



Project Information Document/ Identification/Concept Stage (PID)

Concept Stage | Date Prepared/Updated: 21-Oct-2019 | Report No: PIDC191963

**BASIC INFORMATION****A. Basic Project Data**

Project ID	Parent Project ID (if any)	Environmental and Social Risk Classification	Project Name
P171030		Moderate	Reducing Income- and Health-Related Vulnerability of Older Persons in Vietnam
Region	Country	Date PID Prepared	Estimated Date of Approval
EAST ASIA AND P	Vietnam	21-Oct-2019	
Financing Instrument	Borrower(s)	Implementing Agency	
Investment Project Financing	HelpAge International	HelpAge International	

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PROJECT FINANCING DATA (US\$, Millions)**SUMMARY**

Total Project Cost	2.75
Total Financing	2.75
Financing Gap	0.00

DETAILS**Non-World Bank Group Financing**

Trust Funds	2.75
Japan Social Development Fund	2.75

B. Introduction and Context

Country Context

Vietnam has achieved tremendous poverty reduction over the last couple of decades through distributing the gains of strong economic growth equitably. By 2016, the incidence of poverty had fallen to 9.8 percent (according to the General Statistics Office [GSO]-World Bank poverty line) [1], down from nearly 60 percent in 1993. Over the past half-decade (2010 to 2016), the average consumption level of the bottom 40 percent has grown by 5.2 percent annually. Inequality has remained largely unchanged, with the Gini coefficient even dropping slightly (from 35.7 to 35.3) from 1992 to 2016. [2]



Vietnam's success in reducing poverty is attributed to rapid economic growth and economic restructuring that has also been accompanied by job growth and public investment to improve public infrastructure and service delivery. The economy has transformed from a largely closed and centrally planned one to a dynamic and market-oriented one, integrated and connected to the global economy. Economic growth has also been fairly resilient to a challenging global environment, with recent annual gross domestic product (GDP) growth in excess of 6 percent and only moderate inflation. Vietnam reached middle-income status in 2009.

Poverty reduction has also been accompanied by broader welfare gains and improved living standards. This is evidenced by the fact that Vietnam achieved most of the Millennium Development Goals faster than targeted—and welfare improvements have continued. From 1993 to 2017, the infant mortality rate decreased from 32.6 to 16.7 (per 1,000 live births) [3], while stunting prevalence fell from 61 percent to 24.2 percent [4]. The net enrollment rate for primary school increased from 78 percent in 1992–1993 to 93 percent in 2014, for lower secondary school from 36.0 percent to 84.4 percent, and for upper secondary school from 11.4 percent to 63.1 percent [5]. Access to household infrastructure improved dramatically: by 2016, 99.4 percent of the population used electricity as their main source of lighting (up from 48.6 percent in 1993) [6], 77 percent of the rural population had access to improved sanitation facilities (compared to 33.8 percent in 1993) [7], and 69.9 percent of the rural population had access to clean water (up from 62.9 percent in 1996) [8,9]. Access to all of these services in urban areas is well above 90 percent.

Vietnam has also closed gender gaps across a wide range of social and economic measures (including bringing female labor force participation within 11 percentage points of that of men) [10], but the high and widening sex ratio at birth (115 in 2018) [11] shows that fundamental gender discrimination persists. The 2018 Human Development Index ranked Vietnam at 116 out of 189 countries, in the 'medium' category with a score of 0.694 [12], while the World Bank's 2018 Human Capital Index ranked Vietnam 48th out of 157 countries with a score of 0.67 (exceeding the global, regional, and even upper-middle-income country averages) [13].

