E.4 Who approves procurement transactions, and do they have procurement experience and qualifications?	PPC approve procurement plan with supporting of appraisal of Department of Planning & Investment. PHO for the rest of procurement document	Moderate

QUESTION	RESPONSE	RISK[8]
E.5 Which of the following actions require approvals outside the procurement unit or the evaluation committee, as the case may be, and who grants the approval?		
s) Bidding document, invitation to pre-qualify or RFP	Head of PHO	Low
t) Advertisement of an invitation for bids, pre-qualification or call for EOIs	Head of PMU	Low
u) Evaluation reports	Head of PHO	Moderate
v) Notice of award	Head of PHO	Low
w) Invitation to consultants to negotiate	Head of PMU	Low
x) Contracts	Head of PHO	Low
E.6 Is the same official responsible for: (i) authorizing procurement transactions, procurement invitations, documents, evaluations and contracts; (ii) authorizing payments; (iii) recording procurement transactions and events; and (iv) the custody of assets?	No	Low
E.7 Is there a written auditable trail of procurement decisions attributable to individuals and committees?	Yes	Low

APPENDIX 2: DRAFT PROCUREMENT PLAN

Basic Data

Project Name: Greater Mekong Subregion Health Security Project	
Project Number:	**Approval Number**:
Country: VIET NAM	**Executing Agency**: Ministry of Health (MOH)
Project Financing Amount: **ADB Financing:** **Non-ADB Financing:**	**Implementing Agency:** General Department of Preventive Medicine - MOH
Date of First Procurement Plan {loan (grant) approval date}:	**Date of this Procurement Plan**: 29 April 2016

A. Methods, Thresholds, Review and 18-Month Procurement Plan

1. Procurement and Consulting Methods and Thresholds

Except as the Asian Development Bank (ADB) may otherwise agree, the following process thresholds shall apply to procurement of goods and works.

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
International Competitive Bidding for Goods	$5,000,000	Prior review shall be applied for all packages
National Competitive Bidding for Goods	Beneath that stated for ICB, Goods	Prior review shall be applied for first type of procurement for each IA
Shopping for Goods	$100,000 and below	
Shopping for Works	$30,000 and below	NA

Consulting Services	
Method	**Comments**
Consultant Qualification Selection	Prior Review shall be applied for all packages:
Least-Cost Selection	
Individual Consultants Selection	
Fixed Budget Selection (FBS)	

2. Goods and Works Contracts Estimated to Cost $1 Million or More

The following table lists goods and works contracts for which the procurement activity is either ongoing or expected to commence within the next 18 months.

Package Number	**General Description**	**Estimated Value**	**Procurement Method**	**Review** (Prior / Post)	**Bidding Procedure**	**Advertisement Date** (quarter/year)	**Comments**
	Vehicles	7,525,000	ICB	Prior	1S1E		Goods
	Laboratory High-tech Equipment (multiple)	17,290,000	NCB	Prior/Post	1S1E		**Goods**
	Laboratory Standard Equipment (multiple)	7,480,000	NCB	Prior/Post	1S1E		**Goods**
	Hospital Equipment (multiple)	13,600	NCB	Prior/Post	1S1E		**Goods**
	Office, IT equipment	2,952,000	NCB	Post	1S1E		**Goods**

3. Consulting Services Contracts Estimated to Cost $100,000 or More

The following table lists consulting services contracts for which the recruitment activity is either ongoing or expected to commence within the next 18 months.

Package Number	**General Description**	**Estimated Value**	**Recruitment Method**	**Review** (Prior / Post)	**Advertisement Date** (quarter/year)	**Type of Proposal**	**Comments**
	International Technical Advisor	372,000	ICS	Prior		Biodata	International
	Baseline Survey	150,000	LCS	Prior		Biodata	National
	International Procurement Specialist	195,000	ICS	Prior		Biodata	International
	National Procurement Specialist	126,000	ICS	Prior		Biodata	National

4. Goods and Works Contracts Estimated to Cost Less than $1 Million and Consulting Services Contracts Less than $100,000 (Smaller Value Contracts)

The following table groups smaller-value goods, works and consulting services contracts for which the activity is either ongoing or expected to commence within the next 18 months.

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Procurement Method**	**Review** (Prior / Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
	Civil Works	3,434,000	(multiple)	Shopping	Post	1S1E		
	Laboratory Small Equipment	230,000	(multiple)	Shopping	Prior / Post	1S1E		Goods
	Outbreak Equipment	230,000	(multiple)	Shopping	Prior / Post	1S1E		Goods

Consulting Services								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Recruitment Method**	**Review** (Prior / Post)	**Advertisement Date** (quarter/ year)	**Type of Proposal**	**Comments**
	Financial Audit	30,000	1	LCS	Prior		Biodata	International
	International Gender Specialist	8,000	1	ICS	Post		Biodata	International
	National Training Specialist	60,000	1	ICS	Prior		Biodata	National
	National Gender Specialist	13,000	1	ICS	Post		Biodata	National
	National Project Implementation Adviser	81,000	1	ICS	Prior		Biodata	National

B. Indicative List of Packages Required Under the Project

The following table provides an indicative list of goods, works and consulting services contracts over the life of the project, other than those mentioned in previous sections (i.e., those expected beyond the current period).

