Ethnic Minority Development Plan

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Local Health Care Sector Development Program (LHCSDP)

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ABBREVIATIONS

ADB – Asian Development Bank
CEMA – Committee on Ethnic Minority Affairs
CHS – Commune health station
CPMU- Central Project Management Unit
HHR – Health human resource
HST – Health security threat
LHC – Local health care
MOH – Ministry of Health
NCD – Noncommunicable disease
PHC – Primary health care
PPMU – Provincial Project Management Unit
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.

Table of Contents

Page

I. Project Description 1
II. Legal and Policy Framework 2
  A. National Legal and Policy Framework for Ethnic Minority People..............................2
  B. Policy and Development Program for Ethnic Minority Groups...................................3
  C. ADB Safeguard Policy for ethnic minority people...4
  D. Principles of ADB SPS 2009 for indigenous peoples: 4
III. Social Impact Assessment...5
  A. Methodology 5
  B. General Information of Ethnic Minority in Viet Nam..6
  C. Ethnic Minorities in select provinces 7
  D. Ethnic Minority Health Human Resources in the case study areas 7
  E. Information disclosure and meaningful Consultation. 9
IV. Proposed measures to address barriers to access of ethnic minorities to health services and enhance project benefits. 12
V. Grievance Redress Mechanism..17
VI. Implementation Arrangements...18
  A. Executing agency (EA) 18
  B. Central Project Management Unit (CPMU) 18
  C. Provincial Project Management Unit (PPMU – Implementation Agency)..................19
  D. Project implementation support consultants (PIC)...19
VII. Monitoring and Reporting 19
  A. Reporting...19
  B. Monitoring Indicators 19
VIII. Budget for EMDP Implementation 20
IX. Indicative Implementation Schedule 20

List of Tables

Table 1: Legal documents related to ethnic minority people ... 2
Table 2 Information of ethnic minority people in project provinces ... 7
Table 3 EM health human resource in Kon Tum province ... 8
Table 4 EM health workers at the CHS level in Soc Trang province ... 9
Table 5 Status of health human resource in 6 provinces ... 13
Table 6 Project outputs and proposed measures to mitigate impacts ... 13
Table 7 Monitoring indicators in EMDP ... 19
Table 8 Indicative implementation schedule ... 21

EXECUTIVE SUMMARY

Project description

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, which sets out reforms to improve access to and the quality of the local health care (LHC) system. The program's impact will be a network of local health facilities to ensure responsive primary health care (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. The project grant will be implemented in 6 target provinces.

Ethnic minority groups in project areas

In general, the proportion of ethnic minority people in the select provinces is relatively high, with an average of 25.5%, higher than the national average of 14.6%. Ethnic minority groups present in the select provinces include Thai, Kho Mu, Tay, Dao, San Chay (Cao Lan), Nung, Hoa, H'Mong, San Diu, Xe Dang, Khmer, Xơ Đăng; Ba na; Gia Rai; Gie Trieng; Brau; Ro Nam; Hrê; Muong. Factors that limit the access of ethnic minorities to health services include their location in isolated areas with transportation constraints, and relatively low educational levels leading to a lack of knowledge about health care.

Information disclosure and meaningful Consultation

Several consultations were held during project preparation with the participation of stakeholders, including local authorities and representatives of two ethnic minority groups (Khmer and Xe Dang). Consultations were held from 26 to 29 December 2017 in 4 communes (4 districts) in provinces of Soc Trang and Kon Tum to provide the EM people with information on the project and proposed activities, and to get EMs' feedback and comments on the measures to be included in the ethnic minorities development plan. Participants included 43 ethnic minority households and 36 staff members of the Department of Health (DOH), District Health Stations (DHSs), Commune Health Stations (CHSs) and Committee on Ethnic Minority Affairs (CEMA) in the provinces/districts. Information disclosure and consultation activities will continue throughout project implementation to ensure that EM stakeholders receive adequate information on project activities in a timely manner and are able to provide their feedback towards increasing their access to local health care services: A marketing and awareness-raising strategy on new service models of LHC will be developed that is gender and EM sensitive. Furthermore, all IEC materials used for health prevention and education activities at local health care level in the target districts will be gender and culturally (EM) sensitive.

Proposed measures to address barriers to access of ethnic minorities to health services and enhance project benefits

Consultations were held with CEMA and other relevant agencies such as provincial DOH to identify methods of identifying ethnic minority groups and developing measures to increase access to local health care services. The measures includes (i) development of a communication strategy for women and ethnic minority; (ii) inclusion of ethnic minority medical staff in capacity building activities, (iii) collaboration with concerned agencies for ethnic minority including Provincial/district CEMA during implementation; and (iv) disaggregation of project performance indicator data by ethnicity.

Grievance and redress mechanism

Grievance and redress mechanism in this EMDP have developed based on Vietnam's laws on complaints and denunciations. The proposed GRM has been consulted with local authorities and the ethnic minority communities.

Budget for EMDP implementation

The budget for the EMDP including (i) development of the communications strategy and (ii) training for health human resources and monitoring is included in the overall project grant budget under the following line items: (i) trainings and workshop; (ii) IEC and community mobilization

Implementation Arrangements

The implementation of the EMDP requires the coordination of organizations and agencies from the MOH to the ethnic minority communities at the local level. The Central Project Management Unit (CPMU) under Ministry of Health (MOH) will be the lead organization and coordinate with Provincial Project Management Units (PPMUs) in implementing, monitoring and reporting on EMDP implementation with support from the project implementation consultant.

I. PROJECT DESCRIPTION

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, which sets out reforms to improve access to and the quality of the local health care (LHC) system. 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.

2. **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.

3. **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.

4. **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. In this regard, seven training courses will be delivered to health staff at the commune and/districts level with specific targets for female and ethnic minority participation.

5. To ensure that project benefits reach ethnic minorities in the target provinces, a number of enhancing measures need to be implemented during the preparation and implementation of the project such as: (i) development of a gender and EM-sensitive project communications strategy, and, (ii) encouragement of ethnic minority health staff to participate in capacity building activities. These measures are described further in this report.

II. LEGAL AND POLICY FRAMEWORK

A. National Legal and Policy Framework for Ethnic Minority People

6. According to the Government of Viet Nam, ethnic minorities have the following characteristics including (i) An intimate understanding and long stay in the territory, land or area of their ancestors with close attachment to natural resources; (ii) Self-identification and recognized by neighboring members by their distinctive culture, (iii) A language different from the national language, (v) A long traditional social and institutional system, and (vi) A self-provided production system.

7. Review of the legal and institutional framework applicable to EM Peoples in the project context shows that the Government has a strong commitment to addressing poverty among Viet Nam's EMs, as evidenced by the great number of policies and programs targeting EM development.