Looking ahead, Vietnam is expected to go through further social transformation and may face mounting economic and environmental pressures. First, Vietnam is one of the most rapidly aging countries and the 65+ age group is expected to increase 2.5 times by 2050 [14]. Second, while the population still largely lives in rural areas (64.8 percent in 2017), it has been steadily urbanizing (at about 0.7 percentage points per year) [15]. Expectations of the population in terms of access to quality public services are also changing because of increasing incomes, access to information, and more spatial integration (global and urban-rural). Risks to development include the fragility of poverty gains, as well as the concentration of poverty in ethnic minority communities and rural, mountainous areas [16]; environmental sources of vulnerability (such as climate change, natural disasters, and unsustainable exploitation of natural resources); rising fiscal pressures, including a growing fiscal deficit [17] and a debt-to-GDP ratio that, although having fallen back from its 2016 high (of 63.7 percent) to 61.4 percent is still close to the 65 percent statutory limit; structural constraints in the growth model, including an overreliance on factor accumulation (compared to productivity growth); and limited private sector development. Balancing economic prosperity with environmental sustainability,



promoting equity and social inclusion, and strengthening state capacity and accountability—all within a constantly evolving global and domestic context—will be challenging [18].

[1] World Bank. 2019. World Development Indicators 2019.

[2] Ibid.

[3] United Nations Inter-Agency Group for Child Mortality Estimation 2018.

[4] GSO of Vietnam. 2017. Statistical Yearbook. Hanoi: Statistical Publishing House.

[5] Vietnam Living Standards Survey (VLSS) 1992–1993; Vietnam Household Living Standards Survey (VHLSS) 2014.

[6] VLSS 1992–1993; VHLSS 2016.

[7] World Bank. 2018. *Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam*. Washington DC: World Bank.

[8] Ibid.

[9] World Health Organization (WHO)/United Nations Children's Fund (UNICEF). 2015. *Joint Monitoring Program for Water Supply and Sanitation. Estimates on the Use of Water Sources and Sanitation Facilities*.

[https://www.wssinfo.org/documents/?tx_displaycontroller\[type\]=country_files](https://www.wssinfo.org/documents/?tx_displaycontroller[type]=country_files).

[10] Vietnam Labor and Employment Survey 2018 (quarter 2).

[11] GSO 2018. Socioeconomic Situation 2018

<https://www.gso.gov.vn/default.aspx?tabid=621&ItemID=19037>

[12] United Nations Development Programme (UNDP). Human Development Indices and Indicators. 2018 Statistical Update. New York: UNDP

http://hdr.undp.org/sites/default/files/2018_human_development_statistical_update.pdf.

[13] World Bank. 2018. The Human Capital Project.

<https://openknowledge.worldbank.org/handle/10986/30498>. License: CC BY 3.0 IGO.

[14] GSO and United Nations Population Fund (UNFPA). 2016. Population Projections for the Period 2014–2049. Hanoi: Thong Tan Publishing House.



[15] World Bank. 2019. World Development Indicators 2019.

[16] World Bank. 2018. *Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam*. Washington, DC: World Bank.

[17] The fiscal deficit averaged 5.6 percent of GDP during 2011–2015 and 2.2 percent of GDP during 2006–2010.

[18] World Bank Group and Ministry of Planning and Investment (MPI). 2016. *Vietnam 2035: Toward Prosperity, Creativity, Equity and Democracy*. Washington, D.C: World Bank.

Sectoral and Institutional Context

Vietnam has one of the most rapidly aging populations in the world. By 2049, nearly one quarter of the population will be aged 60 and older. In 2019, the ratio of working-age people to older persons is about 9 to 1, but by 2049 this ratio will fall to only 4 to 1. Currently, there are about 11.7 million persons aged 60 and older, but by 2049 this number will reach nearly 25 million, of whom nearly 4 million will be aged 80 and older [1].

Among the population aged 60 years and older, a majority are women, with the share of females increasing with age. In 2014, about 56 percent of people aged 60 to 69 years were female, increasing to 66 percent among those aged 80 and older [2]. While a majority of older persons live with their children (63 percent in 2011), many are in the more vulnerable position of living with other older persons or alone [3].