Goods and Works							
Package Number	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Procurement Method**	**Review** (Prior / Post)	**Bidding Procedure**	**Comments**
	Civil Works	3,434,000	Multiple	Shopping		1S1E	Small Works
	Vehicles	7,525,000	1	ICB	Prior	1S1E	Goods
	Laboratory High-tech Equipment	17,290,000	Multiple	NCB	Prior/Post	1S1E	Goods
	Laboratory Standard Equipment	7,480,000	Multiple	NCB	Prior/Post	1S1E	Goods
	Hospital Equipment	13,600	Multiple	NCB	Prior/Post	1S1E	Goods
	Office, IT equipment	2,952,000	1	NCB	Post	1S1E	Goods
	Laboratory Small Equipment	230,000	(multiple)	Shopping	Prior / Post	1S1E	Goods
	Outbreak Equipment	230,000	(multiple)	Shopping	Prior / Post	1S1E	Goods

Consulting Services							
Package Number	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Recruitment Method**	**Review** (Prior / Post)	**Type of Proposal**	**Comments**
	Baseline Survey	150,000	1	LCS	Prior	Biodata	National
	Financial Audit	30,000	1	LCS	Prior	Biodata	International
	International Technical Advisor	372,000	1	ICS	Prior	Biodata	International
	International Gender Specialist	8,000	1	ICS	Post	Biodata	International
	International Procurement Specialist	195,000	1	ICS	Prior	Biodata	International
	National Project Implementation Adviser	81,000	1	ICS	Prior	Biodata	National
	National Training Specialist	60,000	1	ICS	Prior	Biodata	National
	National Gender Specialist	13,000	1	ICS	Post	Biodata	National
	National Procurement Specialist	126,000	1	ICS	Prior	Biodata	National

C. List of Awarded and On-going, and Completed Contracts

The following tables list the awarded and on-going contracts, and completed contracts.

1. Awarded and Ongoing Contracts

Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Procurement Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**	**Comments**

Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Recruitment Method**	**Advertisement Date** (quarter/year)	**Date of ADB Approval of Contract Award**	**Comments**

2. Completed Contracts

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Procurement Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**	**Date of Completion**	**Comments**

Consulting Services								
Package Number	**General Description**	**Estimated Value**	**Contract Value**	**Recruitment Method**	**Advertisement Date** (quarter/ year)	**Date of ADB Approval of Contract Award**	**Date of Completion**	**Comments**

D. Non-ADB Financing

The following table lists goods, works and consulting services contracts over the life of the project, financed by Non-ADB sources.

Goods and Works				
General Description	Estimated Value (cumulative)	Estimated Number of Contracts	Procurement Method	Comments

Consulting Services				
General Description	Estimated Value (cumulative)	Estimated Number of Contracts	Recruitment Method	Comments

National Competitive Bidding

1. General

The procedures to be followed for the procurement of goods, non-consulting services, and works under contracts awarded on the basis of National Competitive Bidding shall be those set forth in: (a) Law on Procurement No. 43/2013/QH13 dated November 26, 2013 ("Law on Procurement") and (b) Decree No. 63/2014/ND-CP dated June 26, 2014 (collectively, "National Procurement Laws"). Whenever any procedure in the National Procurement Laws is inconsistent with the ADB Procurement Guidelines (March 2013, as amended from time to time), the ADB Procurement Guidelines shall prevail, amongst others on the following.

2. Eligibility

(i) The eligibility of bidders shall be as defined under section I of the ADB Procurement Guidelines; accordingly, no bidder or potential bidder should be declared ineligible for reasons other than those provided in section I of the ADB Procurement Guidelines, as amended from time to time. Conditions of bidders' participation shall be limited to those that are essential to ensure bidders' capability to fulfill the contract in question. Foreign bidders shall be eligible to participate under the same conditions as national bidders. Foreign bidders shall not be asked or required to form joint ventures with, or be subcontractors to, national bidders in order to submit a bid.

(ii) A firm declared ineligible by ADB cannot participate in bidding for an ADB-financed contract during the period of time determined by ADB.

(iii) A bidder shall not have a conflict of interest; which term shall be defined in accordance with section 1 of ADB Procurement Guidelines[9]. Any bidder found to have a conflict of interest shall be ineligible for contract award.

(iv) Government-owned enterprises in the Borrower's country shall be eligible to participate as a bidder only if they can establish that they are legally and financially autonomous, operate under commercial law and are not dependent agencies of the Borrower or Sub-Borrower.

(v) National sanction lists may only be applied with approval of ADB[10].

