Concept Paper

Project Number: 50285-002
September 2017

Proposed Loan and Grant
Viet Nam: Local Health Care Sector Development Program

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 15 September 2017)

Currency unit	–	Dong (D)
D1.00	=	$0.0000440
$1.00	=	D22,725

ABBREVIATIONS

ADB	–	Asian Development Bank
CHS	–	commune health station
HHR	–	health human resource
HST	–	health security threat
LHC	–	local health care
MOH	–	Ministry of Health
NCD	–	noncommunicable disease
PHC	–	primary health care
RHS	–	regional health security
SDG	–	Sustainable Development Goal
SRH	–	sexual and reproductive health
UHC	–	universal health coverage

NOTES

(i) The fiscal year (FY) of the Government of Viet Nam and its agencies ends on 31 December.

(ii) In this report, "$" refers to United States dollars.

Vice-President	S. Groff, Operations 2
Director General	R. Subramaniam, Southeast Asia Department (SERD)
Directors	A. Inagaki, Human and Social Development Division, SERD
	E. Sidgwick, Viet Nam Resident Mission, SERD
Team leaders	J. Mangahas, Senior Social Sector Specialist, SERD
	G. Servais, Senior Health Specialist, SERD
Team members	L. Balite, Operations Assistant, SERD
	M. Cleto, Safeguards Specialist, SERD
	O. Goh-Livorness, Counsel, Office of General Counsel
	M. K. Guzman, Senior Project Officer, SERD
	M. S. M. Ismail, Senior Financial Sector Specialist, SERD
	L. Levaque, Gender Specialist, SERD
	T. H. L. Nguyen, Associate Project Analyst, SERD
	S. Tanaka, Senior Social Sector Specialist, SERD
Peer reviewer	B. Chin, Social Sector Specialist, South Asia Department

In preparing any country program or strategy, financing any project, or by making any designation of or reference to a particular territory or geographic area in this document, the Asian Development Bank does not intend to make any judgments as to the legal or other status of any territory or area.

CONTENTS

PROGRAM AT A GLANCE

1. Basic Data — **Project Number:** 50285-002

Project Name	Local Health Care Sector Development Program	**Department /Division**	SERD/SEHS
Country	Viet Nam, Socialist Republic of	**Executing Agency**	Ministry of Health
Borrower	Socialist Republic of Viet Nam		

2. Sector	**Subsector(s)**	**ADB Financing ($ million)**
✓ **Health**	Health insurance and subsidized health programs	3.00
	Health sector development and reform	89.00
	Total	**92.00**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	Climate Change impact on the Project	Low

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Institutional development	Effective gender mainstreaming (EGM)	✓
Partnerships (PAR)	Official cofinancing Regional organizations		

5. Poverty and SDG Targeting		**Location Impact**	
Geographic Targeting	Yes	Nation-wide	High
Household Targeting	No		
SDG Targeting	Yes		
SDG Goals	SDG1, SDG3		

6. Risk Categorization: Complex

7. Safeguard Categorization **Environment:** B **Involuntary Resettlement:** B **Indigenous Peoples:** B

8. Financing

Modality and Sources	Amount ($ million)
ADB	**92.00**
Sovereign Project grant: Asian Development Fund	12.00
Sovereign SDP - Program (Concessional Loan): Ordinary capital resources	80.00
Cofinancing	**0.00**
None	0.00
Counterpart	**20.00**
Government	20.00
Total	**112.00**

I. THE PROGRAM

A. Rationale

1. The proposed Local Health Care Sector Development Program will assist the Government of Viet Nam to implement the Master Plan for Strengthening Local Health Care Services,[1] which sets out reforms to improve access to and the quality of the local health care (LHC) system.[2] The design and monitoring framework is in Appendix 1. The problem tree is in Appendix 2.

2. **The development problem**. Inequitable access to responsive and affordable LHC services is a key cause of health status disparities in Viet Nam. Viet Nam's regions show widely differing performance on key health indicators, which vary by a factor of 2.9 for the infant mortality rate, 3.0 for under-5 child mortality, and 2.7 for child malnutrition (Supplementary Document 1). Remote and mountainous areas have inadequate primary health care (PHC) services, and poorer health outcomes. A deficient LHC system increases vulnerability to an epidemic of emerging noncommunicable diseases (NCDs). Weak LHC in border areas can fail to detect and contain emerging, epidemic-prone transboundary diseases and thus decrease regional health security (RHS). The government is aware that LHC reforms are essential for achieving universal health coverage (UHC), meeting the health-related targets of the Sustainable Development Goals (SDGs),[3] ensuring RHS, and supporting inclusive growth.

3. **Binding constraints.** Key obstacles to realizing the LHC system reform agenda contained in the master plan are (i) weak public investment management capacity to ensure adequate local health care infrastructure that meets quality standards, (ii) unresponsive service delivery models, and (iii) weak health workforce development and management.

