**THE WORLD BANK**

***The Innovating and Investing Grassroots Health Service Delivery Project (P161283)***

# ETHNIC MINORITIES DEVELOPMENT FRAMEWORK

# (First Draft)

**January 2018**

## Abbreviations

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| **CPC** | Commune's People's Committee |
| **CPMU** | Central Provincial Management Unit |
| **DPC** | District's People's Committee |
| **EM** | Ethnic minorities |
| **EMPF** | Ethnic Minority Planning Framework |
| **EMDP** | Ethnic Minority Development Plan |
| **GRM** | Grievance Redress Mechanism |
| **HH** | Household |
| **HR** | Human resources |
| **ID** | Identification |
| **PPC** | Provincial People's Committee |
| **SA** | Social assessment |
| **WB** | World Bank |

CONTENT

# I. INTRODUCTION

### *1.1.1.The Project background*

Although the Vietnamese government has made great efforts in investment and development, improve the health system, however the grassroots health system (including commune health stations) in the disadvantaged area are parts of the country, is not yet sufficiently equipped or enabled to tackle the shift in the disease burden, while health financing arrangements fail to incentivize effective and coordinated care. On average, only 23% of outpatient contacts are at the CHS or regional polyclinic, but this share reaches well over 50% in most mountainous provinces. However, the basic infrastructure, equipment and competencies are lacking in many communes. In 2016, only 69.76% of rural communes met the 2014 national commune health benchmarks. Moreover, those largely structural benchmarks do not provide any assurance that the commune health stations are capable of appropriately dealing with specific medical condition in line with diagnostic and treatment guidelines for those conditions and in close coordination with higher-level facilities. Capacity to prevent, detect and manage chronic NCDs, identify pregnancy risks during antenatal care, and provide timely response and transport in case of obstetric emergency, for example, is weak. Creating a stronger primary care function based on a strong health professional team - patient relationship is needed to ensure continuity of care and better patient case management, while also encouraging more patients to seek care at this level rather than bypassing. Another challenge is that current provider payment arrangements do not provide the appropriate incentives to CHS health workers to make more effort to keep patients healthy or manage their diseases effectively. Staff are paid by salary, drugs are provided in-kind from the district hospital, and health insurance reimbursement at the CHS level is only for a small set of medical services and paid on a fee-for-service basis.

The Government of Vietnam and the World Bank are in the process of preparing the Investing and Innovating for Grassroots Service Delivery Reform Project (P161283)to

improve the efficiency of the grassroots health system. The project will achieve this objective through three components:

**Component 1** will strengthen the availability, quality and continuity of care at the grassroots health system by (i) supporting commune health stations (CHS) to meet the national benchmarks for service-readiness and (ii) equipping and enabling the CHS to manage a new set of conditions (mainly non-communicable diseases), most of which are currently managed only at higher levels.

**Ensuring the basic readiness of CHS to deliver health services**: The project will finance the investments needed for the CHSs in the project provinces to reach the national benchmarks for commune health. Investments will include mainly upgrading of existing CHS, but may also include construction of new CHS (either because there is no CHS[1] or because it is better to demolish and rebuild the current CHS than to upgrade). Investments will also be made in regional polyclinics[2]. The national benchmarks for commune health care for the 2014-2020 period have been defined by the Ministry of Health and are described in Circular 4667/QĐ-BYT.

**Enabling the CHS to take on a new role in managing select health conditions that are not currently available at commune level**: This sub-component will finance the additional inputs needed for the CHS to properly manage select non-complicated conditions. These inputs could include infrastructure, equipment, drugs and materials, as well as the training of health workers ("technical transfer") in the relevant competencies and information/education campaigns to inform the public of the CHS' new role and build public confidence. Decision support technologies will be used to guide health care workers through the clinical decision-making process (from examination to diagnosis to treatment), as well as improve select information management functions (e.g. cause of death reporting). It is envisaged that a CHS will first achieve competency (marked by a process

[1] Per the latest Agricultural Census, there are only 19 communes in the country without CHS.

[2] Polyclinics tend to serve multiple communes and are typically found in urban areas where they replace commune health stations.

of certification) in the delivery of one these services before moving to gain certification in others. Not all participating provinces (or districts) will necessarily take on management of all of the select conditions.

**Component 2** will strengthen the double-function district health centers (DH/DHCs) to (i) serve as centralized diagnostic laboratories for the CHS, (ii) provide emergency transfer of patients, and (iii) improve their capacity to serve as referral facilities for specific clinical services needed to ensure continuity of care from the commune to the district level. Not all project provinces will necessarily undertake all of these investments.

**Component 3**: Enabling grassroots reforms, piloting and scaling-up innovations to improve quality, implementation support, and results monitoring.

### 1.1.2. Objectives of the project

The project is expected to to improve the efficiency of the grassroots health system and bring positive impacts to local peoplein the project sites, including those with high population of ethnic minorities (EM), such as selected districts and communes in the provinces of Bac Kan, Cao Bang, Son La, Hoa Binh, Quang Binh, Quang Tri, Quang Ngai, Tra Vinh, and Bac Lieu.

To assist the grassroots health system in order to improve Strengthening district and commune level curative and healthcare services, increase the possibility of the access and use of the medical system by the people, especially the poor, near poor and minority ethnics and partly improve health conditions of the local people.

The objective of the project is to implement an equitable health care policy for the poor, near-poor and ethnic minorities, who have little or no financial means to access and use health services. As a result, the project activities focus on improving the health care capacity of district health facilities to actively support and facilitate the beneficiaries of the project.