About 39.1 percent of older persons are still working, of whom the majority are in government jobs (56.8 percent), followed by self-employed agricultural occupations (22.6 percent) [4]. Among those not working, poor health is cited by a large share of people (39.4 percent in the age group 60-69, rising to 54.7 percent in the 80+ age group) as the reason. The main sources of financial support reported by older persons are their children (31.9 percent), work-related income (29.4 percent), pensions (16.1 percent), and social allowances (9.4 percent). A relatively large share of the elderly (aged 60 and older) report that their financial resources are “insufficient” (26.2 percent) or “sometimes insufficient” (36.2 percent) for daily needs. 17.2 percent of older persons report living in poor households, with only about 30 percent reporting that they receive social allowance payments and 3.7 percent reporting that they receive a pension. The economic situation of older persons in rural areas tends to be worse than in urban areas. Rural older people also tend to need to continue to work in order to support themselves more than urban older people do.

As in other societies, health is an important concern of older persons in Vietnam. In 2015, life expectancy at aged 60 was 25 for women and 20 for men in Vietnam. However, women live seven of those years in poor health and men live five of those years in poor health [5]. When asked about their health, 10.1 percent of older persons report “very weak” health and another 55.3 percent report “weak” health. Among people aged 60 and older, 40 percent of men and 46 percent of women report having some disability. While vision problems are the most prevalent, mobility, hearing and memory/cognition problems are also common [6]. In



2011, 37.6 percent of older persons reported difficulties with activities of daily living (ADLs) [7]. 30.8 percent reported difficulty in getting up from a lying position, 15.1 percent struggled with toilet hygiene, and 14.8 percent had trouble feeding themselves. Health problems among older persons tend to be related to chronic diseases, with the burden of disease from cardio-vascular disease and cancer accounting for nearly half of all Disability-Adjusted Life Years (DALYs) among people aged 60 and older [8].

The Government of Vietnam is increasingly aware of the challenges that an aging population poses and is taking steps to address them. The Law on the Elderly and the Vietnam National Action Plan on the Elderly have laid out some strategic directions. Multiple government agencies have been assigned responsibilities related to caring for the elderly, including the Ministry of Labor Invalids and Social Affairs (MOLISA) and the Ministry of Health (MOH). Quasi-governmental entities, like the Vietnam Association of the Elderly (VAE) [9] and the Red Cross, and non-governmental organizations (like HelpAge International [henceforth, HelpAge]) are implementing community-based interventions to support the elderly and also contribute to policy discussions.

The main direction envisaged by the authorities is to rely on the family's responsibility to care for their elderly members. Financial support from the government is limited to a small monthly pension (about US\$12 per month) and subsidized social health insurance for persons aged 80 and older (although, if living in poverty, people younger than age 80 are also eligible for subsidized social health insurance). Institutionalized care for older persons consists of a small number of state facilities for people who are destitute (without family) and private facilities for those who can afford it.

New models of community-based care, such as intergenerational self-help clubs (ISHCs), are also now being promoted by authorities in order to support families who are caring for older persons or older persons living on their own. The ISHCs are self-managed and financially sustainable community-based organizations that have a membership of 50-70 members and are registered with local commune authorities and supervised by local Associations for the Elderly (AEs).

The Prime Minister's Decision 1533 of 2016 approved the expansion of ISHCs nationwide in order to help care for elderly people and also encourage them to take a more active role in their own care and that of other elderly people. The Decision sets targets for the participation rates of the elderly (55 years and older), access to loans (either in cash or in kind), and improvements in the income of the elderly. There are currently 1,700 ISHCs. They are financed by a combination of internationally-funded projects, funding mobilized by AEs and ISHCs, contributions of the ISHC members, and/or small amounts from the government budget.

Development partners' support to government and communities in addressing the aging challenge is currently quite limited, but future projects are being explored. The Korean International Cooperation Agency (KOICA) is currently providing some support to ISHCs (including by channeling some financing through HelpAge), but these ISHCs have limited links with government service providers. The United Nations Population Fund (UNFPA) actively supports policy discussions on population aging but is not currently implementing any projects. The Japan International Cooperation Agency (JICA), the Asian Development Bank (ADB) and the World Bank are all exploring the possibility of projects with government (including loans)



related to long-term care for the elderly and are actively engaged in policy discussion and analytics related to aging.