4. The Ministry of Health (MOH) and provincial governments lack an investment framework and robust mechanisms to direct investments under the master plan. Reforms to strengthen public financial management capacity are required to ensure sound government and development partner financing for master plan implementation, particularly in upgrading the commune health station (CHS) infrastructure.

5. The LHC system is unresponsive to Viet Nam's epidemiological profile. Up to 70% of patients referred to provincial hospitals, including for NCD management and illnesses related to ageing, could be treated at the PHC level.[4] Utilization of the LHC system, particularly for maternal and child health, remains low. To reverse this trend, service delivery systems need to be reoriented. In border and remote areas, an accessible CHS network is essential for timely detection of and response to emerging and epidemic-prone threats to RHS. Health financing mechanisms for LHC services are needed, including health insurance benefit packages for NCD management, long-term care, and sexual and reproductive health (SRH) services.

6. Ensuring adequate health staff in CHSs with the requisite skills to provide PHC services is a core reform area under the master plan. The regulatory frameworks that govern health workforce development and staffing require strengthening, including policies for the delivery of

---

[1] The Local Health Care Sector Development Program is included in ADB. 2016. *Country Operations Business Plan: Viet Nam, 2017–2019.* Manila as "Grassroots Health Care Centers". The title was revised to better reflect the program's scope and modality. The government's master plan was approved in Decision 2348/QD-TTg (5 December 2016); a summary is in Supplementary Appendix 2.

[2] The LHC system, which encompasses commune health stations and district health centers, is the first point of contact with the health system.

[3] Viet Nam is drafting its National Action Plan on SDG implementation, including country-specific SDG targets.

[4] Ministry of Health. 2016. *Viet Nam Health Financing Strategy Period 2016–2025*. Ha Noi.

continuing medical education and balanced deployment of female, male, and ethnic minority health professionals. Systems for health professional licensing need to be upgraded.

7. **Government strategy.** The government is prioritizing strengthening of LHC as it seeks to achieve UHC and meet the health-related SDGs. The master plan sets out the framework to (i) consolidate the LHC organizational structure; (ii) reorient operational, service delivery, and financing mechanisms; (iii) strengthen LHC human resources; and (iv) guide investments in LHC system infrastructure (Supplementary Appendix 2). The government is committed to meeting its legal obligations under the International Health Regulations, which require that minimum core public health capacities for responding to health security threats (HSTs) be established.

8. **Asian Development Bank engagement.** The Asian Development Bank (ADB) has supported strengthening PHC since 1995 in combination with regional cooperation to control communicable disease (Supplementary Appendix 3). The program will consolidate work undertaken by ADB to improve primary health service delivery through better quality management systems and workers,[5] with an intensified focus on the communes. The program is consistent with the ADB strategy for health cooperation, and continues ADB support for health system strengthening and enhanced health security.[6] The program will strengthen PHC services in border areas by improving disease surveillance and control, enhancing outbreak response capacity, and addressing the needs of mobile populations. The program aligns with the medium- to long-term ADB strategy to assist the government achieve UHC through strengthened health service delivery, health human resources (HHR), and health financing. It complements ADB assistance to policy and institutional reforms on HHR[7] and health financing (Supplementary Appendix 4).[8]

9. **Development partner coordination**. Master plan implementation will be supported by ADB through the program, and by a proposed World Bank project,[9] and will benefit from strong synergies between the proposed interventions (Supplementary Appendix 5). The program will establish the required regulatory frameworks and systems for managing government and development partner investments under the master plan. The World Bank will support investments in infrastructure, equipment, and training. Parallel investments for equipment and training under the program's project grant will complement World Bank investments through delineation in geographic areas of focus. The program will complement the European Union's Health Sector Policy Support Program to enhance health sector policy and planning systems.

10. **Proposed modality**. A sector development program lending is proposed. The program will support key policy reform actions to strengthen the LHC system, including RHS, by establishing a regulatory and institutional framework to direct investments under the master plan to be financed by the government and development partners. The framework will also be critically important as program loan funds will be used for investment in CHSs, which demonstrates the government's commitment to the implementation of the master plan and RHS.[10] The policy

---

[5] ADB. 2010. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and Administration of Grant for the Health Human Resources Sector Development Program*. Manila.

[6] ADB. 2016. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and Grant to the Kingdom of Cambodia, Lao People's Democratic Republic, Republic of the Union of Myanmar, and Socialist Republic of Viet Nam: Greater Mekong Subregion Health Security Project.* Manila.

[7] ADB. 2015. *Technical Assistance to the Socialist Republic of Viet Nam for Health Human Resource Sector Development Program (Phase 2)*. Manila.

[8] ADB. 2016. *Technical Assistance to the Socialist Republic of Viet Nam for Strengthening the Policy and Institutional Framework of Social Health Insurance*. Manila.

[9] World Bank Viet Nam Grassroots Service Delivery Reform Project. Collaborative cofinancing will be explored during loan preparation.

[10] During program preparation, the government will identify recipient provinces and fund flow arrangements. Local level verification of the policy reform actions will also be undertaken.

reforms will provide an enabling environment for effective delivery of project grant support, which encompasses investments in capacity building, equipment, quality assurance, and analytical work for enhancing LHC and responsiveness to RHS threats.