8. The Constitution of the Socialist Republic of Vietnam (2013) recognized the right to equality among the ethnic groups in Vietnam. Article 5, 2013 Constitution promulgates that: "The Socialist Republic of Vietnam is the unified nation of all nationalities living on the territory of Vietnam; All nationalities are equal, solidary, mutually respect and assist in their developments; all acts of national discrimination and division are strictly forbidden; The national language is Vietnamese. Every nationality has the right to use its own language and system of writing, to preserve its national identity, and to promote its fine customs, habits, traditions and culture; The State implements a policy of comprehensive development, and provides conditions for the national minorities to promote their internal abilities and to develop together with the nation."

9. The application of socio-economic policies for each region and ethnic group which takes the demands of the ethnic minority people into account is an essential requirement: The Socioeconomic development plan and strategies in Vietnam give great consideration to the ethnic minority people; Major programs for ethnic minorities include Program 135 (Infrastructure of the poor, remote and mountainous areas) and Program 134 (Eradicating Temporary houses for the poor). In addition to educational and healthcare policies towards the ethnic minority people, the legislative frameworks for the ethnic minority people by 2007 include instruments relevant to regional master planning, the Program 135 - phase II and policies on land management and compensation. Table 1 includes all the references to the legislative instruments.

Table 1: Legal Documents Related to Ethnic Minority People

2013	Joint circular No. 05/2013-TTLT-UBDT-NNPTNT-KHDT-TC-XD dated 18 November 2013 on to guide 135 Program on infrastructure investment, production development for extreme difficulty commune, border commune,Secure area commune, and extreme difficulty hamlet/ 13 village
2012	Decision No. 54/2012-QD-TTg of the Prime Minister dated 4 December 2012 on the Issue of capital lending policy for extreme difficulty ethnic household in 2012-2015 period)
2012	Decree No. 84/2012/ND-CPdated 12 October 2012 of the Government on the function, task, responsibilities and organizational structure of the Committee for Ethnic Minority Affairs.
2012	Joint circular No.01/2012/TTLT-BTP-UBDTdated 17 January 1012 of Ministry of Justice and Committee for Ethnic Minority Affairs on legal guidance for ethnic minority people

2010	Decree No. 82/2010/ND-CPdated 20 July 2010of the Government on learning and teaching in ethnic minority languages at school.
2009	Decision No. 102/2009/QD-TTG dated07 August 2009 of the Prime Minister on direct support policy for ethnic minority people in the difficulty area
2008	Resolution No. 30a/2008/NQ-CPof the Government dated 27 December 2008 on the rapid and sustain poverty reduction program for the most 61 poorest districts.
2007	Circular No. 06 dated 20 September 2007 of Committee for Ethnic Minority Affairs on guidance of livelihood support services, technical support to raise awereness on Laws in accordance with Decision No. 112/2007/QD-TTg
2007	Decision No. 05/2007/QD-UBDT dated06 September 2007 of Committee for Ethnic Minority Affairson the acceptance of three ethnic minority and mountainous areas based on the development status
2007	Decision No. 01/2007/QD-UBDT dated31 May 2007 of Committee for Ethnic Minority Affairson the acceptance of commune, district in the mountainous area
2007	Decision No. 06/2007/QD-UBDT dated on 12 January 2007 of Committee for Ethnic Minority Affairson Communication Strategy for 135 Program – Phase 2.

B. Policy and Development Program for Ethnic Minority Groups

10. The Government has issued and delivered many policies and programs to support ethnic minority groups and improve their living standards. Ethnic Minority Groups receive benefit from the following programs and policies:

(i) Program 135 (Phase 2) on the socio-economical development for the poor commune in ethnic minority and remote area.
(ii) The program invested in accordance with Resolution 30a on the support of seedling, breeds working tools and capital sources
(iii) The National Target Program on rural hygiene and clean water supply.
(iv) The National Target Program on population and family planning.
(v) The national target program on prevention of dangerous social diseases, epidemic and HIV/AIDS.
(vi) The National Target Program on education and training.
(vii) The policy on the granting of health insurance cards for ethnic minorities belonging to the following groups: poor household members, near poor households, people living in areas with difficult socio-economic conditions, People living in areas with particularly difficult socio-economic conditions are required by the Law on Health Insurance.
(viii) Policies to support medical examination and treatment expenses (including food, self-transport, emergency transportation and home death) for the poor and ethnic minority people living in the area where socio-economic conditions are difficult to provide for in-patient medical examination and treatment at district-level medical establishments at the levels prescribed in the Prime Minister's Decision No. 14/2012 / QD-TTg dated on March 1, 2012 revised Decision 139/2002/QD-TTg on medical examination and treatment for the poor.

(ix) Policies to support poor women who are ethnic minority people when having children in accordance with the population policy according to Decree No. 39/2015/ND-CP dated 27/4/2015 of the Government.

(x) Policy on training human resources for difficult and mountainous areas according to the recruitment level in the Prime Minister's Decision No. 1544/QD-TTg dated November 14, 2007 approving the scheme on human resource training for health workers; For disadvantaged areas, the mountainous areas of the Northern and Central provinces, the Mekong River Delta and the Central Highlands according to the nomination regime.

C. ADB Safeguard Policy for ethnic minority people

11. The objectives of the indigenous peoples safeguard as set out in the ADB Safeguard Policy Statement (SPS) 2009 are to ensure that projects are designed and implemented in a way that fosters full respect for indigenous peoples identity, dignity, human rights, livelihood systems, and cultural uniqueness as they define them. This is so that indigenous peoples: 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.

12. Per the ADB SPS, 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.

D. Principles of ADB SPS 2009 for indigenous peoples:

(i) 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;

(ii) Undertake a culturally appropriate and gender - sensitive [assessment of social impacts] or use similar methods to assess potential project impacts, both positive and adverse, on indigenous peoples;

(iii) 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;

(iv) 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;

(v) 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;

(vi) Prepare an Indigenous Peoples Plan (IPP) that is based on the [assessment of social impacts] 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;

(vii) Disclose a draft IPP, including documentation of the consultation process and the results of the [assessment of social impacts] 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;

(viii) 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;

(ix) 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.

III. SOCIAL IMPACT ASSESSMENT

A. Methodology

13. Several methods have been used during the preparation of the Ethnic Minority Development Plan (EMDP), including desk review of available documents[1] on ethnic minority people to determine the status and conditions of ethnic minority groups relating to health issues and access to health services. Focus group discussions and in-depth interviews were also carried out to identify barriers and difficulties faced by ethnic minorities in accessing the basic health services, and to propose measures to enhance the positive impact of the project.

14. The focus group discussions focused on Kon Tum in Central Highland and Soc Trang in the Mekong Delta, which are among the target provinces of the project and were selected because these are relatively poor provinces with high percentages of ethnic minority population, and considering travel time requirements. The sites for the fieldtrip in each province was selected based on the following considerations:

- Priority is given to poor and difficult places (communes of 3rd category classified by the Decision 4667/QD-BYT on 7 November 2014);
- Priority is given to communes with large number of ethnic minority people;

[1] (i) Pre-FS report, (ii) Health Yearbook 2015, (iii) Database of the Department of Organization and Personnel, MOH, for 2016 and report on 53 ethnic minorities conducted by CEMA in 2016.