[1] General Statistics Office. Population Projects 2014-2049. Hanoi: Thong Tan Publishing House. 2016.

[2] Ibid.

[3] Vietnam Aging Survey 2011. http://www.wpro.who.int/vietnam/vietnam_ageing_survey_2011.pdf

[4] Statistics cited in this paragraph are all from the Vietnam Aging Survey 2011. http://www.wpro.who.int/vietnam/vietnam_ageing_survey_2011.pdf

[5] World Health Organization. Global Health Observatory Database. 2016. Available from: <http://www.who.int/gho/database/en/>

[6] UNFPA. 2011. People with Disabilities in Vietnam: Key Findings from the 2009 Viet Nam Population and Housing Census. Hanoi: UNFPA.

[7] Vietnam Aging Survey 2011. http://www.wpro.who.int/vietnam/vietnam_ageing_survey_2011.pdf

[8] Institute for Health Metrics and Evaluation (IHME). Global Burden of Disease Country Profile Vietnam. <http://www.healthdata.org/vietnam>

[9] VAE is the second-largest “mass organization” in the country. It has around 9 million members and aims to realize the aspiration, rights, and entitlement of older persons in Vietnam, as articulated in the Law on the Elderly.

Relationship to CPF

The project is aligned with the objectives set out in the World Bank’s Vietnam Country Partnership Framework (CPF) FY18–FY22 [1], in particular Objectives 5, 6, and 7. Objective 5 is to “broaden the economic participation of ethnic minorities, women and vulnerable groups”. It includes a particular focus on livelihood- and income-generating activities. The proposed project will contribute to this objective through the livelihoods activities for older people, of whom the majority are women, that are organized by the ISHCs. Objective 6 is to “improve access to quality public and private health services and reduce malnutrition” and, within this, focuses especially on access to primary (commune-level) health care services. Under the proposed project, one activity of the ISHCs is to help to ensure that older people receive regular basic health check-ups (including preventive screening) from their local commune health stations. Objective 7 is to “improve integration and efficiency of social assistance, pension, and health insurance systems”. In this area, the proposed project contributes especially to the social assistance dimension, with the ISHCs helping to



arrange for in-kind support to help older people with ADLs, and also helps to ensure that older persons can access the entitlements (including pensions and health insurance) for which they are eligible. Taken together, the project’s investments in preventing the deteriorating of the human capital of older people will contribute to the World Bank’s overarching goals of reducing poverty and promoting shared prosperity.

The proposed project is complementary to on-going and planned World Bank analytics and projects. An Aging Study is being prepared by a multisectoral team (including Social Protection, Macroeconomics, Trade and Investment, and Health, Nutrition and Population Global Practices). The recently-approved Investing and Innovating for Grassroots Health Service Delivery project (P161283) aims to strengthen primary care health services to better prevent, detect and treat non-communicable diseases, which are concentrated among elderly people. By design, three of the project provinces proposed for this JSDF grant/project are also project provinces of the Grassroots Health project. Discussions have been opened with the Government of Vietnam about a possibly future project/loan on elderly care.

[1] World Bank. 2017. *Vietnam - Country Partnership Framework for the Period FY18-FY22 (English)*. Washington, D.C.: World Bank Group.

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C. Project Development Objective(s)

Proposed Development Objective(s)

In order to reduce the income and health-related vulnerabilities of older persons, the project development objective is to increase the participation of older persons in income-generating activities and their use of community-level health and social care services in the project communities.

Key Results

1. Number of older persons in project communities that are participants in the ISHC’s revolving fund activity
2. Number of older persons in project communities that receive (i) at least one health checkup annually and (ii) monthly basic health monitoring (organized by ISHC).
3. Number of older people in the project communities receiving regular (at least twice per week) community-based care services from the ISHC and/or the local commune health stations.

An additional results indicator under consideration is “Number of beneficiaries reporting a minimum x percent increase in income”. The feasibility of its inclusion will be assessed during the remainder of the project preparation period.