B. Impacts, Outcome, and Outputs

11. The program's impact will be a network of local health facilities to ensure responsive PHC for the entire population is strengthened. The outcome will be improved quality of and access to LHC services for women and men, particularly in disadvantaged and remote areas.

12. **Output 1: Public investment management for local health care strengthened.** The program will establish the needed regulatory framework to direct investments under the master plan. Reforms encompass (i) MOH due diligence of provinces to determine their capacity to manage development financing, (ii) completion of a financing framework for the master plan, (iii) categorization of CHSs nationwide as a basis for evidence-based investment prioritization, and (iv) a revised minimum equipment list for CHSs. The project grant will support (i) equipment for CHSs to deliver mandated, gender-sensitive technical services; and (ii) equipment to strengthen surveillance and rapid alert systems for HSTs.

13. **Output 2: Service models of local health care network improved.** The program will establish policies that ensure responsive CHS service delivery through the following reforms: (i) implementing a basic package of health services that are reimbursable by health insurance; (ii) adopting a family doctor model of LHC service delivery; and (iii) delineating and strengthening the preventive health functions of the LHC system, including for health security. The project grant will support (i) developing models for enhanced PHC service delivery and referral; (ii) strengthening CHS response to HSTs, including pandemics, outbreaks and cross-border health risks, following international standards; and (iii) improving systems for quality assurance and integrated management of health information.

14. **Output 3: Local health care workforce development and management strengthened.** The program will enhance HHR quality and deployment through reforms to (i) strengthen system for licensing of practitioners and LHC facilities; (ii) enhance competency standards for health personnel; and (iii) strengthen LHC workforce by addressing incentive structures, and gender and ethnic representation. The project grant will support (i) HHR curriculum on managing NCDs, SRH, ageing-related illness, HSTs, and regional cooperation; and (ii) HHR training that ensure access for female and ethnic minority staff, and those in areas susceptible to public health threats.

C. Program Costs and Financing

15. The indicative investment cost is estimated at $92 million equivalent, with expected financing of $80 million from ADB concessional ordinary capital resources and grant financing of $12 million from the Asian Development Fund Regional Health Security Grant. In 2016, government public debt was 63.5% of gross domestic product, an increase of about 10% since 2010.[11] To finance LHC reforms within these constraints, the government requested concessional ordinary capital resources of $80 million to finance the policy component, to be disbursed in a single tranche, and $12 million in grant financing for the project component.

[11] The Government of Viet Nam, World Bank, International Monetary Fund, and ADB estimates.

Table 1: Tentative Financing Plan

Source	**Amount** ($ million)	**Share of Total** (%)
Asian Development Bank		82.14
Ordinary capital resources (Concessional loan)	80.0	
Asian Development Fund Regional Health Security Grant	12.0	
Government counterpart	20.0	17.86
Total	**112.0**	**100.0**

Source: Asian Development Bank.

D. Indicative Implementation Arrangements

16. MOH will be the executing agency for the proposed program.

II. DUE DILIGENCE REQUIRED

17. Due diligence includes a (i) program impact assessment; (ii) economic and financial viability and sustainability; (iii) financial management and procurement capacity assessment; (iv) poverty, social, and gender analysis; and (v) review of impacts on environment, involuntary resettlement, and indigenous peoples. The initial poverty and social analysis is in Appendix 3.

III. PROCESSING PLAN

A. Risk Categorization

18. The program is complex because the aggregated loan amounts exceed $50 million.

B. Resource Requirements

19. Ongoing technical assistance[12] supports preparatory work. Processing will require 122 weeks of staff resources: mission leader and co-mission leader (48 weeks), senior social sector specialist (8 weeks), gender specialist (6 weeks), safeguards specialist (8 weeks), legal counsel (8 weeks), national officers and analysts (24 weeks), and operations assistant (20 weeks).

C. Processing Schedule

20. The major milestones are in Table 2.

Table 2: Proposed Processing Schedule

Milestones	**Expected Completion Date**
Concept paper approval	September 2017
Loan fact-finding mission	November 2017
Management review meeting	March 2018
Loan negotiations	April 2018
Board consideration	June 2018
Loan signing	December 2018
Loan effectiveness	March 2019

Source: Asian Development Bank.

IV. KEY ISSUES

21. No key issues.

[12] ADB. 2016. *Technical Assistance to the Socialist Republic of Viet Nam for Support to Strengthening Local Health Care Program.* Manila.