General objectives: To develop the grassroots health care network to become the cornerstone of the health system, provision of preventive services, primary health care,

improved health, early diagnosis and treatment, prioritize BMTE, the elderly, the disadvantaged people in the disadvantaged areas, contributing to ensuring health, improving life expectancy, and improving the quality of life.

Detailed objectives:

i) To invest in enhancing material foundations and equipment for grassroots medical networks in project areas.

ii) To improve the quality of human resources to ensure effective delivery of health care services at the provincial level through training, technical transfer and professional guidance, and focus on a number of prominent diseases and groups, areas in the community that need prioritized.

iii) To support to formulate policies on public health and hygiene, pilot some models to strengthen professional and management activities in commune health stations to provide preventive services, PHC and improve public health, the primary health care service based on a basic health care package, aiming at home-based care.

### *1.1.3. Main expected outcome of the project*

The results of the project contribute to the establishment and development of the grassroots health network in the new situation approved by the Prime Minister in accordance with Decision No. 2348 / QD-TTg dated 5 December 2016. Specific outcome are as follows:

- Commune CHSs in project area reach the national health standard in the period of 2011-2020, of which around 400-500 CHSs are invested to build, upgrade and provide equipment.
- Health staffs at district and commune levels to improve their management and professional capacity, including the contents of preventive medicine and family medicine, ensuring the effective delivery of health care services at the primary levels.
- Centralized testing at the district level for serving commune level is invested, tested and replicated.

- Piloting and replication of effective models for non-communicable disease management at the grassroots level; improve emergency referral and hospital services.
- Ensure the supply and quality of services in the basic service package at the primary level;
- Renovated CHS management model, improved operation and exploitation of the individual and family health management records system for prevention and treatment of non-communicable diseases; Application of information technology in quality management of commune health services.
- Renovation of financial mechanisms for the operation of public health services, capitation payments for outpatient services at commune and district levels, diagnostic groups for inpatient treatment at district hospitals, payment for health insurance services for preventive services.
- Increased participation and coordination of the private sector contributes to improving the performance of grassroots health facilities.
- Capacity building and effective implementation of technical transfer and technical support from higher level health facilities for commune health stations.

Based on the objectives and expected results, the Ministry of Health shall jointly develop and agree with the WB donor on the disbursement-linked indicators (DLI) of the project. The indicator set is used to measure the progress achieved and is the annual disbursement target of the project.

### *1.1.4. Beneficiaries of the project*

The draft project document has been prepared based on the preliminary agreed framework. The Ministry of Health has developed a draft project proposal based on the proposal of the provinces to invest in strengthening the facility, equipment and facilities for the grassroots level, strengthening the professional capacity and management for grassroots health care in the project provinces.

Project beneficiaries:

- Mothers, children, especially the poor, ethnic minority people, the near poor are the ultimate and most important beneficiaries of the project. The poor, near-poor and ethnic minority people will be supported by the project to better access and utilize health services (which have been invested to improve quality). In addition, the near poor will receive some direct support to alleviate financial difficulties and to facilitate access to health services. The project focuses on district, commune clusters and commune health stations, which are accessible to by the poor, near-poor and ethnic minorities when there is a need for health care.

- Service delivery system: district and commune health service delivery systems, polyclinics. The project invests in upgrading medical equipment, training to improve professional capacity and management for health workers at grassroots level. To build and expand the models of grassroots health care.

- Support to enhance the capacity of project management, strengthen the inspection and supervision. Agencies involved in the implementation of health care for the poor (DOLISA, health insurance / social insurance ...) are invested by the project to better organize health care for the poor and ethnic minority people.

### *1.1.5. Project Implementation area*

The project is expected to invest in 10 provinces with the following selection criteria: i) The localities have commitment, enthusiasism and capability to manage, administer and receive the project; ii) CHS qualified and committed to human resources: with doctors, nurses if not, new recruitment or rotation and transfer; iii) Prioritize difficult areas in remote areas; commune health stations which have not met standards; lack of investment. The project will select a number of capable districts to build a standard model. Therefore, it is expected to select 7 disadvantaged provinces and 3 provinces that have the capacity to develop the pilot model for the whole country

Total estimated capital of the project is US $ 113 million, the project implementation period is expected to be 5 years (2018-2023).

## 1.1. Objectives of the Ethnic Minority Planning Framework (EMPF)

The objectives of the Ethnic Minority Development Framework are set out in concrete plans based on cultural characteristics, customs and factors that restrict access to health services by ethnic minorities to identify the project activities to minimize those barriers to the health care needs of ethnic minorities.

The EMPF is an instrument that not only minimizes the negative impact, but also ensures that Ethnic minorities will benefit from the project, leading to the support of the EM community. The EMPF is prepared based on the results of community consultation during project preparation and dissemination to the EM people. The EMPF is designed to: (i) ensure that ethnic minority people in the project area receive culturally appropriate socio-economic benefits; (ii) avoid negative impacts on ethnic minority communities;

The EMPF will ensure that the needs, concerns and priorities of the EM will be taken into account when designing and implementing the project and identifying the activities to be designed in the project to ensure ethnic minority people full participation. This EMPF was prepared on the basis of (i) a social assessment survey in the project area; (ii) consultation with villagers and people living in the project area; (iii) consultation with the project stakeholders, including district health workers, commune health workers, village health workers and representatives of the commune authorities who participate in social assessment activities.