3. Preferences

No preference of any kind shall be given to domestic bidders over foreign bidders or for domestically manufactured goods over foreign manufactured goods. Unless otherwise stated in the applicable financing agreement, preferences among domestic bidders set forth in Article 14(3) of the Law on Procurement shall not be applied.

4. Bidding Procedure

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[9] Detailed guidance on how to apply conflict of interest test is available under section 1 of ADB's standard bidding documents for goods and works (as amended from time to time).

[10] For fraud and corruption cases, Section 50 of ADB's Integrity Principles and Guidelines provides that ADB may decide that another international financial institution's or legal or regulatory body's determination that a party has failed to adhere to appropriate ethical standards, as defined by any established system of principles, rules, or duties, including the laws or regulations of a state, constitutes that party's failure to maintain the highest ethical standards as required by ADB's Anticorruption Policy. The party may be subject to remedial action in accordance with the Integrity Principles and Guidelines. http://www.adb.org/sites/default/files/integrity-principles-guidelines.pdf

Single stage-single envelope shall be the default bidding procedure and application of other bidding procedures shall require ADB's prior approval.

5. Time for Bid Preparation

The time allowed for the preparation and submission of bids for large and/or complex packages shall not be less than thirty (30) days from the date of the invitation to bid or the date of availability of the bidding documents, whichever is later.

6. Standard bidding documents

The Harmonized Standard Bidding Document jointly issued on July 2, 2015 by the WB and ADB, shall be used. Bidders shall be allowed to submit bids by hand or by mail/ courier.

7. Bid Opening and Evaluation

(i) Bids shall be opened in public, immediately after the deadline for submission of bids, regardless of the number of bids received.

(ii) Except with the prior approval of ADB, merit points shall not be used in bid evaluation.

(iii) No price adjustments shall be made for evaluation purposes in accordance with Article 117(6) of Decree 63 when unit rates offered by the bidder are determined to be abnormally low.

(iv) Bidders shall be given commercially reasonable time period to respond to clarification requests.

(v) Bidders shall not be eliminated from detailed evaluation on the basis of minor, non-substantial deviations[11].

(vi) Except with the prior approval of ADB, negotiations contemplated under paragraphs 7 and 8 of Article 117 of Decree No. 63/2014/ND-CP shall not take place with any bidder prior to contract award.

(vii) A bidder shall not be required, as a condition for award of contract, to undertake obligations not specified in the bidding documents or otherwise to modify the bid as originally submitted.

8. Rejection of All Bids and Rebidding

(i) No bid shall be rejected on the basis of a comparison with the Procuring Entity's estimate or budget ceiling without ADB's prior concurrence.

(ii) All bids shall not be rejected and new bids solicited without ADB's prior approval.

9. Publication of the Award of Contract. Debriefing.

(i) For contracts subject to prior review, within 2 weeks of receiving ADB's "No-objection" to the recommendation of contract award, the borrower shall publish in the Government Public Procurement Gazette, or well-known and freely-accessible website the results of the bid

[11] A minor, non-substantial deviation is one that, if accepted, would not affect in any substantial way the scope, quality, or performance specified in the contract; or limit in any substantial way, the Contracting entity rights or the Bidder's obligations under the proposed contract or if rectified, would not unfairly affect the competitive position of other bidders presenting substantially responsive bids.

evaluation, identifying the bid and lot numbers, and providing information on: i) name of each bidder who submitted a bid; ii) bid prices as read out at bid opening; iii) name and evaluated prices of each bid that was evaluated; iv) name of bidders whose bids were rejected and the reasons for their rejection; and v) name of the winning bidder, and the price it offered, as well as the duration and summary scope of the contract awarded.

(ii) For contracts subject to post review, the procuring entity shall publish the bid evaluation results no later than the date of contract award.

(iii) In the publication of the bid evaluation results, the Borrower shall specify that any bidder who wishes to ascertain the grounds on which its bid was not selected, may request an explanation from the Borrower. The Borrower shall promptly provide an explanation of why such bid was not selected, either in writing and/or in a debriefing meeting, at the option of the Borrower. The requesting bidder shall bear all the costs of attending such a debriefing.

10. Contract Administration

The Contract Agreement, as such term is defined in the relevant bidding document, shall be applied without any modification during implementation except as otherwise agreed by ADB.

11. Fraud and Corruption

A provision shall be included in all bidding documents for NCB works and goods contracts financed by ADB stating that ADB will sanction a party or its related parties, including declaring ineligible, either indefinitely or for a stated period of time, to participate in ADB-financed, administered or supported activities if it at any time determines that the party has, directly or indirectly through an agent, engaged in integrity violations as defined under ADB's Integrity Principles and Guidelines, including corrupt, fraudulent, collusive, or coercive practices in competing for, or in executing, an ADB-financed, administered or supported contract.

12. Right to Inspect/ Audit

Each bidding document and contract financed by ADB shall include a provision requiring bidders, contractors, agents (whether declared or not), sub-contractors, sub-consultants, service providers, or suppliers and any personnel thereof, to permit ADB to inspect all accounts, records and other documents relating to any prequalification process, bid submission, and contract performance (in the case of award), and to have them audited by auditors appointed by ADB.