15. In total, the team had visited 4 districts, and 4 communes in Kon Tum and Soc Trang

B. General Information of Ethnic Minority in Viet Nam

16. According to the report of 53 ethnic minorities prepared by CEMA in 2016, up to July 1, 2015, the total population of 53 ethnic minorities in Viet Nam is about 13.4 million people (representing 14.6% of the country's population) with 3.04 million households, scattered over 63 provinces/cities with 30,616 communes, wards and towns, of which 11% are wards and townships. The Northern Midlands and Mountains area has the highest number of ethnic minority people (6.7 million people), the Central Highlands (about 2 million people), the North Central Coast and the Central Coast (1.9 million people), the rest is concentrated in the South. Each ethnic group lives in different places and each village usually consists of several ethnic groups. Distribution of ethnic groups has changed due to migration, especially in Central, Central Highlands and the South areas.

17. Population size of ethnic groups is uneven: the Tay, Thai, Muong, Khmer, Nung and Mong communities have over one million people while the O Du, Brau, Ro Mam, Pu Peo and Si ethnic groups La, Cu, Y Bo, Lao, Ar, Lo Lo number only from a few hundred to less than 5000 people. 89.6% of ethnic minority people live in rural areas. Hoa is the only ethnic minority living in urban areas (61.9%).

18. By gender, the proportion of males and females is relatively balanced (50.4% male and 49.6% female) except for the San Chay, Tho, Pu Peo, San Diu, Ngai and Ou tribes. The percentage of males was higher (52%) than females.

19. In terms of household size, ethnic minority households range from 3.4 to 5.6 members. Ethnic minorities with less than 4 members per household include Brau, Hre, Ro Mam, Ngai, Giie Trieng, and Tay. Ethnic minorities with 5 or more members per household include Pa Dam, Ha Nhi, La Chi, H'Mong.

20. The percentage of ethnic minority people using health insurance cards is not high. As a rule, people with health insurance cards in general and ethnic minority people in particular will be entitled to health insurance policies. However, the rate of use of health insurance cards of the ethnic minorities was only 44.8%, and for some ethnic groups, the rate of using health insurance cards was less than 1/3 of the population (La Ha, Xtieng, Ngai, Xinh Mun, Muong, Gia Rai, Bo Y). The use of health insurance cards by ethnic minorities also serves as an indicator of the proportion of ethnic minority people going to medical facilities for medical examination and treatment.

21. Regarding the low rate of use of health insurance cards, some surveys conducted by CEMA in 2016 have indicated that the situation is due to: (i) use of alternative methods of treatment including self-treatment based on traditional methods (medicine folklore, superstitions). Ethnic minority community members only go to the commune or district health station when the disease has become too serious, while the capacity and conditions for treatment at the commune and district are weak; (ii) inadequate understanding of the benefits of health insurance cards; (iii) difficult economic conditions; (iv) the distance to medical facilities is very far: difficulties with transportation (limited vehicles, road conditions) combined with fears of travelling too far. The surveys by CEMA show that the distance from home to medical facilities is relatively far away, especially for some ethnic groups such as Mu, Cong, Lo Lo, La Hu. On average, homes are 3.8 km from clinics and 16.7 km from the hospital, with some ethnic groups living further away from hospitals such as: O Du - 72km, Ro Mam - 60.1km, Ha Nhi - 53.8km, Chut - 48km. In addition,

there are about 24 ethnic groups where the distance from home to hospital ranges from 20 km to 40 km.

C. Ethnic Minorities in select provinces

22. In general, the proportion of ethnic minority people in the select provinces is relatively high, with an average of 25.5%, higher than the national average of 14.6%. Ethnic minority groups are also diverse and include Thai, Kho Mu, Tay, Dao, San Chay (Cao Lan), Nung, Hoa, H'Mong, San Diu, Xe Dang, Khmer, Xơ Đăng; Ba na; Gia Rai; Gie Trieng; Brau; Ro Nam; Hrê; Muong. More information on ethnic minorities in the project provinces is shown in the table below

Table 2: Information of Ethnic Minority People in Select Provinces

No	Provinces	Population	EM	% EM
1	Quang Ninh	1,250,284	148,127	11.8
2	Tuyen Quang	760,300	433,832	57.1
3	Bac Giang	1,672,000	245,188	14.7
4	Phu Tho	1,369,700	234,014	17.1
5	Dien Bien	566,803	462,398	81.6
6	Lai Chau	425,100	358,879	84.4
7	Quang Nam	1,565,121	133,472	8.5
8	Phu Yen	893,400	57,063	6.4
9	Binh Thuan	1,215,200	89,906	7.4
10	Kon Tum	513,790	273,364	53.2
11	Gia Lai	1,306,649	650,816	49.8
12	Dak Nong	587,800	170,363	29.0
13	Binh Phuoc	972,937	178,551	18.4
14	Soc Trang	1,365,174	472,428	34.6
15	Ca Mau	1,018,788	40,425	4.0
	Whole country	**91,713,300**	**13,386,330**	**14.6**

Sources: for the whole country and provinces Phu Tho, Lai Chau, Phu Yen, Binh Thuan, and Dak Nong the data from the Health Yearbook 2015; for other provinces the data come from the database of the Department of Organization and Personnel, MOH, for 2016

D. Ethnic Minority Health Human Resources in the case study areas

a) Health Human Resource in Kon Tum Province

23. In Kon Tum province, there are 2,636 health workers, including 507 medical doctors, working in provincial and district hospitals, and in the commune health stations. About half of the health workforce and medical doctors work at the provincial-level hospitals (1,244 staff including 253 medical doctors). The remaining half of the health workforce work at district and commune levels.

24. Ethnic minority health workers account for 20% of the total workforce at district and commune levels. This scale is far below the 53% of ethnic minorities among the total provincial population. However, the representation of ethnic minorities among medical doctors is quite impressive, with 54% of medical doctors being ethnic minority people for the total district and commune health care levels—the scale that is compatible with the share of ethnic minority in the

general population. At district level, ethnic minority doctors account for 34% (54 out of 161 doctors), but at the commune health stations ethnic minority doctors account for as high as 90% total number of medical doctors at commune level (84 out of 93 medical doctors working in CHSs). The high scale of ethnic minority medical doctors at commune level is perhaps the result of the government policy giving priority and favorable conditions for recruitment of EM from difficult areas for medical training (they do not need to take university entry examination) according to Decision 1544/QD-TTg by the Prime Minister on 14 November 2007. For other qualifications, the scales of ethnic minority people are far below the share of EM among general population. Please see below table for more information on EM health workers in Kon Tum province.