The objectives of ethnic minority development plan (EMDP) of the Project are to reduce at minimum level of undesired impacts to the ethnic minority groups. Especially for the land area reclaimed to build Preventive Health Center, it is promoted to reduce at mínimum level the impacts to the ethnic minority and avoiding to moving and resettlement.

2. Number of impacted households was reduced at mínimum level through avoiding to reclaim resident land, cultural, religional architect Works and farming land for building the Preventive Health Center to reduce the impacts to the living of the local people.

3. The Project objectives are aiming at implementing the equity policy in health care for the poor, near-poor and ethnic minority people who have no or not enough money to access and use the health services. Therefore, the Project activities emphasize on capacity

building of health care of the health facilities at district level to support positively to and give more favors to the benficiaries of the Project. EMDP policy of the Project is established by detail plans based on the features of cultura, customs and habits and elements that bare the Access to the health services by the ethnic minority in order to address the Project acitities to reduce at mínimum level of obstacles to the needs of health care of the ethnic minorities.

4. The report on EMDP prepared was based on the World Bank's policies for the indigenous people. WB has its own policy for the indigenous/ethnic minority peole (OP4.10; 7.2005). The bank appeals the projects to invest to the ethnic minority areas and perform fully the priorities to ethnic minority groups to be impacted by the Project implementation. It should be reduced negative impacts to the indigenous people and enhancing the activities which bring the benefits and reserve their traditional culture value. WB requests the people should have adequately informed and freely participated in the Project, and it should have received the supports by most of the ethnic minorities impacted by the Project. The Project design must ensure that the ethnic minorities should have received the socio-economic benefits in accordance with the cultura features including gender issues and multigeneration characteristics.

## II. THE LEGAL AND POLICY FRAMEWORK

### 2.1. General information on EM groups in Vietnam

Vietnam is a multi-ethnic country with 54 different ethnic groups who have formed the language, lifestyle and cultural characteristics of their nation for quite a long time. The Kinh people (also known as the Viet ethnic group) are the majority group, accounting for 85% of the population in the country. According to the survey data of 53 ethnic minorities in 2015, the total population of 53 ethnic minorities is about 13.3 million people, accounting for 15% of the population in the country. Among ethnic minorities in Viet Nam, there are some ethnic groups living in the delta areas such as Cham, Khmer, Hoa, mainly in the South West and South Central. The remaining 50 ethnic minorities reside in the midland and high mountains in the North, Central and Central Highlands.

In terms of population size, there are some ethnic groups with a population of over one million people such as: Tay, Thai, Muong, Khmer, Hmong. There are 14 ethnic groups

with a population of over 100,000 people; 34 ethnic groups have a population of less than 100,000, of which 16 are ethnic minorities with a population of less than 10,000 and 5 ethnic minorities with population of less than 1,000, such as Si La, Pu Peo, Brau, Ro Mam, O du.

The gaps between the majority and EMs reflect historical patterns. Among the different groups in Vietnam, the historically poor are much more likely to be poor today. But their ranking has not changed substantially. The Hmong, for example, remain among the poorest groups, and the Tay remain among the wealthier EMs. The persistence of EM poverty is the product of factors across a broad set of domains: social exclusion, culture, and language; geographic isolation and low mobility; limited access to high-quality land; low education levels; and poor health and nutrition, often reflecting limited access to services.

The first set of factors consists of social exclusion as well as cultural and language barriers, which may prevent ethnic minorities from better integrating into society. Language constraints create difficulty for EMs in accessing public services and information. EM women are reluctant to use free services. There may also be cultural barriers to economic advancement, such as social pressure against excess economic accumulation and cultural perceptions of social obligations. Due to the successful push to expand primary education, language will likely be much less of a barrier for EMs in the future. Attitudes toward and treatment of the EMs are related barriers. Studies in many countries have shown that unconscious or implicit biases, usually favoring one's own group, are pervasive among all human beings. Thus even Kinh who do not see themselves as prejudiced may have unconscious biases that affect the way they treat EMs. Qualitative work has found that many Kinh hold negative stereotypes toward EMs and view them as "backward."

A second set of factors is geographic isolation, limited market access, and disconnection from economic growth centers, particularly for those living in the Northern Mountains. One study found that location accounts for 21 percent of the overall difference in consumption levels between minority and majority households. But geography by itself has only limited explanatory power, as EM groups in the Mekong Delta and Central Highlands regions—which are less isolated and more economically connected—still have high poverty rates, while the Kinh in the Northern Mountains have much lower poverty.

A final set of factors consists of nutrition and health. Surveys have seen little improvement in the under-5 malnutrition rates and worsening infant mortality rates. Malnutrition rates in 2014 were twice as high among s as among the Kinh and Hoa. Infant mortality rates are low for the country's income level but are four times as high among EMs.

## 2.2. The existing legislation relating to EMs

The existing legal framework has reflected that the Communist Party and the Government of Vietnam has always placed the issue of ethnicities and ethnic affairs at a position of strategic importance. Citizens from all ethnicities in Vietnam enjoy full citizenship and are protected through equally enforced provisions according to the Constitution and laws, as listed in the framework. The underlying principle of the framework is 'equality, unity, and mutual support for common development', with priorities given to 'ensuring sustainable development in ethnic minorities and mountainous areas'.

The Constitution strongly commits to equality for ethnic minorities. In particular, Article 5 proclaims all ethnicities to be equal, prohibits discrimination by ethnicity, asserts the right of ethnic minorities to use their own languages, and commits the state to implementing a policy of comprehensive development for ethnic minorities. Other parts of the Constitution specifically prioritize ethnic minorities in policies for health care and education.