DESIGN AND MONITORING FRAMEWORK

Impact the Program is Aligned with

Network of local health facilities to ensure responsive PHC for the entire population strengthened (Master Plan on Construction Development [a] and International Health Regulations)[b]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Outcome Quality of and access to LHC services for women and men, particularly in disadvantaged and remote areas improved	By 2024 a. _% of CHSs in target zone 3 communes meet MOH technical service requirements related to obstetrics, gynecology, neonatology, family planning, and abortion[c] (Baseline 2018: NA). b. Outpatient visits per person per year to CHSs in target zone 3 communes increased by xx with data disaggregated by age, gender, and ethnic group (Baseline 2018: TBD).[d] c. The proportion of pregnant women in targeted zone 3 communes that have three antenatal care visits throughout three trimesters increased by xx, disaggregated by ethnicity (Baseline, 2018: NA).[d] d. Score on JEE assessment of human resources available to implement IHR core capacity requirements (Baseline 2016: JEE Indicator D.4.1 Score = 3)	a. MOH PPMS, MF-MPSLHCS b. MOH PPMS c. MOH PPMS d. JEE Assessment	Shift in political leadership weakens support for investment in the LHC system
Outputs 1.Public investment management for local health care strengthened.	**Program** **By 2018:** 1a. _% of provincial governments in target provinces that have an investment plan for upgrading CHS infrastructure, including communes susceptible to RHS threats (Baseline 2017: TBD) 1b. 100% of prioritized provinces comply with national government standards and requirements for financing CHS investments (Baseline 2017: TBD) **Project** **By 2022:** 1c. _% increase in budget allocation to provinces for CHS infrastructure (Baseline 2018: TBD) 1d. _% of CHS undertaking notifiable disease reporting via a web-based software (Baseline 2018: TBD)[e] 1e. _% of CHSs in target provinces meet the minimum equipment requirements per MOH guidelines (Baseline 2018: TBD) 1f. _% of zone 3 CHS buildings in target provinces meet the National Standards for Commune Health,[c] including gender-sensitive services (Baseline 2018: 0)[d]	1a–1b. Decisions, circulars, guidelines, and supporting documents issued by MOH 1c–1f. MOH PPMS and MF-MPSLHCS; annual project progress report	Expansion of national debt beyond projected levels leads to more restrictive policies on the use of public investment for LHC.
2.Service models of local health care network improved	**Program** **By 2018:** 2a. New regulation removing inconsistencies in the requirements and procedures for the granting of operating licenses approved (Baseline 2017: Not approved). 2b. New regulation on the list of basic health services to be delivered by CHS and funded through health insurance approved (Baseline 2017: Not approved)	2a–2c. Decisions, circulars, guidelines, and supporting documents issued by MOH	

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	2c. Multisectoral steering committee for one health response to health security threats established at local level (Baseline 2017: TBD) **Project** **By 2022:** 2d. _% of CHS in target provinces implementing family doctor model (Baseline 2018: TBD) 2e. _% of CHS in target provinces issued with operating licenses (Baseline 2018: TBD) 2f. _% of CHSs in target provinces delivering the full list of basic health services covered by health insurance (Baseline 2018: TBD) 2g. _% of outbreak response reports from target communes indicate appropriate measure (Baseline 2018: TBD) 2h. _% of CHS with SOPs on cross-border disease outbreak response (Baseline 2018: TBD)[e]	2d–2h. MOH PPMS and MF-MPSLHCS; annual project progress report	
3.Local health care workforce development and management strengthened	**Program** **By 2018:** 3a. Practitioner licensing system that monitors practitioner compliance with CME established in _% of target provinces (Baseline 2017: TBD) 3b. Minimum professional standards and requirements for ensuring quality pharmacy, nutritionist, nursing, and midwifery professionals updated and issued (Baseline 2017: Not issued) 3c. An incentive and payment mechanism for the preventive health care workforce to ensure recruitment and retention of properly qualified preventive staff in the system to meet IHR core capacities established (Baseline 2017: Not established) **Project** **By 2022:** 3d. _% of licensed doctors and _% of licensed nurses practicing in public LHC facilities (Baseline 2018: TBD) 3e. _% of CHSs providing staff with e-learning modalities for continuous professional development (Baseline 2018: TBD) 3f. _% of commune health staff with increased knowledge on RHS threats, NCD, ageing-related illnesses, and SRH, _% of which are women (Baseline 2018: TBD) 3g. _% of zone 3 CHSs in targeted provinces that meet the minimum personnel requirements specified in the National Standards for Commune Health[c] (Baseline 2018: TBD) 3h. _% of CHSs in areas susceptible to RHS threats participating in simulation exercises for responding to cross-border disease outbreaks (Baseline 2018: TBD)[e]	3a–3c. Decisions, circulars, guidelines, and supporting documents issued by MOH 3d–3h. MOH PPMS and MF-MPSLHCS; project annual progress report	

Key Activities with Milestones

1. Public investment management for LHC strengthened (Project)

1.1 Establish and staff PMU by April 2018
1.2 Develop equipment lists for CHSs in prioritized areas by January 2020
1.3 Supply equipment to CHSs in prioritized areas by December 2021
1.4 Operate systems for detection of and response to RHS threat by June 2021