Table 3: EM Health Human Resource in Kon Tum province

No.	Qualification	Total			District level facilities			Commune health stations (CHSs)		
		Total	Female	EM	Total	Female	EM	Total	Female	EM
	Total	**1392**	**893**	**280**	**771**	**490**	**100**	**621**	**403**	**180**
1	Medical doctors	254	90	138	161	52	54	93	38	84
2	University pharmacists	16	8	5	15	8	5	1	0	0
3	2nd degree pharmacists	154	122	6	54	57	0	100	65	6
4	Elementary pharmacists	6	5	0	1	1	0	5	4	0
5	Assistant doctors	252	147	40	110	56	7	142	91	33
6	High degree medical technician	9	4	0	9	4	0	0	0	0
7	2nd degree medical technician	53	22	16	51	21	16	2	1	0
8	Elementary technician	1	1	0	1	1	0	0	0	0
9	High degree nurses	20	9	3	17	8	3	3	1	0
10	2nd degree nurses	289	227	26	146	155	10	143	72	16
11	Elementary nurses	29	23	15	6	0	0	23	23	15
12	University degree midwives	8	6	1	4	2	1	4	4	0
13	2nd degree midwives	151	148	21	55	52	0	96	96	21
14	Elementary midwives	9	12	5	1	4	0	8	8	5
15	University or higher degree of public health	6	0	0	6	0	0	0	0	0
16	Other qualifications	135	69	4	134	69	4	1	0	0

Source: Report on health workers of Kon Tum province in 2016

b) Health Human Resource in Soc Trang Province

25. The total number of health workers in Soc Trang province is 3,376, including 654 doctors, 105 university pharmacists, 359 intermediate pharmacists, colleges, 720 physicians, 97 university nurses, 847 midwives, college; 31 primary care nurses, 394 middle-school midwives and 169 mid-level and college-level examiners. The scale of ethnic minority people in the health workforce is only 21.8% (21.7% are permanent staff and 0.1% are working on a contractual basis), far below the share of ethnic minority people in the general population.

26. The number of health workers in CHSs ranges from 8 to 12/CHS depending on the size of the commune population: 8 health workers for CHSs in communes with less than 10 thousand population; 9 health workers for CHSs in communes with 10-12 thousand population; 10 workers for communes with 12-14 thousand population; 11 workers for communes with 14-16 thousand

population; and 12 workers for communes with more than 16 thousand population. Please see below table for more details on the EM health workers at the CHS level in Soc Trang province.

Table 4: EM health workers at the CHS level in Soc Trang province

No.	District	Population	% EM	% Poor households	Number of CHS	Number of CHS with medical doctor	Total number of CHS health workers	% of CHS EM health workers
1	Ke Sach	168000	10.7	22.0	13	13	114	7.0
2	Cu Lao Dung	65596	30.7	10.6	8	8	65	0.0
3	Soc Trang city	143213	22.4	5.9	10	8	86	30.2
4	My Xuyen	161994	35.6	7.2	11	11	93	21.5
5	Long Phu	113856	28.6	13.0	11	11	85	21.2
6	Tran De	134409	49.0	11.3	11	4	98	29.6
7	Thanh Tri	100258	29.7	12.6	10	7	76	23.7
8	Chau Thanh	105026	46.6	13.6	8	7	67	29.9
9	Nga Nam town	90740	9.2	16.0	8	8	75	9.3
10	Vinh Chau town	187278	70.7	17.0	10	9	101	33.7
11	My Tu	110865	75.5	8.5	9	8	77	31.2
	Total	**1381235**	**39.8**	**12.7**	**109**	**94**	**937**	**21.8**

Source: Report on health workers of Soc Trang province in 2016

E. Information Disclosure and Meaningful Consultation

27. During project preparation, four focus group discussion/consultations (FGD) were conducted with 43 EM households in 4 communes, including two groups of ethnic minorities (Khmer and Xe Dang) from 26 to 29 December 2017 in provinces of Soc Trang and Kon Tum. In addition, 6 other group discussions with 36 staff members of DOH and CHCs of Kon Tum and Soc Trang provinces were conducted. (The list of participants is in the Appendix 1).

28. During project implementation, information dissemination and consultation meetings with local authorities and ethnic minority households will be held at each important stage of the project. A communications strategy will be developed by a Communications Specialist, supported by a Gender and Ethnic Minorities Specialist, and in consultation with relevant agencies such as provincial/district CEMA to ensure that project messages are delivered in a gender-sensitive and culturally-appropriate manner, considering the conditions of ethnic minority groups in the project areas.

29. During project implementation, all communes which have ethnic minority communities and are candidates for the project will be visited (at the time of first consultation with communes) by PPMUs, relevant local authorities and consultants. At this visit, the gender and ethnic minority/communication specialist and/or local Women's Union will undertake a screening for ethnic minority population with the help of ethnic minority leaders and local authorities. The screening will check for the following:

(i) Names of ethnic groups in the commune
(ii) Total number of ethnic minority groups in the commune
(iii) Percentage of ethnic minorities in the commune population
(iv) Characteristics of the ethnic minority groups including language commonly used, and access to information
(v) Status of access to health care services by EM communities, including barriers to accessing health care

30. Based on the information collected, the gender and ethnic minority experts and PPMU staff will design the communication strategy and organize consultation meetings with ethnic minority people in the area. Information to be disclosed will include (i) project activities, (ii) project objectives and (iii) project implementation plan. Opinions from ethnic minority people on how to maximize project benefits will also be obtained during the consultation meetings and incorporated as much as possible during project implementation.

31. The below is summary of results from consultation meetings and focus group discussion with ethnic minorities and other stakeholders during project preparation.

a) Characteristics of the Khmer and Xo Dang Ethnic Groups

<u>Xo Dang Ethnic Groups</u>

32. Xo Dang ethnic minority is concentrated in Kon Tum province, with a few members also residing in the mountainous areas of Quang Ngai and Quang Nam. Xo Dang has a close relationship with the Gie Trieng, the Co, the Hre and the Ba Na ethnic groups. According to the 2009 Population and Housing Census, the Xo Dang population in Viet Nam has a population of 169,501 and is present in 41 out of 63 provinces and cities. In Kon Tum province, their population is at 104,759 people, accounting for 24.4% of the province's population and 61.8% of the total number of Xo Dang in Vietnam. They are also present in Quang Nam (37,900 people, accounting for 22.4%), Quang Ngai (17,713 people), Dak Lak (8,041 people), and Gia Lai (705 people).

33. Each Xo Dang village has a communal house and tombstones to mark the burial areas. The houses are located close together so villagers can help each other. The most respected "village elder" is the person who runs all village activities and serves as the representative of the villagers. The name of the Xo Dang are gender indications: male is A, female is Y (such as A Nhong, Y Hon).