The fundamental principle has been institutionalized in laws, Government decrees and resolutions and the Prime Minister's decisions, which can be divided into three following categories by: (i) ethnicities and ethnic groups; (ii) by geographical areas (for socio-economic development); and (iii) by sectors and industries (for socio-economic development), such as support for production, poverty reduction, vocational training and job creation, protection of the eco-environment, preservation and promotion of culture and tourism, communication, and awareness raising in legal issues and legal aid.

In terms of the national legal framework, equality and rights of ethnic people was stipulated clearly in the Vietnam Law. Article 5 in the Vietnam Constitution (1992) is as follows: the Socialist Republic of Vietnam is a united nation having many nationalities. The State implements a policy of equality and unity and supports the cultures of all nationalities and prohibits discrimination and separation. Each nationality has the right to use its own

language and characters to preserve their culture and to improve its own traditions and customs. The State carries out a policy to develop thoroughly and gradually improve the quality of life of ethnic minorities in Vietnam physically and culturally.

Decree No. 05/2011/ND-CP (January 14th, 2011), provides the guidance for activities related to EMs which include support for the maintenance of language, culture, customs and identities of every Ethnic Minority.Article 3 of that Decree lays out general principles when working with Ethnic Minority people as follows:

- To implement the EM policy on the principles of equality, solidarity, respect and mutual assistance for development;
- To assure and implement the policy on comprehensive development and gradual improvement of material and spiritual life for EM people;
- To assure preservation of the language, scripts and identity, and promotion of fine customs, habits, traditions and culture, of each EM group; and
- An EM group shall respect customs and habits of other groups, contributing to building an advanced Vietnamese culture deeply imbued with the national identity.

The document of the Government on the local democracy and citizen participation is directly related to EMPF. Ordinance No. 34/2007/PL-UBTVQH11 dated April 20th, 2007 of the Standing Committee of the National Assembly, of the XIth National Assemblyon exercise of democracy in communes, wards and townships had provided the basis for the participation of the community in preparing the development plans and the supervision of community in Vietnam. Decision No.80/2005/QD-TTgof the Prime Minister dated April 18th, 2005 on investment supervision by the community.

**The policies relating to healthcare for poor and EM households:**

The Goverment of Viet Nam made its Decision No.135/1998/QD-TTg dated July 31st, 1998 approved "*The socio-economic development programme for the extremly difficult mountainous and remote comunes*". Accordingly, those people who live in the extremely

difficult area in the mountainous and remote area will receive the favours in health examination and treatment.

The Resolution No. 18/2008/QH12 issued by the National Assembly stipulated the acceleration of the performance of socializational policies and laws promote the quality of health care service for the people. The National Assembly has its direction to increase the rate of annual budget expenses for the health cause, ensures the rate of expense increase for the health is higher than the average expense increase of the national budget. It is spent at least 30% health budget for the preventive health. It also concerns to spend the budget line for health care for the poor, farmers, ethnic minorities and the people in the regions with a difficult and extremely difficult socio-economic situation.

On October 15th, 2002, the Government promulgated the Decision No.139/QD-TTg on "*Checking up and treatment of health for the poor*" addressing all people are the poor and those who live in the extremely difficult region under Program 135, and the ethnic minorities will have received freely checking up and treatment of health policy of the Government. The budget for the fund of this program will be withdrawed from the national and local budgets (accounting for 75%) and mobilizing the organizations and individuals's contributions. The level of payment is following the real expense-payment regulation.

Thank to enforcement of Decision 139, the issue of health care for the poor and ethnic minority people has been greatly changed. The provinces where there are the poor patients stipulated the documents regulating the execution of health checking up and treatment for the poor and established the Fund of Checking up and Treatment for the poor. In the extremely difficult provinces in the North Central Region, due to a high rate of ethnic minority people and most of people living in the area under Program 135, the beneficiaries who receive the Policy 139 are very numerous. Since the performance of health checking up and treatment for the poor, number of patients going to the health facilities has increasing significantly. This also is a huge challenge to the extremely difficult provinces in the North Central Region because of limited state budget source in the context of increasing needs of health checking up and treatment of the poor in the region.

The Prime Minister has especially signed the *Decision No.139/2002/QD- TTg* on October 15, 2002 on "*Check up and Treatment for the poor*" providing for eligible people for

granting the Health Insurance Card and benefiting from non-advance payment medical examination and treatment, and from fundable medical examination and treatment not the originally registered health care establishments. Beneficiaries in the case are the poor according to the poverty line, the population in extremely difficult communes (Program 135), and the ethnic minority population.

The privileged medical examination and treatment given to the poor according to the Decision 139 of the Government has significantly contributed improvements to health care situation of the poor, especially of those in mountainous areas and ethnic minorities groups. However, access to health care services of the poor and ethnic minorities groups North Central Region is still difficult. The poor cannot go to health care units because they cannot afford the transport or the patients' caring costs, or they cannot access to modern health care services at provincial and central health care establishments. Meanwhile, at district level medical equipment and facilities are inadequate, human resources are not satisfactory in both quantity and quality to provide ensured examination and treatment for local people in general, and for the poor and ethnic minorities in particular.