2. Service models of LHC network improved (Project)

2.1 Assess the capacity of CHSs in targeted provinces to implement the BHSP and family doctor model by December 2019
2.2 Assess local-level mechanisms and capacity for response to HSTs, including cross-border response
2.3 Implement models for enhanced PHC delivery and financing (BHSP, family doctor) and enhanced response to health security threats in prioritized areas by January 2022
2.4 Expand approaches for strengthened health information management and evidence-based service planning by January 2022

3. LHC workforce development and management strengthened (Project)

3.1 Assess local level health human resources training needs by September 2019
3.2 Develop curriculum and delivery mechanisms by December 2020
3.3 Provide training to CHS staff in prioritized areas by December 2022
3.4 Expand approaches for knowledge and skills transfer from DHCs to CHSs by January 2022

Inputs

ADB Concessional Ordinary Capital Resources: $80,000,000
ADF Regional Health Security Grant: $12,000,000
Government: $20,000,000

Assumptions for Partner Financing

Not applicable.

ADB = Asian Development Bank, ADF = Asian Development Fund, BHSP = Basic Health Service Package, CHS = commune health station, CME = continuing medical education, DHC = district health center, DOH = Department of Health, HST = health security threat , IHR = International Health Regulations, JEE = joint external evaluation, LHC = local health care, MOH = Ministry of Health, MF-MPSLHCS = Monitoring Framework—Master Plan for Strengthening Local Health Care Services, MOF = Ministry of Finance, NA = not applicable, NCD = noncommunicable disease, PHC = primary health care, PMU = project management unit, PPMS = project performance management system, SDG = Sustainable Development Goal, SOP = standard operating procedure, SRH = sexual and reproductive health, RHS = regional health security, TBD = to be determined, UHC = universal health coverage.

Notes:

[a] Decision 2348/QD-TTg (5 December 2016): Approval of the Master Plan on Construction and Development of Local Health Facility in the New Situation.

[b] World Health Organization. 2005. International Health Regulations.
Decision 43/2013/TT-BYT (11 December 2013) detailing levels of technical service delivery applicable to health facilities. Technical services to be performed at CHSs and family doctors' clinics include several techniques related to obstetrics, gynecology, neonatology, family planning, and abortion.

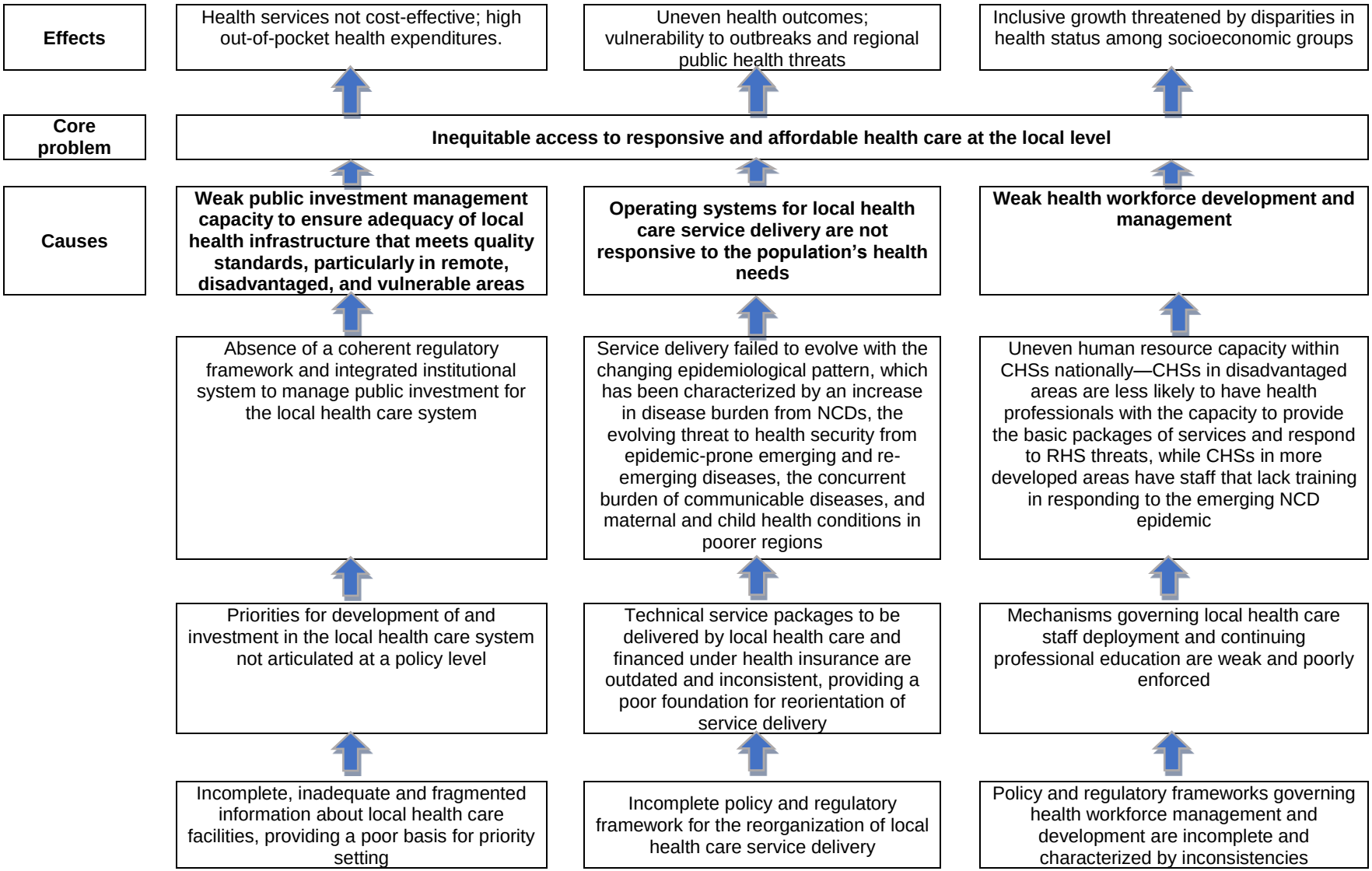
[c] Decision 4667/QD-BYT (7 November 2014) on the National Standards for Commune Health for the Period to 2020.