Economic and Financial Analysis

Project number: 48118-REG
27 June 2016

R-PPTA 8842: THE GREATER MEKONG SUBREGION HEALTH SECURITY PROJECT

ECONOMIC AND FINANCIAL ANALYSIS

A. Project Design

1. The Greater Mekong Subregion Health Security Project is a $132 million[1] project to assist the governments of Myanmar, Cambodia, the Lao People's Democratic Republic, and Viet Nam to strengthen systems for the control of communicable diseases that have, or can have, a major impact on the region's public health and economy. The rationale for this investment project is based on market failure and the need for government interventions for infectious diseases.

2. To facilitate comparisons, this analysis follows the basic methods used in economic analyses of prior GMS CDC projects. The $37.1 million investment and $19.8 million ongoing recurrent costs of the related previous CDC1 project were estimated to have an Economic Internal Rate of Return (EIRR) of 34% over a 25-year benefit stream[2]. Calculating only a 5-year benefit stream (2011-2015) for another project, CDC2, resulted in an EIRR of 28%[3].

B. Macroeconomic Context and Sector Analysis[4]

3. All four countries have experienced high rates of GDP growth in the past decade, but at the same time populations face rising prices and increased income inequity. Government Health Expenditure (GHE) is relatively low as a percentage of GDP. Funding gaps in the health sector along with large investments in advanced technology and hospitals have led to high out-of-pocket (OOP) spending, and insufficient investment for both urban and rural basic health services. In addition, several important bilateral partners have scaled down their inputs or left the sub-region. There is a general need for sector investment, especially for prevention and public goods.

C. Project Beneficiaries

4. The four countries had a combined population of 171.2 million people in 2015, with about 28.7 million living below the national poverty line, including about 13.9 million in Myanmar (25.6% poverty rate), 10.6 million in Viet Nam (11.3%), 1.5 million in Lao PDR (22%), and 2.7 million in Cambodia (17%)[5]. The majority of the poor live in rural areas and many belong to ethnic minority groups in border areas, where the prevalence of communicable disease is disproportionately high, mortality rates are higher and the poor have low access to health services. The project targets the poorest groups in these areas. In terms of indirect beneficiaries, the project will benefit at least 27.7 million people who live in the nominated 388 project districts within the 67 provinces/states/regions. In Myanmar, the number of expected beneficiaries is 2.2m; in Viet Nam, 20.01m; in Lao PDR, 1.4m; and Cambodia, 4m. Of this, there are approximately 18.85 million people living in border areas.

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[1] Amount of the project at the time of report elaboration, May 2016

[2] ADB. 2005. *Report and Recommendation of the President to the Board of Directors: Proposed Grant to the Kingdom of Cambodia, the Lao People's Democratic Republic, and the Socialist Republic of Viet Nam for the Greater Mekong Subregion Regional Communicable Diseases Control Project.* Manila

[3] ADB. 2010. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Grants to the Kingdom of Cambodia, Lao People's Democratic Republic, and Socialist Republic of Viet Nam for the Second Greater Mekong Subregion Regional Communicable Diseases Project.* Manila.

[4] The information in this section is summarized from the Poverty and Social Assessments for Greater Mekong Subregion Health Security Project, which show all referenced data sources.

[5] The World Bank 2016. *Poverty and Equity Regional Dashboards 2016*

D. Rationale for Public Sector Involvement

5. The project addresses market failures in terms of regional public goods, externalities, and gaps in services for the poor. It addresses missing information and information asymmetry that can inhibit regional response to outbreaks. Demand for public education, epidemiological surveillance and cross-border vector control, immunization, and other preventive actions is likely to be lower than desired, making it less attractive for the private sector unless publicly subsidized.[6]

6. There are strong linkages between health and the burden of infectious diseases and labor productivity. Poor educational achievement by sick school-age children results in lower human capital formation.[7] High prevalence of some communicable diseases is associated with significantly lower rates of economic growth. Economic effects at the societal level include productivity losses, costs to the public health system, and other costs discussed below. For example, by 2025, if Indonesia fails to halt and reverse the HIV/AIDS epidemic, this will increase annual hospital workload by 2.1% and lead to four million extra outpatient visits. Without anti-retrovirals, providing care for those with HIV would cost around $1 billion per year.[8]

7. Indirect benefits of preventing transmission of diseases include reducing the spread, avoiding disruption of economic activity, especially trade and tourism, reduced public anxiety, and maintaining business confidence. The SARS outbreak in 2003 and the avian influenza outbreak in 2004 highlighted the vulnerability of national economies to epidemics. The culling of domestic fowl during outbreaks reduced family incomes in the region. In Viet Nam, the value of birds culled represented 0.3% of GDP, and in Thailand, $276 million.[9] Recent outbreaks elsewhere demonstrate the need for vigilant surveillance and outbreak control for future epidemics including human influenza, which has large human and economic costs.