The Vietnam government has spent big efforts on improving the access to health care services for the poor ethnic minorities and people in ethnic minority areas for the last years. The health care policies have been quite comprehensive, covering the support health care infrastructure development, human resource development, education, information and communication to the people in these areas to raise the awareness of preventive health, supporting the poor to get health care services through providing health care insurance cards. The national strategy for people health protection, care and promotion in the period of 2011-2020 and vision to 2030 which is approved by the Prime Minister in accordance with Decision No.122/QĐ-TTg dated 10/01/2013 states clearly: "ensure every people, especially the poor, the ethnic minorities, the children under 6 ages, the prioritized persons, the people living in disadvantaged, remote area and the vulnerable groups access to quality basic healthcare services".

One of the barriers to accessing health care services for ethnic minorities is the impact of ethnic minorities'custom and limited awareness on their health care practices. On the other hand, the infrastructure and quality of primary care services at the grassroots level are also

difficult to access to modern medical services for ethnic minorities. According to the Ministry of Health's assessment of the quality of medical examination and treatment services at the grassroots level, although Viet Nam has achieved some achievements in maternal and child health care after 30 years of change, the inequalities in the health outcomes in ethnic minority areas are still very different from those of the majority population. Ethnic minority child mortality is three times higher than that of Kinh/ Chinese children; The incidence of low birth weight, stunting, prevalence of antenatal clinic visit, or birth rate among health facilities varies between ethnic minority and urban areas. According to the Ministry of Health's statistics in 2014, the grassroots health network in the northern mountains is facing many difficulties. Out of more than 2,560 commune health stations, there are 78 Commune Health Centers, which are not headquartered, or are housed in temporary houses; Over 2,200 health stations have been degraded and need to be upgraded. The percentage of doctors working at the stations is lower than in the lowlands. Efforts to improve the quality of grassroots health services for mountainous health care areas in order to strengthen the health care needs of ethnic minority communities are one of the key priorities of the sector health today.

According to UN Women's Report on Gender Equality in Viet Nam in 2016, adolescent births are a concern because they are a big threat to the health of young women and their babies. This issue is also linked to early marriage and child marriage, early dropouts, lack of services for adolescents and young people. According to the Viet Nam Assessment of Children and Women Targets, the birth rate for women aged 15-19 is 45 births per 1,000 women, of which the proportion in rural areas is doubled in urban areas (56 births per 1,000 rural women compared to 24 in urban areas). Adolescent pregnancies are also related to economic status, residence and ethnicity, with a higher proportion among the poorest quintile, and among women in the midland and Northern mountainous areas and Central Highlands, where ethnic minorities are concentrated and where teenage births are about three times higher than in other regions due to the practice of early marriage and child marriage. (GSO and UNICEF, 2015), the Mekong River Delta, the Red River Delta, and the North Central Coast and Central Coast have the highest rates of contraceptive use, while the upland areas as in the Northern Midlands and Mountains and the Central Highlands, the contraceptive prevalence is much lower. The percentage of ethnic minority

women using any contraceptive method (70.6%) was lower than that of Kinh and Chinese women (76.6%), but interestingly, Ethnic minorities women tend to use more modern contraceptives than Kinh and Chinese women (GSO and UNICEF, 2015).

Studies have shown that there are many obstacles facing ethnic minority women when it comes to reproductive health services, especially ethnic minorities residing in mountain ranges such as Hmong, Ha Nhi, Lo Lo who have very difficult living conditions such as: low education level, low income, limited awareness of individuals, families and communities, Influence of customary factors on decision-making behavior and participation in using health services ... But the most important reason is the limitations in service delivery, especially the problems In the process of medical examination and treatment, the use of health insurance cards has made ethnic minority women with less access to health insurance. It is becoming more difficult, even inaccessible, to have access to the services they should benefit from. Meanwhile, health care policies remain general and no new efforts have been made to bring health care services, especially reproductive health care services to ethnic women, especially ethnic women with extreme difficulty. Some ethnic minority women in the northern mountainous areas still give birth at home with the help of relatives. This is a customary habit and difficult to change. Research results of the Institute of Ethnology together with the research results of Dam Khai Hoan and associates (2013), the proportion of H'mong women giving birth at home is almost absolute (98.9%). The proportion of mothers receiving antenatal care and vaccination is lower in the Hmong and Dao than in the Tay and Thai. According to this observation, Tran Mai Oanh et al. (2012) found that 81% of the poor attended health clinics in the commune health center, 47% did not attend antenatal care during pregnancy and the percentage of mothers giving birth at home is still high, with only 30% of births using clean delivery packages. Research results from the Center for Community Health Research and Development show that access to health services for reproductive health care among ethnic minority women has not been improved. Home delivery rates have dropped by only 6.9% while child and maternal malnutrition rates remain above 20%[3].

[3] Center for Community Health Research and Development, Mid-Term Review of the Project to Improve Maternal and Child Health through Eradication of Health Behaviors, 2013

## 2.3. Ethnic minorities in the provinces expected to be located in the project area

Of the provinces projected to be included in the project portfolio, most provinces have ethnic minority and representative of ethnic minority regions and groups. For example, Tra Vinh, Bac Lieu are inhabited by Khmer; in provinces of the South Central Coast such as Ninh Thuan there are are ethnic Cham and Raglai, Quang Tri and Quang Binh have ethnic groups such as Bru Van Kieu, Ta Oi, Co Tu and Chut ethnic minority people. Provinces of the North West such as Son La, Hoa Binh, Yen Bai there are are ethnic Thai, Muong, Tay, Hmong, Dao resident...