34. During pregnancy, women regularly visit commune health stations. However, at birth, they often do not come to the station because of (i) Psychological anxiety, (ii) The road is far and difficult and (iii) There are some experienced midwives in the village.

35. Because, the communication campaigns have been implemented quite well for Xo Dang ethnic minority people, so Xo Dang people have also had changes in health perception, and Xo Dang people always go to the CHS instead of asking the shaman. Besides, village health staffs

periodically inform and remind households to vaccinate at the station, therefore, most of Xo Dang people have their children vaccinated.

36. The distance from the villages to the commune health station is about 4-5 km. The road is difficult, but everyone in the village always go to the CHS for illness treatment. Most of Xo Dang people have health insurance cards, so the Xo Dang people are completely free of medical examination and treatment costs at the CHS. Xo Dang people in Kon Tum are fully satisfied with the current services of the health station, however, the Xo Dang people also want more health care facilities so that they can take treatment for severe illnesses at the CHS and they will not have to go to the district health center, which is difficult to reach due to road conditions.

Khmer Ethnic Groups

37. The Khmer in Vietnam (also known as Khmer Krom, Khmer-Crom, and Khmer-under) is a Khmer ethnic group living in the Mekong Delta of Vietnam. This group is also called Cambodian Vietnamese. Most Khmer people live in Cambodia. In Vietnam, the Khmer live mainly in the Mekong Delta, such as in Soc Trang, Tra Vinh, Bac Lieu, Ca Mau, Kien Giang, An Giang, Hau Giang, Can Tho, Vinh Long and Dong Thap , Long An, Tien Giang.

38. According to the 2009 Population and Housing Census, the Khmer population in Vietnam has a population of 1,260,640 and is present in many provinces in the South. The Khmer population is concentrated in the provinces of Soc Trang (397,014 people, accounting for 30.7% of the province's population and 31.5% of the Khmer population in Vietnam), Tra Vinh (317,203 people, accounting for 31.6% Kien Giang (210,899 people, accounting for 12.5% of the province's population and 16.7% of the Khmer population in Viet Nam), An Giang 90,271 people, Can Tho (21,414 people), Hau Giang (21,169 people), Bac Lieu (21,694 people), Bac Lieu Phuoc (15,578 people), Binh Duong (15,435 people).

39. Khmer People often go to commune health stations when they are sick, and they are quite satisfied with the services and attitudes of the commune health staffs. During pregnancy, women often go to the station for antenatal care and give birth at the CHS. Elderly patients with chronic diseases such as hypertension also regularly visit the station to treat and receive medication during the program organized by health staffs in each village and hamlet for elderly people twice a year. In terms of communication activities for health care, health staffs and health collaborators at the villages regularly visit the households, especially the poor and sick households to encourage and support them to visit CHS.

b) The barriers of EM people in accessing local health care services.

40. According to consultations carried out with ethnic minority households and with CEMA, ethnic minority people often live in isolated areas; thus, traffic and transportation are constraints to accessing health services in specialized health facilities, especially the upper level hospitals. Furthermore, the economic conditions are difficult, the income is low, so it is difficult to pay for medical examination and treatment due to the additional costs of medical examination and treatment (expenses not covered by health insurance) and food and travel expenses.

41. Additionally, due to low educational level, there is a lack of knowledge about health care among some ethnic minorities who live in remote and disadvantaged areas, which also limits access to health services.

42. Limited provision of health services, especially at commune level due to lack of infrastructure and equipment, lack of skills and limited qualifications among staff are also factors that prevent ethnic people from accessing health services.

43. Also, many ethnic minority people migrate from one place to another without registering with commune officials. These EM people do not have health insurance cards. Thus, they face difficulties in accessing health insurance services.

c) Project potential to increase EM access to local health care services

44. Based on the impact assessment, it is concluded that the project grant activities; specifically, components relating to provision of equipment for CHSs; developing models for enhanced PHC service delivery and referral; and HHR training that ensures access for female and ethnic minority staff; has the potential to improve ethnic minorities' access to health care services. Measures to help ensure that project benefits reach ethnic minority communities are discussed in the following chapter.

IV. PROPOSED MEASURES TO ADDRESS BARRIERS TO ACCESS OF ETHNIC MINORITIES TO HEALTH SERVICES AND ENHANCE PROJECT BENEFITS

45. A communications strategy will be developed early during project implementation based on specific characteristics of ethnic minorities in the project areas, including analysis of factors that limit their access to local health care services. The strategy would potentially involve integration of information dissemination activities with village meetings; development of simple, easy-to-understand IEC materials in ethnic minority language; and involvement of village chiefs, village patriarchs or prestigious people in ethnic minority communities. Specifically:

- All communication materials revised/developed and reproduced/produced under the project for dissemination in the target districts on new service models of LHC will be gender and culturally (EM) sensitive.
- All IEC materials used for health prevention and education activities at local health care level in the target districts will be gender and culturally (EM) sensitive

46. Budget for development and implementation of project communications strategy is included in the project grant. Development of the strategy will be led by a Communications Specialist (national, 5 person-months), supported by a Gender and Ethnic Minorities Specialist (national,15 person-months).

47. The fair participation of female and EM health workers in all capacity development activities supported by the project will also be ensured. Proportions of women and EM health workers participating in all training, study tours and other professional development activities supported by the project should be no less than their representation in the local health care workforce. Participation of ethnic minority staff in capacity development activities will be included in regular semi-annual social monitoring reports.

48. The table below provides the indicators and proportions for gender and ethnic minority health workers in the current CHS in the 6 participating provinces. Based on these indicators, the implementation of the project, particularly training activities that require attention to ethnic minorities, will be assessed, to ensure the inclusion and participation of Ethnic minorities staff in training activities, or to make adjustments to ensure the effectiveness of the project for ethnic minorities.

Table 5: Status of Health Human Resource in 6 provinces

No	Province	CHS staff	CHS female staff	% female	EM staff	% EM staff	CHS doctors	CHS female doctors	% female doctors	Year of data
1	Tuyen Quang	765	458	59.9	378	49.4	100	39	39.0	2016
2	Phu Tho	1424	922	64.7	250	17.6	252	87	34.5	2015
3	Quang Nam	1235	910	73.7	212	17.2	76	43	56.6	2016
4	Gia Lai	1231	844	68.6	341	27.7	166	71	42.8	2016
5	Dak Nong	558	353	63.3	66	11.8	51	32	62.7	2015
6	Soc Trang	775	454	58.6	190	24.5	73	21	28.8	2016
	Whole country	**70143**	**48811**	**69.6**	**12617**	**18.0**	**8528**	**3222**	**37.8**	**2015**

Sources: for the whole country and provinces Phu Tho and Dak Nong the data from the Health Yearbook 2015 (forthcoming); For other provinces the data come from the database of the Department of Organization and Personnel, MOH, for 2016.