8. The four governments are major providers of preventive and promotive health care in rural areas. Despite high economic rates of return for many investments in the health sector, private participation is suboptimal. The gaps in quality rural health services justify continued government intervention. A counterfactual question is why governments should be providing the services, rather than encouraging and subsidizing the private sector to do so. Partly, the inherited system is difficult to change in the short term. There are few regulatory barriers that prevent more qualified providers from entering the rural market but there is limited interest in offering preventive and promotive services. Contracting out also requires considerable administrative and monitoring capacity.

9. Global financing to fight communicable diseases is not always aligned with the disease priorities of developing countries, and since donors tend to imitate each other's funding decisions, the real needs of developing countries may be overlooked.[10] Applying the concept of global public good to health funding decisions reprioritizes financing for communicable

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[6] J. Knowles. 2003. *Health Nutrition and Infectious Disease and Economic Growth in Cambodia*. Bangkok,

[7] Sachs, J. and others. 2001. *Macroeconomics and Health: Investing in Health for Economic Development, Report of the Commission on Macro-economics and Health*. Geneva: WHO.

[8] M. Haacker and M. Claeson. 2009. *HIV and AIDS in South Asia: An Economic Development Risk.* World Bank; S. Fabricant. 2014. *Economic Analysis of the Proposed DFAT HIV Programme in Indonesia*. Unpublished

[9] D. U. Pfeiffer, M. J. Otte, D.Roland-Holst, and D. Zilberman. 2013. *A One Health Perspective on HPAI H5N1 in the Greater Mekong sub-region*, *Comparative Immunology, Microbiology and Infectious Diseases*, Volume 36, Issue 3, pp. 309-319.

[10] I. Gupta and P. Guin. 2010. *Communicable diseases in the South-East Asia Region of the World Health Organization: towards a more effective response*. Bulletin of the World Health Organization. pp. 88,199-205.

diseases. The project will support the implementation of strategies, diagnostic and treatment standards, and public education.

10. External aid may replace government funding, and thus allow the government to finance a marginal program that was lacking funds. The possibility of fungibility was examined for CDC2, which was found to supplement government funding and external aid[11]. Beyond the health sector, there can be a fungibility problem of balancing allocations among sectors within the overall public resource envelope. The project will increase sector allocations for preventive services, which are associated with more health impact. In addition, the project targets remote border districts where the economic returns on investment are likely to be much higher despite higher unit costs for service delivery.

11. Monitoring and appropriate incentives are needed to ensure that project inputs achieve their intended results. All four countries face chronic funding, staff, and operational problems, especially for preventive services in rural areas. As far as financially possible, the four countries are making long-term adjustments in the form of pay rises and incentives for posting to rural areas, to offset social, transport, and opportunity costs. Financial sustainability is addressed in a later section of this economic analysis.

E. Economic Costs and Benefits

12. The human capital approach is an accepted tool for measuring economic benefits of ADB health projects. Burden of disease as expressed in Disability-Adjusted Life Years (DALYs) is the most common quantitative measure of health impacts. A reduction in DALYs can accrue through decreased incidence of disease(s) targeted by the project[12]. One approach is that economic benefits accrue to the entire population through better health; another is that the benefits accrue only to the economically productive population, approximately 77% to 83% [13] of the age group 15-64 who participate in the labor force. Both approaches have been used in recent ADB projects[14]. In this analysis the basic assumption is that the entire population benefits from improved disease control, but the alternate scenario is modeled in the sensitivity analysis. The economic value of a DALY is generally taken as the loss of contribution to the economy; in developing countries it is customary to use GDP per capita as the value of a DALY, but adjustments should be made if the target population is poorer than average, as is generally true of rural areas. Although there have been estimates of border incomes as low as 30% to 40% of national GDP/capita, no hard data was available so rural incomes were used as a proxy[15]. Again, different income levels in the border areas are modeled in the sensitivity analysis. Economic benefits are calculated as the expected reduction in DALYs multiplied by

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[11] An exception was the explicit use of external funding in Viet Nam to finance hospital services, with increases in Government co-financing to the likely detriment of basic and preventive health services.

[12] The output target for CDC1 was clearly quantifiable: to contain the spread of epidemic diseases at local level and reduce the burden of common endemic diseases in the CLV countries by about 15% in the targeted provinces, and more for certain specific infections.

[13] ADB. 2014. *Key indicators for Asia and the Pacific 2014: Framework of Inclusive Growth Indicators, Special Supplement*. Manila.

[14] The Viet Nam Health Care in the Central Highlands Project (37115) had as a major output reduction in infant and child mortality, and valued the lives of all children saved, while CDC2 only considered DALYs in the working-age population.