The ethnic groups residing in the projected provinces can represent 53 ethnic minorities in Viet Nam, for example, among ethnic groups, there are more than one million ethnic people in groups such as the Khmer, Muong, Thai, ethnic minorities less than 10,000 people such as Chut ethnic; There are also ethnic groups representing ethnic groups with very difficult socio-economic conditions such as Ta Oi, Co Tu, Chut ...

## 2.4. The World bank's policy toward the ethnic minoritites (OP 4.10)

The WB's Operational Policy 4.10 (Indigenous Peoples) requires to engage in a process of free, prior, and informed consultation[4]. The Bank provides project financing only where free, prior, and informed consultation results in broad-based community access and support to the project by the affected Indigenous Peoples. Such Bank-financed projects include measures to (a) avoid potentially adverse effects on the Indigenous Peoples' communities; or (b) when avoidance is not feasible, minimize, mitigate, or compensate for such effects. Bank-financed projects are also designed to ensure that the Indigenous Peoples receive social and economic benefits that are culturally appropriate and gender inclusive.

The Policy defines that ethnic minority peoples can be identified in particular geographical areas by the presence in varying degrees of the following characteristics:

[4]Free, prior, and informed consultation with the affected Indigenous Peoples' communities" refers to a culturally appropriate and collective decisionmaking process subsequent to meaningful and good faith consultation and informed participation regarding the preparation and implementation of the project. It does not constitute a veto right for individuals or groups.

a) self-identification as members of a distinct indigenous cultural group and recognition of this identity by others;
b) collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories;
c) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and
d) an indigenous language, often different from the official language of the country or region.

As a prerequisite for an investment project approval, OP 4.10 requires the borrower to conduct free, prior and informed consultations with potentially affected ethnic minority peoples and to establish their broad-based community access and support to the project objectives and activities. It is important to note that the OP 4.10 refers to social groups and communities, and not to individuals. The primary objectives of OP 4.10 are:

- to ensure that such groups are afforded meaningful opportunities to participate in planning project activities that affects them;
- to ensure that opportunities to provide such groups with culturally appropriate benefits are considered; and
- to ensure that any project impacts that adversely affect them are avoided or otherwise minimized and mitigated.

### 2.5. Consultation and participation with EM people at each stage of the project

This section provides a framework for ensuring that the affected EMs (equivalent to the indigenous peoples as defined in OP 4.10) has equal opportunity to share the project benefits, that free, prior and informed consultation will be conducted to ensure their broad-based community access and support to the project are obtained, and that any potential negative impacts are properly mitigated and the framework will be applied to all the subprojects. It provides guidance on how to conduct preliminary screening of EMs, and identification of mitigation measures given due consideration to consultation, grievance redress, gender-sensitivities, and monitoring. An outline of the EMDP report is provided in Annex 1.

In terms of consultation and participation of ethnic minorities, when the subprojects affect EMs, the affected EM peoples have to be consulted in a free, prior, and informed manner, to assure:

(a) EM and the community they belong to are consulted at each stage of subproject preparation and implementation,

(b) Socially and culturally appropriate consultation methods will be used when consulting EM communities. During the consultation, special attention will be given to the concerns of EM women, youth, and children and their access to development opportunities and benefits; and

(c) Affected EM and their communities are provided, in a culturally appropriate manner at each stage of subproject preparation and implementation, with all relevant project information (including information on potential adverse effects that the project may have on them.

During project implementation, as a principle of ensuring inclusion, participation and cultural suitability, the project should hold continuous consultations including soliciting feedback from all communities so that remedial actions can be taken to support improved participation and provision of benefits to households including those of EMs. The consultation methods to be used are appropriate to social and cultural traits of EM groups that the consultations target, with particular attention given to land administrators, household land users, village leaders and other service providers related. The methods should also be gender and inter-generationally inclusive, voluntary, free of interference and non-manipulative.

The process of consultation should be two-way, i.e. both informing and discussing as well as both listening and responding. All consultations should be conducted in good faith and in an atmosphere free of intimidation or coercion, i.e. without the presence of those people who may be intimidating to respondents. It should also be implemented with gender inclusive and responsive approaches, tailored to the needs of disadvantaged and vulnerable groups, enabling incorporation of all relevant views of affected people and other stakeholders into decision making.

## III. PREPARATION OF AN EMDP

An EMDP should be developed on the basis of consultation with EMs in the project areas. Consultation is important to EMDP preparation since it provides EM groups (both potentially affected and not affected by subprojects) with opportunities to participate in planning and implementation of subprojects. More importantly, it helps identify potential adverse impacts, if any, as a result of subproject, on EM groups, thereby enabling devising of appropriate measures as to how adverse impacts could be avoided, minimized, and mitigated. Consultation also aims to ensure EM people have opportunities to articulate, on the basis of their understanding of subprojects/project goals, their needs for support from the project in relation to the project goal/project activities. The whole exercise of developing an EMDP is grounded on a study that is referred to, in the Bank-funded projects, as a Social Assessment(SA).

### 3.1.Social assessment

**Purpose.** SA, in the context of the Bank's OP 4.10, is a study that aims to explore how planned project activities under a Bank financed subproject would affect the life of EMs present in the subproject areas. The purpose of the SA is to ensure if there is any potential adverse impact as a result of the subproject, appropriate measures are in place (in advance of subproject implementation) to avoid, mitigate, minimize such potential adverse impacts, or to compensate for affected population, if unavoidable. The SA also aims to explore, based on the understanding of EM's cultural, socio-economic characteristics of the EM communities, possible development activities that the project can implement (in relation to the project goal/objectives) to ensure EM peoples in the subproject area receives socio-economic benefits that are culturally appropriate to them.