Table 6: Project Outputs and Proposed Measures to Mitigate Impacts

Project Outputs	Anticipated Positive Effect	Anticipated Negative Effect	Proposed Measures to Enhance positive impact (by output and sub –output)	Lead Unit (Indicative)
Output 1: Public investment management for local health care strengthened				
Improve the capacity of the grassroots health system **Activities:** (i) Providing specialized cars (ii) Additional equipment for some district hospitals to meet the needs of people in the region. (iii) Equip the vehicle for the project management unit to monitor the implementation of the project	Ethnic minority people have better access to health services, Reduce travel costs and other related expenses when ethnic minorities' access health centers	None expected	Carry out communication campaigns to disseminate project activities Through village meetings, or through the village patriarch, village chief or a reputable person, to disseminate project activities and basic health services.	MOH, DOH, CHSs
Output 2: Service models of local health care network improved				
Reforming the operation mechanism of the grassroots health	Improved access to basic health services	None expected	Ensure that medical records contain	MOH,

Project Outputs	Anticipated Positive Effect	Anticipated Negative Effect	Proposed Measures to Enhance positive impact (by output and sub –output)	Lead Unit (Indicative)
system, improving the quality of health services at the commune health stations **Activities:** (i) Providing additional health equipment, especially information technology, health management software for commune health stations in 12 districts of 6 pilot provinces to meet the requirements for the activities of the commune health stations in disease prevention, health care, reproductive health care, health care for the elderly at the local. (ii) Training on principles of the family doctors and information technology (the use, management and import of the electronic medical records) for health staffs of commune health stations, and hospitals in the project areas.	for ethnic minority people Enhanced capacity of ethnic minority health staff		information on ethnic group Through village meetings, or through the village patriarch, village chief or a reputable person, to disseminate information on project activities and enhanced health services at the commune health stations. Ensure fair participation of ethnic minority staff in training/capacity building activities	
Technical assistance for the Ministry of Health on developing and promulgating the policies for the development of the Grassroots health system in the new situation **Activities:** (i) Organizing workshops to develop and issue the policy documents on the	None expected	None expected	N/A	

Project Outputs	Anticipated Positive Effect	Anticipated Negative Effect	Proposed Measures to Enhance positive impact (by output and sub –output)	Lead Unit (Indicative)
financial mechanism reform, the operation mechanism of the grassroots health care as follows: Integrating the model of the family doctor clinic, payment options for the insurance service, health management records. (ii) Issuing guidelines on technical and professional procedures, improving the quality of services, regulations on management, quality assurance (iii) Supporting for activities of policy advocacy: mobilize the Party, National Assembly, the Government to support the new mechanisms and policies to improve the effectiveness of the Grassroots health's activities.				
Output 3: Local health care workforce development and management strengthened				
Improving the capacity of the health staff **Activities:** (i) Trainings on management of planning for operation of the CHS and district health centers (ii) Training on management skills for non-communicable diseases and some infectious diseases such as tuberculosis, malaria and HIV in community for staffs of	Increased capacity of EM staff, increased health care services in remote areas where EM live far from the CHSs	None expected	Fair participation of EM health workers in all capacity development activities – proportions of ethnic minority health workers participating in trainings/other capacity development activities will be no less than representation in the local health care workforce	MOH, DOH

Project Outputs	Anticipated Positive Effect	Anticipated Negative Effect	Proposed Measures to Enhance positive impact (by output and sub –output)	Lead Unit (Indicative)
the commune health stations. (iiii) Organizing training of trainers at provincial and district level to improve the capacity of professional health training at the local level (iv) Trainings on testing skills and operation of testing centers in accordance with biosafety standards; on medical pedagogy and other skills. (v) Training on the use of health service packages for the staff of the commune health stations. (vi) Study tour, sharing experience. (vii) Training the staff of CPMU, PPMU on project management skills, financial accounting, environmental management, monitoring. (viii) Organize annual conferences to review, summarize and share experiences in management and operation of the grassroots health care. (ix) Organizing seminars, disseminating experience in the prevention and treatment of diseases. (x) Organizing workshops to evaluate the operational efficiency of the project				

Project Outputs	Anticipated Positive Effect	Anticipated Negative Effect	Proposed Measures to Enhance positive impact (by output and sub –output)	Lead Unit (Indicative)
at the beginning, the mid and the end.				
Technical assistance and project management **Activities:** (i) Establish and operating activities of CPMU and PPMU . (ii) Hiring consultant firms, consultants to support the implementation of the project (iii) The annual monitoring and evaluation of the project activities and quality of the commune health station's services (iv) Auditing activities of the project	Ensuring participation of ethnic minorities and benefits from the project	None expected	Provide staff with knowledge on ethnic minorities and issues relating to the implementation of the EMDP Encourage ethnic minority people to participate in project management support activities	MOH, DOH

V. GRIEVANCE REDRESS MECHANISM

49. A grievance redress mechanism will be put in place to ensure that ethnic minority community members can (i) communicate their needs concerning project activities; (ii) report any negative impacts; and, (iii) inform project implementers about any gaps in their inclusion in project benefits. Information on the grievance redress mechanism will be provided to all affected communities in culturally-appropriate form/language early during project implementation. Ethnic minority communities are not required to pay any fee during any of the procedures associated with seeking grievance redress, including if resolution requires legal action to be undertaken in a court of law. Complaints will pass through four (04) stages described below. The complainant can, if necessary, take the matter to a court of law. It is noted that this grievance redress mechanism does not impede access to the country's legal system, meaning that an aggrieved person is free to access a court of law even at the initial stage of his/her grievances.

50. The grievance redress mechanism will be established based on Complaint law No. 2/2011/QH13 and Decree No.75/2011/ND-CP guiding implementation of the complaint law as follows:

(i) **First Stage: Commune Peoples' Committee (CPC)** - An aggrieved EM people may lodge his/her complaint to any member of the CPC, either through the Chairperson or directly to the CPC, in writing or verbally. It is incumbent upon the village chief to notify the CPC about the complaint. The CPC will meet personally with the aggrieved affected household and will have 30 days and maximum of 45

days following the lodging of the complaint, depending on complicated case or distance, to resolve it. The CPC secretariat is responsible for documenting and keeping file of all complaints that it handles.

(ii) **Second Stage: District/Town People's Committee (DPC)** - If after thirty (30) days or 45 days (depending on complicated cases) the aggrieved AP affected household does not hear from the CPC, or if the affected household is not satisfied with the decision taken on his/her complaint, the affected household may bring the case, either written in writing or verbally, to any member of DPC. The DPC in turn will have thirty (30) days or maximum of 70 days following the lodging of the complaint, depending on complicated case, to resolve the case. The DPC is responsible for documenting and keeping files of all complaints that it handles. The DPC must ensure their decision is notified to the complainant.