All indicators will be disaggregated by gender. Indicators (1) and (2) are also JSDF Tier I indicators, per the JSDF Results Framework guidelines. Estimates of baseline and end target values are included in the JSDF Annex and will be shown in the Results Framework at appraisal stage.

D. Preliminary Description

Activities/Components

The core activity of the project is the establishment of community-led sustainable ISHCs to promote economically productive, healthy and active ageing, while enhancing the contributions of older persons to their own families/communities, and also reducing the burden of care of older people on these families/communities. The ISHC development model closely follows the community driven development (CDD) approach through which communities are given control over the development process, resources and decision-making authority. The underlying assumption is that communities are the best judges of how their lives and livelihoods can be improved and, if provided with opportunities, information and adequate resources, they can organize themselves to provide for their immediate and future needs.

The existing model of community-level ISHCs that has been established in Vietnam (including through HelpAge) provides a strong foundation upon which the proposed activities (and their innovations) will be built.

The ISHCs supported by this project will implement four types of activities:

Livelihoods program for needy ISHC members: At the core of the ISHCs is an income-generation program that provides capital for ISHC members to start small age-appropriate and environmentally-friendly income-generating activities. Operated as a revolving fund, this program allows members to access capital to start livelihoods activities (e.g. small-scale agriculture, animal husbandry, handicrafts, or small business) to provide much needed income in old age. The fund, which is directly managed and owned by the ISHCs, is replenished

through returns on activities (when the borrowers pay back through the income generated through the livelihoods activities) as well as through community contributions to the fund.

Activities focused on the health of older persons: Clubs will give presentations and demonstrations on health-related topics, organize physical exercise, promote access to health insurance and, with support from local Association of the Elderly, collaborate with health facilities to ensure that members have health checkups twice a year. The ISHC management boards will also help to arrange for the provision of low-cost home-based medical care for people who are not able to easily leave home (e.g. help with rehabilitation exercises, monitoring of blood pressure and/or blood glucose, help with taking of medication etc). This home-based medical care will be provided by retired health workers or certified volunteer health workers.



Activities focused on community-based care: Each club will have at least 10 volunteer caregivers (mostly older persons) trained in the knowledge and skills to provide home care for those in need. This includes support for activities of daily living (ADLs), instrumental activities of daily living (IADLs), and companionship. Volunteers will prioritize the most vulnerable older persons, such as those with disabilities and illnesses or without family caregivers. In addition, the ISHC will support elderly people in carrying out household maintenance activities (such as housing repairs, harvesting of crops) if needed, through cash or in-kind (labor and materials) support. For more active members, the club will organize regular social activities.

Activities to help older persons receive their entitlements: In collaboration with VAE and/or the Women's Union (WU), the clubs will inform older persons of their entitlements (such as old age pension, benefits for people with disabilities, veterans' benefits) and help them to complete the administrative procedures needed to access them.

The communities in which the ISHCs are established will contribute, in cash and in-kind, to the organization and financial sustainability of the ISHCs. Each community must make a minimum financial contribution in the form of membership fees, provision of a venue for ISHC activities, financial contribution, and commitment to local fund-raising.

For purposes of project implementation, these above activities will be organized into the following project components.

Component 1: Establishing ISHCs and supporting their on-going community-level health and social care services (estimated at US\$1,500,000)

This component has three sub-components:

Sub-component 1.1 Initial establishment and on-going capacity-building of ISHCs: This sub-component includes the activities associated with establishing new ISHCs and providing ongoing capacity-building for the ISHCs, their local partners and government health workers. Examples of such activities include project orientation meetings, institutional set-up of clubs, development of training materials, initial and on-going training activities, meetings of the project's advisory committees, regular technical support supervision visits, and small monthly grants (less than US\$20) to cover the ISHCs' basic operating and monthly meeting costs during the first 1-2 years.