For the proposed project of the MOH, it is proposed to collect relevant information on the demographics of ethnic minority communities, socio-economic status and health services of primary health levels and the barriers in accessing grassroots level health services (mainly CHSs) of the general population and EM groups in particular in 5 districts and 5 communes of Tra Vinh, Quang Tri and Yen Bai.

The social assessment also includes information consultation with ethnic minorities who have used or using commune and district level health services and providers of grassroots health services (district and commune) to determine whether there are any risks that may prevent the EM communities from accessing and benefiting from the investment project at the grassroots level.

### 3.2. Methodology for preparing EMDP(s)

To prepare EMDPs, consultations are conducted with various stakeholders at the national level and at sub-nationalones in the project provinces. A number of conventional qualitative research instruments are employed, including focus group discussions, in-depth interviews, note-taking, and photographing, and non-participant observation.

- **Focus group discussions**: Each FGD usually includes 6-8 participants who are recommended and invited by local guides following the requirements of the research team. Gender-disaggregated data are paid attention through the establishment of gender sensitive FGDs. Local guides are the chiefs of the selected residential units who have a very good understanding of the community. In order to understand likely different impacts and their responses to the project, a variety of respondent groups are selected, including administrators from Local and MoH at the national and subnational levels, users of health insurance services, and social assistance beneficiaries, including local poor/near-poor and representatives from local EM groups.
- **In-depth interviews**: The team may plan to explore some case studies with more in-depth information. The informants for such in-depth interviews may be selected from the FGDs (researchers may find some discussants who have more interesting details to provide so have him/her for a separate in-depth interview). Also, the interviewees may be recommended directly by local guides after researchers have fully explained the assessment objectives.
- **Triangulation**: A few extra interviews with local and MoH administrators are added under a technique known as ‘triangulation’ to validate the information that the researchers have obtained from local residents. They are an additional source rather than a proper sub-group. Also, there are some issues the latter may raise but

do not understand why, given their positions. In such cases, the extra interviews would help clarify or supplement what local residents have stated. These interviews serve to validate and, in some cases, supplement the information provided by local residents.

- **Consultation with local managers:** The consultant will organize consultations with local managers on health and health care. The management team was selected in two respects: the team carried out professional activities in health and health care; State management staffs involved in the planning and implementation of local socio-economic development tasks, including government, mass organizations...
- **Gathering available information**: Collecting and distilling from existing research results on issues related to investment in basic health care, collecting secondary data and information in survey area.

### 3.3. Suggestive steps in developing an EMDP

The following steps should be followed by the PMU or its consultant, in order to prepare an EMDP for a subproject. The PMUor its consultants should comply with the suggestion steps for preparing an EMDP for the project.

| Step | Implementation plan | Monitoring theimplementation |
|---|---|---|
| 1 | ***EMDP*** targets<br>For ensuring: (1) Avoiding, minimizing, mitigating potential negative impacts (if yes) and (2) Receiving the benefits for EM groupsthat are suitable to their cultures. | Monitor whether public consultation is organized or not. |
| 2 | ***Developing the data collection plan***<br>Thedata to be collectedcan be both quantitative and qualitative regarding: | Factors to monitor (whether they are in accordance with the plan) |

| | | |
|---|---|---|
| | • Natural conditions;<br>• Socio-economic conditions: the population of the selected project sites, the EM populations (broken down by each ethnicity group, by household and individuals); economic structures, growth rates, etc.<br>• Project beneficiaries of using services, providing health care services to minority groups.<br>• EM groups' perceptions on the legislation, accessibility to information, and both positive and negative potential impacts. These qualitative data come from local consultations.<br><br>Secondary data can be collected from organizations and individuals involved: Department of Health, District Hospital, District Health Center, Commune People's Committee, Commune Health Station.<br><br>They can collect qualitative data through conventional qualitative methods, such as group discussions, in-depth interviews, observation and photographing. Such direct consultations with representatives from the related VSS and MOH administrators as well as individual service users and beneficiaries, including those from EMgroups.<br><br>The team leaders should communicate regularly witha focal point at the central level to report emerging issues, consult necessary issues and report the progress to make the study to be followed. The focal | The data(both quantitative and qualitative) collected (whether they are relevant and reliable; any discrepancies found)<br><br>Methods used to collect the data (whether they are relevant and effective) |

| | | |
|---|---|---|
| | point would provide adequate supervision and guidance to the teams as needed.<br><br>***Review and analysis the data:***<br><br>• Compilation and aggregation of the data from the focus group meetings and participant groups in each location;<br>• Based on this type of aggregation it is possible to begin analyzing patterns in the data according to the frequency with which certain responses occur. This is where triangulation of the responses and recommendations made by different participant groups becomes important. The purpose of this is to identify areas of commonality in which there is a high degree of consensus and also areas in which there major differences of opinion between one or more groups;<br>• Iterative analysis of the data and in-depth knowledge of the local situation is required to interpret and assess the relevance and implications of this type of information; and<br>• It is important to verify the findings and the main conclusions with participants and other stakeholders to ensure that the analysis has not somehow drifted away from what people were trying to say. | The approaches employed to analyse the collected data (whether they are relevant and effective; identify any constraints) |