(iii) **Third Stage: Provincial People's Committee (PPC)** - If after thirty (30) days to 45 days the aggrieved AP does not hear from the DPC, or if the affected household is not satisfied with the decision taken on his/her complaint, the affected household may bring the case, either in writing or verbally, to any member of the PPC. The PPC has 30 days or maximum of 70 days, depending on complicated case, to resolve the complaint to the satisfaction of all concerned. The PPC secretariat is also responsible for documenting and keeping file of all complaints that it handles.

(iv) **Final Stage: People's Court** - If after 30 days following the lodging of the complaint with the PPC, the aggrieved EM people do not hear from the PPC, or if he/she is not satisfied with the decision taken on his/her complaint, the complainant can appeal again to the PPC. If the complainant is not satisfied with the second decision of the PPC, the case may be brought to a court of law for adjudication. If the court rules in favor of the complainant, then PPC will have to increase the compensation at a level to be decided by the court. In case the court will rule in favor of PPC, then the complainant will receive compensation approved by PPC.

51. Complainants may send their case in writing directly to ADB's Southeast Asia Department (SERD) through ADB Vietnam Resident Mission. If the households are still not satisfied with the responses of SERD, they can directly contact the ADB's Office of the Special Project Facilitator: https://www.adb.org/site/accountability-mechanism/main.

VI. IMPLEMENTATION ARRANGEMENTS

A. Executing agency (EA)

52. MOH as the executing agency and project owner, is responsible for general coordination tasks and cooperation with concerned PPC, related Ministries and Departments to carry out the project in accordance with the government regulations.

B. Central Project Management Unit (CPMU)

53. CPMU will be established at MOH. It will support Executing Committee/MOH, in organizing and carrying out investment project, support the MOH in monitoring the policy and evaluate the progress in investment and development for commune health care with support from the project implementation consultant.

C. Provincial Project Management Unit (PPMU – Implementation Agency)

54. Provincial People's Committees will set up provincial project management Unit (PPMU) in 6 provinces with ADB's non-refundable aid. The PPMU will be responsible for project implementation, monitoring, and periodic reporting on project progress. In addition, the task of PPMUs also includes (i) identification of EM communities, (ii) development of communication strategy, (iii) implementation of communications strategy and (iv) monitoring and evaluation.

D. Project implementation support consultants (PIC)

55. A project implementation support consultant (PIC) will be established with a variety of specialist positions, the objective of the PIC team is to ensure the effectiveness of project implementation. They will provide support to the CPMU and PPMU in the implementation of the Ethnic Minority Development Plan, to ensure measures of enhancing positive impacts on ethnic minorities, as well as to ensure that ethnic minority people can access and receive benefits from project activities. A gender and ethnic minority specialist (15 man- months) and a communications specialist (5 man- months) will be mobilized to assist the project in implementing and monitoring the measures described in the Ethnic Minority Development Plan.

VII. MONITORING AND REPORTING

A. Reporting

56. The IAs (PPMUs) will be responsible for internal monitoring of EMDP implementation. Semi-annual monitoring reports will be prepared and submitted to EA until project completion.

57. The monitoring reports will summarize the progress of EMDP implementation, compare with monitoring indicators; and when required, propose changes to ensure that objectives of the EMDP are met. The EA will submit the semi-annual monitoring report to ADB for disclosure on ADB website.

B. Monitoring Indicators

58. Semi-annual monitoring reports will include information on the below indicators:

Table 7: Monitoring indicators in EMDP

Monitoring and Evaluation Issues	Basic indicators
1. The progress of EMDP implementation	- The plan has been shared with the community. - The plan is suitable with the implementation conditions of ethnic minority people and the EM people have participated during EMDP implementation. - The plan is relevant to the progress of other project activities. - Adequate human resources available to implement the plan. - Sufficient funding for implementing the plan.
2. Implementing community consultations and local people's participation	- Communication strategy is developed and implemented as planned - Local EM community, commune authorities and village leaderships and mass organizations are provided sufficient information on EMDP, implementation plan and grievance mechanisms.

Monitoring and Evaluation Issues	Basic indicators
	- Local EM community, commune authorities and village leaderships and mass organizations are involved in relevant activities, especially monitoring the implementation of EMDP.
4. Implementation of specific developmental interventions for local ethnic minority people	- All activities that support the EM development as set out in the EMDP are implemented effectively. - Various sectors and branches effectively collaborate in implementing activities described in the EMDP.
5. Grievance Mechanisms	- Ethnic minority community has a clear understanding of the grievance mechanism. -District Health Centers, commune-level social organizations and commune people's committee have a clear understanding of grievance mechanism and are able to assist EM people to implement such mechanisms.

VIII. BUDGET FOR EMDP IMPLEMENTATION

59. The budget for the EMDP including (i) development of the communications strategy and (ii) training for health human resources and monitoring is included in the overall project grant budget under the following line items. The costs are estimated at $150,000.

a) Trainings and Workshops

60. This is to improve the capacity of the workforce and management in the field of the Grassroots health including following trainings:

- Training on planning management for managers of the health stations, the district hospitals and the health centers in the project.
- Training on management skills for non-communicable diseases and some infectious diseases such as tuberculosis, malaria and HIV in community for staffs of the commune health stations.
- Organizing training courses for the staffs who responsible for training at provinces and districts to improve the capacity of the professional health training at the local.
- Training in the testing skills at the Centralized testing centers accordance with Biosafety standards.
- Training on the use of health service packages for the staffs of the commune health stations.
- Study tour, sharing experience at some locals in Viet Nam and foreign.
- Training the staffs of CPMU, PPMU on the project management skills, financial accounting, environmental management, monitoring

b) System development

- IEC and community mobilization and gender, ethnic minority strategy

IX. INDICATIVE IMPLEMENTATION SCHEDULE

61. The implementation of the EMDP requires close coordination of organizations and agencies from provincial level to local level, as well as with the ethnic minority community. EMDP will be implemented in parallel with other activities during project implementation as shown in table 8 below.