[d] Following the classification in MOH Decision 4667/QD-BYT (2014). Zone 3 includes communes in mountainous, remote border, and island areas >5 kilometers (km) from the CHS to the nearest higher-level facility (>3 km in areas of particularly difficult terrain), and >15 km in delta or midland areas. Zone 2 includes communes in mountainous, remote border, and island areas <5 km from the CHS to the nearest higher-level facility (<3 km in areas of particularly difficult terrain), and 3 km–15 km in delta or midland areas. Zone 1 includes communes in delta or midland areas <3 km from the CHS to the nearest higher-level facility. Per the master plan, normal delivery services, obstetric techniques, and provision of family planning services are included in the mandatory tasks that CHSs in zone 3 are requested to perform.

[e] Outputs will complement those under ADB. 2016. *Report and Recommendation of the President to the Board of Directors: Proposed Loans and Grant to the Kingdom of Cambodia, Lao People's Democratic Republic, Republic of the Union of Myanmar, and Socialist Republic of Viet Nam: Greater Mekong Subregion Health Security Project.* Manila.

Source: Asian Development Bank.

PROBLEM TREE



CHS = commune health station, NCD = noncommunicable diseases, RHS = regional health stations.
Source: Asian Development Bank.

INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	Viet Nam	Project Title:	Local Health Care Sector Development Program
Lending/Financing Modality:	Sector Development Program	Department/ Division:	SERD / SEHS

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

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

Viet Nam has made significant progress in reducing poverty and improving health status since 2000, but challenges remain. Inequity in health is increasing between rapidly developing urban areas and disadvantaged remote areas, where morbidity and mortality associated with communicable disease and maternal, perinatal, and nutritional conditions remains high. Ethnic minorities and members of poor households in remote areas bear a disproportionate share of the disease burden. Communicable diseases in border areas pose an ongoing threat to regional health security, while Viet Nam faces a significant and growing burden from NCDs. World Health Organization estimates for 2012[a] show NCDs accounted for the highest share of the overall disease burden in Viet Nam, and 72.9% of deaths. As the population ages, the share of the disease burden attributable to NCDs is likely to rise. NCDs are a financial burden for households, particularly the poor. The dual burden of communicable diseases and NCDs presents challenges for the institutional capacity of Viet Nam's health system, particularly at the local level.

The proposed Local Health Care Sector Development Program will assist the Government of Viet Nam to implement its Master Plan for Strengthening the Local Health Care Program to achieve UHC and help meet the health-related Sustainable Development Goals. The program will benefit (i) the poor and ethnic minorities, who suffer high morbidity and mortality attributable to communicable disease, and maternal, perinatal, and nutritional conditions; and (ii) vulnerable populations in disadvantaged communities where the NCD burden is highest. The loan supports implementation of the government's plan for people's health protection, care, and promotion 2016–2020,[b] which prioritize addressing the supply-side constraints to LHC service delivery and demand-side strengthening of health financing as a strategy for achieving UHC. The program is included in the ADB country operations business plan, 2017–2019 for Viet Nam, and aligned with the development objectives of the country partnership strategy for Viet Nam 2016–2020, particularly in increasing inclusiveness of infrastructure and service delivery.[c] It is consistent with the ADB operational plan for health and sector strategy for Viet Nam, which prioritize health system strengthening.[d]

B. Poverty Targeting

☐General Intervention ☐Individual or Household (TI-H) ☒ Geographic (TI-G) ☐Non-Income MDGs (TI-M1, M2, etc.)

The MOH National Standards for Commune Health classify CHSs into one of three zones based on the proximity of a CHS to higher-level facilities. The program will focus on CHSs in zone 3 communes, which (i) are disadvantaged communes in remote, mountainous, and border areas more than 5 km from a higher-level health facility (>3 km in areas of particularly difficult terrain and >15 km in delta or midland areas); (ii) have a poverty incidence significantly above the national average; (iii) have large differentials on key health indicators compared to national measures; (iv) have a high ethnic minority population; and (v) are identified as priority locations for socioeconomic assistance.