[15] Data on poverty levels is more readily available than for rural incomes. There is a correlation between them near the lower tail of a normal distribution that allows approximation of rural mean incomes, e.g., in a population with mean income of $2000 (SD=$1500), 20% fall below a $2/day poverty line (PL), For a similar distribution in a poorer population with 30% below the PL the mean income is $1520, and if 40% fall below the same PL, the mean income is $1110. This can be expressed as [income ratio = (0.45 x poverty level ratio) + 1.44]. (Consultant's own work, verified where both sets of data are available.)

this economic unit value. Treatment costs and household benefits such as the value of time saved in transportation and child care were not counted because they require more assumptions or difficult-to-obtain community level data, and would amount to double-counting of some benefits covered through the disability component of DALYs.

13. All three outputs of the project are aimed at strengthening country health systems and regional linkages, and the outputs listed in the Report and Recommendation of the President are described only in these terms rather than as reductions in disease incidence. Unfortunately, relationships between systems strengthening and the downstream health impacts are difficult to measure as they are separated by intermediate processes and time.[16] Estimating economic benefits of this project therefore requires that related quantifiable outputs be inferred or extrapolated from past disease-reduction projects or other published data.

14. Economic benefits were calculated based on the assumptions in Table 1[17]. The high number of variables means that the sensitivity of the calculated EIRR to variances in each individual factor is low, so that errors tend to cancel out.

Table 1: Assumptions and inputs used in Economic Analysis

Basic data or assumptions	Baseline rates	Units	Myanmar	Viet Nam	Lao PDR	Cambodia
ADB data 2014	Country population 2015	million	54.2	94.3	6.90	15.8
ADB data 2014	Population growth rate	% per yr	0.82%	1.12%	1.66%	1.62%
RRP	Total provinces/states/regions		15	63	18	24
RRP	total districts/wards/towns		67	645	144	203
RRP	Target provinces/states		6	36	12	13
RRP	Target districts		12	250	36	42
calculated	average population by province/state	million	3.613	1.497	0.383	0.658
RRP	Target District pop'n.	million	2.20	20.01	1.43	4
RRP	Targeted Health Centers		74	2053	263	422
calculated	(estimated) target Provincial population	million	11.10	40	3	7.62
ADB data 2014	Country GDP (local currency/avg exch rate)	USD billion	64.5	186.2	11.7	16.8
ADB data	Border (rural) area income factor		0.87	0.78	0.82	0.78
ADB data 2014	GDP growth rate	% per yr	8.70%	6.00%	7.60%	7.10%
Domestic price numeraire	apply to foreign costs		1.1	1.1	1.1	1.1
Dengue Matters 2015	Base year costs of dengue	$ millions	14.0	23.0	5.0	16.0
ADB data	Urban-rural composite differential		1.10	1.15	1.41	1.35
estimates	Inpatient utilization rate	bed-days per 1000 population	300	300	300	300
calculated	Inpatient utilization	million bed-days	16.26	28.29	2.07	4.74
estimates	Inpatient cost (total public and private costs)	$/day	$15.0	$20.0	$15.0	$15.0
ADB studies	Probability of occurrence	percent	8%	8%	8%	8%

[16] L. Hatt, B. Johns, C. Connor, M. Meline, M. Kukla, and K. Moat. 2015. *Impact of Health Systems Strengthening on Health.* Bethesda, MD: Health Finance & Governance Project, Abt Associates.

[17] Appendices are available upon request.

Basic data or assumptions	Baseline rates	Units	Myanmar	Viet Nam	Lao PDR	Cambodia
	of major epidemic					
ADB studies	Cost of a major epidemic	percent of GDP	3%	3%	3%	3%
estimates	Benefit of S&R on reducing epidemic probability	percent	10%	10%	10%	10%
CDC in border areas	*A) Direct impact on districts*					
	Identification of TB cases	Level of Effort/Relative	0.5	0.5	0.5	0.5
	Hygiene, sanitation, deworming education	As above	2.0	2.0	2.0	2.0
	Vector control for dengue	As above	2.0	2.0	2.0	2.0
	HIV screening	As above	1.0	1.0	1.0	1.0
	B) Indirect impact on provincial pop'n	*% of direct impact*	5.0%	5.0%	5.0%	5.0%
Border Surveillance & Response	Contribution of GMS HS on S&R	% GMS HS effectiveness on S&R	5.0%	5.0%	5.0%	5.0%
Lab services/IPC	Reduction in economic costs of dengue		10.0%	10.0%	10.0%	10.0%
	Hospital infection prevention	Effectiveness	5.0%	5.0%	5.0%	5.0%