Table 8: Indicative Implementation Schedule

Activities	Indicative Dates
Development of Communications Strategy	January 2019
Implementation of communications strategy	February 2019 - Continuous
Capacity Development Activities	January 2019 – January 2021
Monitoring and evaluation (semi-annual monitoring reports to be submitted)	January 2019 – January 2023

List of EM participated in FGDs

No	Name	Year of birth	Gender	Village	Ethnic
I.	**Dak Tram Health Station – Dak To district, Kon Tum Province**				
1	Y Phim	1989	Female	Tepen	Xe Dang
2	Y Ly	1988	Female	Tepen	Xe Dang
3	Y Lan	1984	Female	Tepen	Xe Dang
4	Y Ly	1987	Female	Tepen	Xe Dang
5	Y Lien	1990	Female	Tepen	Xe Dang
6	Y Ha	1978	Female	Tepen	Xe Dang
7	Y Phuong	1982	Female	Tepen	Xe Dang
8	Y Quyen	1980	Female	Tepen	Xe Dang
9	Y Dung	1963	Female	Tepen	Xe Dang
10	Y Max	1985	Female	Tepen	Xe Dang
11	Y Phep	1964	Female	Tepen	Xe Dang
12	Y Phan	1969	Female	Tepen	Xe Dang
13	Y Krin	1981	Female	Tepen	Xe Dang
II.	**Van Xuoi health station – Tu Mo Rong district, Kon Tum province**				
14	A Nam	1950	Male	Dak van II	Xe Dang
15	A Hoàn	1985	Male	Dak van II	Xe Dang
16	Y Be	1997	Female	Dak van II	Xe Dang
17	Y Nghe	1986	Female	Dak van II	Xe Dang
18	Y Sam	1977	Female	Dak van II	Xe Dang
19	A Can	1992	Male	Dak van II	Xe Dang
20	Y Vi	2000	Female	Dak van II	Xe Dang
III.	**Vinh Quoi health station – Nga Nam town, Soc Trang province**				
21	Le Kim Tran	1968	Female	Vinh Thinh	Kinh
22	Ly Thi Sang	1957	Female	Vinh Thinh	Khmer
23	Danh Tho	1962	Male	Vinh Thinh	Khmer
24	Lam Vuon	1963	Male	Vinh Dong	Khmer
25	Luu Thi Tieu	1983	Female	Vinh Thuan	Khmer
26	Ly Thi Thanh	1985	Female	Vinh Thuan	Khmer
27	Ly Thi Nhien	1981	Female	Vinh Thuan	Khmer
28	Ly Thi My	1963	Female	Vinh Thuan	Khmer
29	Nguyen Hong Kien	1950	Female	Vinh Dong	Khmer
30	Phan Hong Duyen	2004	Male	Vinh Dong	Khmer
31	Danh Thi Lien	1950	Female	Vinh Thuan	Khmer
32	Quach Thi Si Ly	1951	Female	Vinh Thinh	Khmer
33	Kiem Thi Lan	1987	Female	Vinh Thinh	Khmer
IV.	**Long Phu health station – Long Phu district, Soc Trang province**				
34	Phan Thi Thuy	1964	Female	Tan Lap	Kinh
35	Nguyen Thi Le	1955	Female	Tan Lap	Kinh
36	Kiem Thi My Dung	1958	Female	Bung Long	Khmer
37	Ly The Nguyen	1976	Male	Phu Duc	Khmer
38	Lam Phuong	1989	Male	Nuoc Man 2	Khmer
39	Danh Vinh	1966	Male	Nuoc Man 2	Khmer
40	Lam Thanh Tung	1967	Male	Nuoc Man 1	Khmer
41	Danh Minh Tam	1958	Male	Nuoc Man 1	Khmer
42	Mai Minh Chau	1955	Female	Soc Moi	Khmer
43	Trieu Duong	1993	Male	Kenh Nga	Khmer

List of local staffs

No	Name	Position	Institutions
1	Mr. Tran Ai	Director	DOH of Kon Tum province
2	Mr. Tran Duy Hoa	Vice Director	DOH of Kon Tum province
3	Mr. Le Duc Hieu	Deputy Manager of Finance and planning Department	DOH of Kon Tum province
4	Ms. Dinh Thi Ngan Ha	Doctor	DOH of Kon Tum province
5	Ms. Y Lieu	Head of Dak Tram CHS	Dak To district, Kon Tum province
6	Ms. Nguyen Thi Duyen	Officials	Health Station of Dak To district
7	Ms. Pham My Hanh	Officials	CEMA of Kon Tum province
8	M. Bui Van Thang	Officials	Communication Department of Kon Tum CEMA
9	Mr. Nguyen Thanh Thai	Vice Director	DOH of Kon Tum province
10	Ms. Pham Binh An	Manager of administration derpartment	DOH of Kon Tum province
11	Mr. Le Van Cong	Head of planning department	DOH of Kon Tum province
12	Mr. Nguyen Dinh Dung	Head of finance and planning departmengt	DOH of Kon Tum province
13	Mr.Nguyen Ngoc Son	Official	DOH of Kon Tum province
14	Mr. Nguyen Hoang Cat	Vice director	DOH of Soc Trang province
15	Mr. Huynh Tu Nhon	Deputy Manager of administration department	DOH of Soc Trang province
16	Mr. Tran Van Luong	Official of planning department	DOH of Soc Trang province
17	Mr. Nguyen Hoang Nam	Director	Health Center of Nga Nam town, Soc Trang province
18	Mr. Thach Thanh Hiep	Head of station	Vinh Quoi Health station, Nga Nam town, Soc Trang province
19	Ms. Trinh Thi Le Hong	Deputy Manager of the station	Vinh Quoi Health station, Nga Nam town, Soc Trang province
20	Mr. Nguyen Hoang Dung	Head of health department	Health Center of Nga Nam town, Soc Trang province
21	Mr. Huynh Duc	Vice Chairman	Long Phu district
22	Mr. Le Van Toi	Director	Health Center of Long Phu district, Soc Trang province
23	Mr. Ngo Phat Loi	Deputy Manager of labor DOLISA	Long Phu district, Soc Trang province
24	Ms. Tran Thi Thanh Nhan	Deputy manager of women union	Long Phu district, Soc Trang province
25	Mr. Le Manh Duc	Vice Director	Health Center of Long Phu district, Soc Trang province
26	Mr. Trieu Ret	Head of Long Phu commune Health Station	Long Phu district, Soc Trang province
27	Ms. Ly Thi My Chau	Head of Tan Hung commune Health Station	Long Phu district, Soc Trang province
28	Ms. Thach Thi Hong Sinh	Vice chairman	Tan Hung commune, Long Phu district, Soc Trang province
29	Mr. Hoang Tho	Chairman	Long Phu commune, Long Phu district, Soc Trang province
30	Mr. Luu Duc Minh	Manager of health department	Long Phu district, Soc Trang province
31	Mr. Thach Thanh Tra	Head of ethnic minority department	Long Phu district, Soc Trang province
32	Mr. Truong Hoai Phong	Director	DOH of Soc Trang province

No	Name	Position	Institutions
33	Mr. Tran Van Khai	Vice Director	DOH of Soc Trang province
34	Mr. Tran Van Dung	Head of finance and planning department	DOH of Soc Trang province
35	Mr. Huynh Tu Nhon	Deputy manager of administration department	DOH of Soc Trang province
36	Mr. Tran Van Lua	Officials	DOH of Soc Trang province

Some pictures of consultation with EM people in Kon Tum and Soc Trang

Meeting with health Staffs at CHS of Nga Nam town, Soc Trang Province

Consultation meeting with Khmer people in Soc Trang province

Consultation meeting with Khmer people in Soc Trang province

Consultation meeting with Xe Dang people in Kon Tum province