C. Poverty and Social Analysis

1. Key issues and potential beneficiaries.

The program component will benefit the populations residing in the most disadvantaged communes nationally, with the master plan specifying zone 3 communes in remote and disadvantaged areas are priorities for investment.[e] The project component will target up to six provinces where ADB operates.[f] The program will enhance the availability, accessibility, and acceptability of LHC services in these areas and will benefit (i) the poor and ethnic minorities who suffer high morbidity and mortality attributable to communicable disease, and maternal, perinatal, and nutritional conditions; and (ii) vulnerable populations in disadvantaged communities with the highest NCD burden.

2. Impact channels and expected systemic changes.

The program is a geographically targeted intervention that addresses constraints to the availability and accessibility of LHC services for populations in disadvantaged, mountainous, remote, and border areas. The program will help improve health status, especially for the poor and ethnic minority populations. It will indirectly contribute to poverty reduction by reducing expenditures on catastrophic illness and improving the productivity of the population.

3. Focus of (and resources) allocated in the loan program for due diligence.

The loan program will undertake safeguards assessment for (i) environment, (ii) involuntary resettlement, (iii) indigenous peoples, and (iv) poverty and social analysis. The loan program will prepare the required plans and frameworks, which will provide specific strategies for mitigating safeguards risks and improving the social development, gender, and community empowerment aspects of the program.

II. GENDER AND DEVELOPMENT

1. What are the key gender issues in the sector/subsector that are likely to be relevant to this project or program?

Gender disparities with regard to social, economic, and health indicators in Viet Nam are stark, and driven largely by gender-based cultural, physical, and/or social barriers that render critical health services inaccessible and/or unacceptable to certain groups of women. Examples include (i) limited access to family planning and reproductive health services—particularly for young and unmarried women and migrants in remote regions—which underlies the increasing incidence of adolescent pregnancy, and heightened risk of exposure to HIV and other sexually transmitted infections; and (ii) the inability of ethnic minority women to seek services—due to remoteness, poor quality of care, language and cultural barriers, and their inability to pay—which contributes to very high maternal mortality ratios (rates among some ethnic minority populations exceed those of majority Kinh by a factor of four). Bridging gaps between women and men in socioeconomic and health outcomes requires LHC system reforms that address the barriers to access. Ensuring gender equality in access to and benefits from health services is an objective of the National Strategy on Gender Equality 2011–2020,[g] and requires (i) increased access to SRH services and information; and (ii) provision of responsive SRH services at no cost in ethnic minority areas.

2. Does the proposed project or program have the potential to make a contribution to the promotion of gender equity and/or empowerment of women by providing women's access to and use of opportunities, services, resources, assets, and participation in decision-making?

☒ Yes ☐ No

The program will provide women and girls with improved access to quality essential health services in their locality through (i) development of commune-level health infrastructure incorporating gender-friendly design features; (ii) service delivery and financing modalities that accommodate women's social and cultural preferences, including ethnic minority women; and (iii) the availability of services critical to the health and well being of women, example, e.g., comprehensive antenatal in remote areas and universal access to SRH services. The program will contribute to gender equality and women's empowerment through improved health outcomes for women and girls.

3. Could the proposed project have an adverse impact on women and/or girls or widen gender inequality?

☐ Yes ☒ No

4. Indicate the intended gender mainstreaming category:

☐ GEN (gender equity) ☒ EGM (effective gender mainstreaming)
☐ SGE (some gender elements) ☐ NGE (no gender elements)

The possibility to elevate the gender category to GEN will be explored during due diligence and will depend on the extent to which gender-related reforms can be included in the policy matrix. Relevant gender targets, gender-related policy actions as well as gender measures for the project component will be identified and further developed during program preparation. Focus will be given to increasing access to SRH information and services in line with the National Strategy on Gender Equality 2011–2020 and the master plan for strengthening LHC services.

III. PARTICIPATION AND EMPOWERMENT

1. Who are the main stakeholders of the project, including beneficiaries and negatively affected people? Identify how they will participate in the project design.

The program's key institutional stakeholders are (i) MOH officials from relevant departments; (ii) health staff from provincial, district, and commune levels; (iii) people's committees and mass organizations in program localities; and (iv) other development sector partners supporting LHC system strengthening in Viet Nam. Beneficiary stakeholders are (i) women, girls, men, and boys living in the communes the program targets; and (ii) commune health staff working in target communes. MOH has undertaken initial consultations with institutional stakeholders during program scoping, using data from these consultations to identify the most disadvantaged communes to target under the program. Consultations will be informed by a review of the substantial body of literature on health equity in Viet Nam.

2. How can the project contribute (in a systemic way) to engaging and empowering stakeholders and beneficiaries, particularly, the poor, vulnerable, and excluded groups? What issues in the project design require participation of the poor and excluded?