Sub-component 1.2 Health promotion and access to community-level healthcare: This sub-component focuses on improving older persons health-related behaviors and use of community-level health care interventions. It will include quarterly health awareness talks (provided by commune health station staff or trained club members) on disease prevention, managing chronic conditions, proper nutrition and other health-related issues relevant to older persons; health promotion through physical exercise and sports and



cultural groups, established by the ISHC to promote healthy and active lifestyles; community health awareness campaigns; basic monthly health monitoring (such as measurement of body mass index, blood pressure, sugar levels) in collaboration with the local commune health stations; health check-ups conducted in collaboration with the local district and/or commune health stations to provide more comprehensive check-ups on a semi-annual basis; promoting access of ISHC members to the health insurance benefits to which they are entitled and educating them in how to use them. The costs associated with the development of training materials and the training of those people who will provide these health-related interventions to the elderly will be financed under the first sub-component.

Sub-component 1.3 Community-based social care services: Under this sub-component, homecare volunteers (drawn mainly from among the ISHC's members) will deliver care to people who are largely housebound and need assistance with ADLs and IADLs. Depending on the needs, care might include social care (information-sharing, companionship), personal care (house cleaning, food preparation, personal hygiene), health-related care (monitoring of general health status, purchasing and administering medicine, physical rehabilitation), and support with household maintenance (including house and farm maintenance, provision of food or other basic necessities), and help with access to entitlements. For the provision of in-home health-related support, the homecare volunteer will be supported by local healthcare providers (typically retired doctors or nurses or commune health workers). The costs associated with the development of training materials and the training of homecare volunteers will be financed under the first sub-component.

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Component 2: Income security (estimated at US\$900,000)

This component focuses on strengthening the livelihoods of older persons through access to capital from a revolving fund managed by the ISHC. This component will include grants to the ISHCs to cover the costs of setting up the self-managed revolving fund schemes; training of the fund participants (as well as other community members) in techniques and skills related to their selected livelihoods projects; formation of groups to share knowledge and experience across fund participants; facilitating access to government entitlements related to income security (e.g. old age, disability, widow and veteran social allowances); and small social funds maintained at club level (and financed by ISHC club income from the revolving fund, membership fees, and local fundraising) to help club and community members in the event of financial shocks. The costs associated with the training activities related to the revolving fund (including on fund management and how to identify needy and credit-worthy beneficiaries) will be financed under the first sub-component of Component 1.

Most of the funds in this component will be allocated to the revolving fund. Details of the operation of the fund, including criteria for the selection of beneficiaries of the revolving fund, guidelines on fund management, loan amount, loan terms, exit strategy upon closure (among others) will be described in the project operations manual and also in a user-friendly ISHC revolving fund manual. It is currently anticipated that around 40-50 percent of ISHC members (20-30 people) will participate in the revolving fund. Loan amounts are expected to average around US\$250, be repaid over a 12-18 month period, and have a monthly



interest rate of 1 percent. The livelihood activities to be funded will typically be small scale husbandry (raising chicken, ducks, fish, goats, pigeons, rabbits and pigs), agriculture (vegetable and fruits), or small businesses. Training on environmentally-friendly livelihood schemes or techniques (suitable to adoption by older person) will also be provided to fund participants as well as to others in the community, with the local AEs facilitating links to the local agricultural sector for technical support where appropriate.

The revolving fund is key to the sustainability of the ISHC model: 50 percent of the revolving fund monthly interest (1 percent) will be used to augment the ISHC's total livelihood revolving fund (to grow the fund, as well as to cover the risk of non-repayment) and the remaining 50 percent will be used to cover the costs of ISHC operation and activities (fully replacing the club's monthly grants after 1-2 years). To enhance local ownership and sustainability, a local contribution to the revolving fund (of VND 15 million per ISHC) is required.

Component 3: Project Management and Administration, Monitoring and Evaluation, and Knowledge Dissemination (estimated at around US\$300,000)

Sub-component 3.1 Project management and administration: This sub-component will cover the costs associated with project management and administration, including the management of the project by HelpAge and local partners, the annual mandatory audit, and the project's mandatory Implementation Completion Report. Project management activities will also include activities related to ensuring compliance with the World Bank's fiduciary and safeguards requirements and other project reporting and financial management guidelines. Specific project management functions and key staff roles (including related to project management, procurement and financial management) will be elaborated in the project paper / appraisal document.