15. The impact of community outreach activities conducted under output 1 is based on narrowing health status and disease incidence gaps between target areas and the rest of the country. A composite of indicators (Table 1) suggests geographic differentials ranging from of 10% in Viet Nam and Myanmar and 40% in Cambodia and Laos. Data specifically for border areas is unavailable, but the overall rural levels likely underestimate the disadvantage.[18] We conservatively assume that focused health and surveillance system strengthening will reduce this gap by half over five years, or 10% per project year, and continuing for another five years. An adjustment is also made for relative progress towards the 10% target based on past performance of CDC efforts in the region, e.g. slower for TB control and faster for deworming. For Output 2, the total benefit from averting or mitigating epidemic outbreaks is estimated as a percentage of national GDP and based on published studies as was also done for CDC2, but the potential contribution of the project's border-level surveillance activities is impossible to estimate due to lack of documented experience[19]. A conservative estimate is that improved surveillance and response at border areas may reduce the overall risk by 5 percent. For Output 3 there are several other (non-quantifiable) outputs, but the impact on DALYs is based on the finding that 30-90% of reported dengue cases are actually negative after lab testing. It is expected that the economic costs of the disease can be reduced by testing at least 10% of cases at project health centers[20]. Benefits due to hospital infection control are calculated on the basis of published experience and estimated present hospital costs.

[18] Footnote 12, page 5; The 4 indicators are 1-year old immunization coverage, ANC1 visit, improved drinking water, and improved sanitation. Each indicator was given the same weight. The composites are shown in Appendix 1c.

[19] The impact of an avian influenza pandemic in Asia was estimated at 2.6%-6.8% of GDP; E. Bloom, V. de Wit, and M. Carangal-San Jose. 2005. Potential Economic Impact of an Avian Flu Pandemic on Asia. *ERD Policy Brief No. 42*. Manila: Asian Development Bank.

[20] Economic burdens of dengue in 2010, a peak year, were estimated as $16 million for Cambodia, $5 million for Lao PDR, $14 million for Myanmar, and $23 million for Viet Nam (http://www.denguematters.info/content/issue-15-spotlight-dengue-southeast-asia).

16. Project financial costs used are from the Cost Tables as estimated during project design. Table 2 summarizes the capital equipment, recurrent costs and other costs. On a per-beneficiary (target district population) basis, the five-year costs range from $3.72 in Cambodia to $6.06 in Myanmar.

Table 2: Project cost estimates by expenditure category (from Cost Tables)

All costs in $millions	Myanmar	Viet Nam	Lao PDR	Cambodia	Totals	% of total
Investment* (capital items)	8.9	69.0	9.3	17.3	104.5	79.1%
Recurrent**	2.6	5.1	2.5	3.6	13.8	10.5%
Contingency	0.9	7.4	0.7	1.3	10.3	7.7%
Finance	0.3	2.5	0.1	0.6	3.5	2.7%
Totals	12.8	84.0	12.6	22.8	132.2	100.0%
Cost per beneficiary	$6.06	$4.62	$3.92	$3.72		

*Facility repair/maintenance, equipment, vehicles, consulting services, local trainings/workshops, community mobilization, project management, and duties and taxes.
**PMU operating cost, biosafety supplies, Lab consumables, other operating cost, regional activities.

17. For foreign purchases a domestic price numeraire is used, with shadow exchange rate factor (SERF) of 1.1 to convert foreign (border) costs to domestic economic costs[21]. Foreign costs for Myanmar, Vietnam, Lao PDR and Cambodia are 56.2%, 75.8%, 58.3%, and 56.1% respectively (PPTA Cost Tables, PAM Table 4). Most local costs are for skilled labor in high demand, so a shadow wage rate factor (SWRF) of 1.0 was assumed to be relevant for this component, which comprise 31% of all project costs. The effect of different SERFs is modeled in the sensitivity analysis.

18. As with the previous GMS CDC projects, the effects of the project are expected to continue for at least five years after the five-year implementation period. Using conservative estimates of the impacts of each component, there will be a net annual benefit in each country by the third or fourth project year. The cumulative net benefits will exceed cumulative costs one year after the project implementation ends. Five years after the end of ADB investment it will have generated cumulative net benefits of $129.6 million. The relative economic benefits from each project output are distributed as shown in Table 3. With the baseline assumptions used, most benefits derive from CDC in border areas (Component 1), where over half of total benefits accrue, followed by Component 3, where about 40% of benefits accrue.

Table 3: Economic Benefits from Project Outputs

		Myanmar		Vietnam		Lao PDR		Cambodia	
Benefits/level		**$millions**	**%**	**$million**	**%**	**$millions**	**%**	**$millions**	**%**
Output 1	HIV	1.707		16.566		7.133		11.795	
(districts)	TB	2.745		12.347		17.548		13.528	
	Dengue	0.199		4.867		3.368		3.375	
	Helminth	0.689		24.184		7.159		0.385	
(province)		0.267		2.898		1.760		1.454	
	CDC total	**5.606**	**23.6%**	**60.863**	**40.1%**	**36.969**	**76.1%**	**30.536**	**55.8%**

[21] Based on SCF= 0.9 used in recent projects in other sectors: Vientiane Sustainable Urban Transport Project, Feb 2015. RRP LAO 45041-002, Third Cambodia Education Sector Development Program, 2012 and GMS East-West Economic Corridor Towns Development Project. Oct 2012. (RRP LAO 43319-022).