The program will help empower stakeholders and beneficiaries, particularly the poor and vulnerable, through interventions to reorient LHC service delivery models to respond to primary health care needs and address the social determinants of health in each community. During program design, barriers to the accessibility and acceptability of LHC services experienced by poor and vulnerable groups, including ethnic minority people, will be assessed to inform the development of service delivery modalities that accommodate social and cultural preferences.

3. What are the key, active, and relevant civil society organizations in the project area? What is the level of civil society organization participation in the project design?

M Information generation and sharing M Consultation L Collaboration N Partnership

Community mass organizations (e.g., women's unions) are among stakeholder groups to be consulted during the design. International and national nongovernment organizations with experience working in the program's target areas will be engaged as a source of information.

4. Are there issues during project design for which participation of the poor and excluded is important? What are they and how shall they be addressed? ☒ Yes ☐ No During program design, barriers to the accessibility and

acceptability of LHC experienced by poor and vulnerable groups, including ethnic minorities, will be assessed through consultations, focus group discussions, and review of literature on health equity in Viet Nam.

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☒ B ☐ C ☐ FI

1. Does the project have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☒ Yes ☐ No If construction of new CHS requires land acquisition.

2. What action plan is required to address involuntary resettlement as part of the project preparatory technical assistance (PPTA) or due diligence process?

☒ Resettlement plan ☐ Resettlement framework ☒ Social impact matrix
☐ Environmental and social management system arrangement ☐ None

B. Indigenous Peoples Category ☐ A ☒ B ☐ C ☐ FI

1. Does the proposed project have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☒ Yes ☐ No Program locations include regions with large ethnic minority populations. The program seeks to improve health service access and, ultimately, the socioeconomic status of disadvantaged groups.

2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No

3. Will the project require broad community support of affected indigenous communities? ☐ Yes ☒ No

4. What action plan is required to address risks to indigenous peoples as part of the PPTA or due diligence process? ☒ Indigenous peoples plan ☐ Indigenous peoples planning framework ☒ Social Impact matrix
☐ Environmental and social management system arrangement ☐ None

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the project design?

☐ Creating decent jobs and employment ☒ Adhering to core labor standards ☐ Labor retrenchment
☐ Spread of communicable diseases, including HIV/AIDS ☐ Increase in human trafficking ☐ Affordability
☐ Increase in unplanned migration ☐ Increase in vulnerability to natural disasters ☐ Creating political instability
☐ Creating internal social conflicts ☐ Others, please specify _____

2. How are these additional social issues and risks going to be addressed in the project design? Each civil works contract will include provisions requiring the contractors to (i) follow the government's core labor laws and regulations, and (ii) ensure compliance with occupational health and safety standards.

VI. PPTA OR DUE DILIGENCE RESOURCE REQUIREMENT

1. Do the terms of reference for the (or other due diligence) contain key information needed to be gathered during PPTA or due diligence process to better analyze (i) poverty and social impact; (ii) gender impact, (iii) participation dimensions; (iv) social safeguards; and (v) other social risks. Are the relevant specialists identified? ☒ Yes ☐ No

2. What resources (e.g., consultants, survey budget, and workshop) are allocated for conducting poverty, social and/or gender analysis, and participation plan during the PPTA or due diligence?

Poverty, social, and gender analyses will be undertaken by social development consultants (international, 2 person-months; national 4 person-months). Safeguard consultants (international, 1 person-month; national, 4 person-months) will consult with affected persons and prepare a resettlement framework and/or plans (as required) and indigenous peoples plan. Resources ($10,000 for surveys, and $34,000 for workshops and seminars are allocated).

ADB = Asian Development Bank, CHS = commune health station, km = kilometer, LHC = local health care, MOH = Ministry of Health, NCD = noncommunicable disease, SRH = sexual and reproductive health, UHC = universal health care.

[a] World Health Organization. 2014. *Global Status Report on Noncommunicable Diseases 2014*. Geneva.
[b] Ministry of Health. 2016. *Plan for people's health protection, care, and promotion in the period 2016–2020.* Hanoi. World Health Organization. 2014. *Global Status Report on Noncommunicable Diseases 2014*. Geneva.
[c] ADB. 2016. *Country Operations Business Plan: Viet Nam, 2017–2019*. Manila; ADB. 2016. *Country Partnership Strategy: Viet Nam, 2016–2020*. Manila
[d] ADB. 2015. *Health in Asia and the Pacific—A Focused Approach to Address the Health Needs of ADB Developing Member Countries: Operational Plan for Health, 2015–2020*. Manila.
[e] Specified in Section III 5 b of the Master Plan for Strengthening Local Health Care Services. Decision 2348/QD-TTg (5 December 2016): Approval of the Master Plan on Construction and Development of Local Health Facility in the New Situation.
[f] Beneficiary numbers to be determined during program preparation following province selection.
[g] Government of Viet Nam. 2011. *National Strategy on Gender Equality for the 2011–2020 period.* Hanoi. http://www.chinhphu.vn/portal/page/portal/English/strategies/strategiesdetails?categoryId=30&articleId=10050924