Sub-component 3.2 Monitoring and evaluation (M&E): This sub-component will cover the costs associated with project monitoring, project evaluation, and capturing the lessons learned from the project – both to further strengthen implementation of the project and also to demonstrate its results. All assessment and evaluations will be carried out in a participatory manner in order to give voice to beneficiaries' concerns and help create a feedback loop from the findings to the interventions in a way that addresses beneficiaries' needs. The main M&E activities will include the development of an annual participatory work plan, annual participatory project assessments (including at baseline), and a mid-term and end-of-project evaluation carried out by an external evaluator. These activities are described further in the JSDF Annex and will be confirmed during the remainder of project preparation and appraisal as well as detailed further in the operations manual. The costs of the regular monitoring and technical support visits and meetings by project staff and/or consultants will be covered under Component 1.

Sub-component 3.3 Knowledge dissemination: The sub-component will cover costs associated with knowledge dissemination related to the ISHC model. These include developing materials on the project's best practices and an on-line knowledge resource portal to share the project's materials and lessons learned widely throughout the six project provinces and beyond, and activities to advocate for the scaleup of the



project’s ISHC development at national level and in non-project sites.

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Environmental and Social Standards Relevance

E. Relevant Standards

ESS Standards		Relevance
ESS 1	Assessment and Management of Environmental and Social Risks and Impacts	Relevant
ESS 10	Stakeholder Engagement and Information Disclosure	Relevant
ESS 2	Labor and Working Conditions	Relevant
ESS 3	Resource Efficiency and Pollution Prevention and Management	Relevant
ESS 4	Community Health and Safety	Relevant
ESS 5	Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
ESS 6	Biodiversity Conservation and Sustainable Management of Living Natural Resources	Not Currently Relevant
ESS 7	Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Relevant
ESS 8	Cultural Heritage	Not Currently Relevant
ESS 9	Financial Intermediaries	Not Currently Relevant

Legal Operational Policies

Safeguard Policies	Triggered	Explanation (Optional)
Projects on International Waterways OP 7.50	No	The project will not carry out any investment linked to international waterways as defined in the Policy.
Projects in Disputed Areas OP 7.60	No	The project will not be implemented in areas known to involve disputed areas.

Summary of Screening of Environmental and Social Risks and Impacts

The project is expected to bring about significant positive impacts by reducing income- and health-related vulnerabilities of older persons. The project will not generate any substantial risk or adverse environmental impact on the environment. The main adverse environmental and social risks would be expected from the livelihoods program and would be likely temporary, reversible, low - to moderate in magnitude and site-specific given the nature and scale of the investment, and the health status of the benefited old people. The civil works would not involve construction and building of new infrastructure but would focus on



rehabilitation of small assets, which are developed by small age-friendly and pro-poor income-generating enterprises. These potential impacts are assessed to be of small scale, localized, in short-term period and manageable. It is anticipated that the project activities will not cause long-term, cumulative impact to environment and human health if good design and construction practices are followed. Health promotion activities can improve the access to health check-up and low-cost home-based health services, however, these services by their nature will not deploy any invasive procedure and will not increase hazardous waste significantly. There may be risks of failure to familiarize older persons from remote rural areas and from ethnic minority groups with the proposed health promotion models given their cultural differences. For activities focused on personal care, it is concerning that it may be impossible to mobilize enough volunteers who can work on a part-time and unpaid basis to meet the increasing demand for basic personal care from older persons. Exposing to age-unfriendly jobs under the livelihoods program and unqualified health workers under the health promotion program can raise a concern about the safety of older people. There is a risk that the older persons may not be able to pay back their loans to the revolving fund if they fail to generate incomes through the project's livelihood activities for various reasons, which may undermine their self-esteem and self-confidence and add to their socio-economic vulnerability.

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