Output 2									
(province)	**S&R total**	**10.818**	**45.5%**	**27.216**	**17.9%**	**1.855**	**3.8%**	**2.597**	**4.7%**
Output 3									
(province)	Dengue costs	2.700		8.757		2.377		7.532	
(district)	IPC	4.633		55.088		7.381		14.034	
	IPC total	**7.333**	**30.9%**	**63.846**	**42.0%**	**9.758**	**20.1%**	**21.566**	**39.4%**
total benefits		**23.758**	**100.0**	**151.926**	**100.0**	**48.583**	**100.0**	**54.700**	**100.0**

19. The EIRR and NPV were calculated from a 10-year stream of net economic benefits, which in turn are the differences between total benefits and total costs for each year. The costs are from the Cost Tables, converted to economic costs as described above in paragraph 26. Benefits were calculated as described in paragraph 24. With the inputs and baseline assumptions used, the project is expected to have an EIRR after 10 years of 21.81%, and the Net Present Value (NPV), at 12% discount rate of the net benefits, is $31.21 million for the four countries combined. EIRRs and NPVs vary among countries as shown in Table 4.

Table 4: Economic Returns of the Project

	Myanmar	**Viet Nam**	**Lao PDR**	**Cambodia**	**Four countries**
Economic internal rate of return (EIRR)	15.2%	16.0%	63.3%	28.1%	21.81%
10-year NPV @12% ($ million)	0.87	8.25	13.69	8.40	31.21

The economic returns are sensitive to the baseline assumptions and to estimates of project impact. The selective sensitivity analysis is shown in Table 5. The EIRRs and NPVs are quite robust with respect to variations in most of the "structural" variables, such as the border income factor, projected GDP growth, etc. EIRRs and NPVs are still positive if the border income factor is assumed to be 40%, or if there is a one-year delay in project outputs. The sensitivity of EIRRs and NPVs to the "project effectiveness" variables suggests that increased level of effort and/or effectiveness of some Project components such as TB case finding and hospital infection control will offer high economic return.

Table 5: Sensitivity Analysis

Baseline	**EIRR (%)**	**21.81**	
	NPV (12%)	**$31.21m.**	
Structural data	**Baseline**	**Change value to**	
GDP growth all	6% to 8.7%	4%	
	EIRR	18.94%	
	NPV	$21.04	
Inpatient utilization/100,000	300	200	400
	EIRR	17.37%	26.28%
	NPV	$17.04	$45.37
Performance/level of effort variables			
	0.5	0.25	1
TB case finding	EIRR	18.07%	29.15%

	NPV	$19.04	$55.55
Hygiene to reduce helminthiasis	2	1	4
	EIRR	19.17%	27.03%
	NPV	$22.62	$48.38
HIV screening	1	0.5	2
	EIRR	18.79%	27.76%
	NPV	$21.38	$50.87
Delayed project outputs 1 year	EIRR	14.72%	
	NPV	$10.41	

F. Financial Sustainability

20. This analysis assesses the financial sustainability of necessary government co-financing for the project. Since this is a non-revenue generating investment, the analysis takes into account the projected recurrent costs together with an assessment of the governments' capacity to absorb them. These costs include health system development that also benefits other health services and compliance with International Health Regulations (IHR) as mandated by governments' policy and plans. Recurrent costs have been calculated carefully because of the underfunding of recurrent costs that have reduced the efficiency of past investments such as the use of provided laboratory equipment. Although not calculated here, the returns to these modest recurrent costs are therefore very high. Recurrent costs will total $13.79 million during implementation, and are assumed to not decline in the 5 years following project implementation.

21. Table 6 shows that the recurrent costs for the five years of the implementation period and the following five years will represent not more than 0.27% of annual government health expenditure (GHE)[22] projected for any of the four countries. Over the following 5 years, this recurrent cost burden will be less than 0.20%. Furthermore, in three of the four countries, GHE is a very low percentage of GDP, meaning that there is headroom for expanding GHE. Based on this analysis, it is confirmed that all four governments can cover the recurrent costs of the project during the project life and beyond.

Table 6: Projected Health Recurrent Cost Financing 2017–2025

Indicator	Myanmar	Viet Nam	Lao PDR	Cambodia
Average projected GHE ($ million) 2017-2022	708	8,035	218	271
GHE/GDP 2010-2014 average	0.7%	2.9%	1.3%	1.3%
Total country project cost 2017-2022 ($ million)	14.2	84.1	12.6	25.4
Project recurrent costs 2017-2021 ($ million)	3.66	2.62	2.48	3.55
Recurrent cost as % of total country Project	20.5%	6.1%	19.7%	15.6%
Average of recurrent cost/GHE 2017-2021	**0.11%**	**0.01%**	**0.23%**	**0.27%**
Average of recurrent cost/GHE 2022-2026	**0.09%**	**0.01%**	**0.18%**	**0.20%**

[22] A growth rate of 5% per year is assumed for GHE, rather than the current GDP growth rates.