| | | |
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| | Some data should be tabulated properly and placed either in the main text or annexes, whichever is more relevant depending on the specific report structure of each province. | |
| 3 | Based on the data collected and findings from public consultation, the study team should determine:<br><br>(a) The factors from the project activities that may cause potential positive and negative impact (if any) and<br><br>(b) Assess the needs of the related EM groups (with clear targets and priority strategy).It is important to prioritize their needs based on the sources (human resources, technology, finance, and institutions) available to the project.<br>On a basis of the identified factors, the team should discuss and propose what specific measures the project can do to avoid, minimise and mitigate the negative impacts, specifying who should do what and how given the available resources. | Check whether beneficiaries and impacts on them have been identified appropriately.<br><br>Check whether all the existing resources have been sought to address to maximise positive impacts and minimise potential negative impacts.<br><br>The expectation of beneficiaries and whether the project objectives can be met. |
| 4 | ***Writing up an EMDP*** | |

| | | |
|---|---|---|
| | An EMDP should be structured to address the important social safeguards issues relating to the EM groups in the project sites (more detailed information can be found at Annex 2):<br><br>• Background information on the project sites and a profile of the related EM groups in the project sites (the related socio-economic and political conditions as well ethnic cultures and customs);<br>• Key activities/mitigation measuresthat should be implemented locally, as identified on a basis ofthe assessment of specific needs from the public consultation with the related EM groups in each study site;<br>• Key stakeholders who will implement these activities;<br>• Resources needed(finance and human resources) for these key stakeholders to implement these activities.<br>• A timeframe (frequency) to implement these activities;<br>• An GRM mechanism (in addition to the existing government structure);<br>• An institutional arrangement for implementing the identified activities;<br>• Disclosure of EMDF; | Determining the implementation plan can be successful or not, and how the PMU perceive the effectiveness of this plan.<br><br>The implementation and monitoring plan should be developed with the PMU to make it easier to them to adopt it. |

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| | • An indicated budget estimates. | |

### 3.4. The proposed measures for an EMDP

Specific measures will be required to ensure that EM groups receive project benefits in a culturally appropriate manner, and the most vulnerable EM communities in upland areas are not disadvantaged by MOH. EMDPs, prepared in conjunction with the SA findings, are a vital tool in this regard. The needs and approaches to the project information vary considerably among EM groups, depending on their differences in the level of development, ability to receive, environmental conditions and platform experiences. Cultures and customs also vary among ethnic groups as well as within an ethnic group. Mitigation measures are very different in each province as a result of differences in their cultures and customs. Hence, MOH should have different measures for different EM groups to avoid irrelevance. Below are some development measures which may be considered for preparation of EMDPs.

**Timing strategy**: Given many constraints in the EM areas, many respondents, both administrators and beneficiaries, suggested piloting and phasing for EM areas and EM groups to learn lessons. They preferred the phased implementation from the lower to the higher land areas, from towns to rural areas, as well as from areas with better educated people to those with less educated ones.

**Training**: Adequate training should be provided for administrators and beneficiaries. In particular, ToT may be considered for training district and commune cadres first, and then village heads and local people. Furthermore, training sessions for EM beneficiaries should ideally be conducted directly at a village level, with hands-on demonstration, in EM languages, and by the same EM people, preferably village heads. More careful training may be provided to village heads who can later serve as focal points for queries on the use of ICS cards and benefits. Also, guidance should be recorded on CD and transmitted through by community sessions, smart phones and local TVs, among small groups, with due attention to poorly educated EM beneficiaries. Adequate timing of training sessions to

maximise attendance is essential. In addition, assistance should be provided during the registration, issuance and guidance for use

**Communication**: It is important to prepare a communication strategy with culturally appropriate activities for EM people regarding project information. Awareness-raising activities and events in EM areas are important so that EM beneficiaries would know how to use and protect cards well, possibly through the FPIC process, village heads, role-plays, and DVDs.

It is important totake advantage of socio-cultural characteristics for the communication strategy, including for community activities and events, although a diversity of situations may exist across the country.Amongst the EM populations, wherever possible written forms of information should be minimised, while greater attention should be paid to capacity building amongst heads of villages and local cadre to ensure that these individuals fulfill their current role as key disseminators of information more effectively. As EMs tend to be heavily dependent on village leaders and cadre as sources of information, capacity should be built at this level to ensure householders are regularly updated about the processes, and their potential involvement. For example, for the H'mong and Dao groups in Ha Giang, it is important to communicate project information and guidance to village heads who are considered closer to their community and can make a substantial impact on households and individuals. It is ideal to produceuser-friendly guidance with pictures and short, as well practical hands-on demonstration guidance, which could be recorded into DVDs for standard and repeated use among EM groups. Moreover, finger-print technology should be used for illiterate people.

**Consultation with and participation of EM stakeholders**:

Based on the results of community consultation from commune health sector users and from the grassroots level health service providers, some measures proposed in the EMPF, or integrated into the EMPF may include:

a) Develop a communication strategy to raise awareness among EM community in general and women in particular about primary care and reproductive health care.

- Implement communication activities to raise awareness of ethnic minority

communities about the need for health examination and treatment, community promotion to change the concept of medical examination and treatment today. The proposed communication activities are based on assessments in some areas where people's perceptions of treatment are limited. Ethnic minorities often go buy medicine and pray for them without going to the clinic for medical treatment. They only go to CHS or other health services when the disease becomes severe, difficult to cure. For women, many are not yet aware of the importance of adequate antenatal care and prenatal care as well as postnatal care.

- The importance of implementing communication activities is the use of spoken languages that are close, relevant to the culture and cognitive ability of ethnic minority communities. Avoid the use of many documents and documents on paper. In addition, the location of the communication activities should be places that people normally focus on, such as village community culture houses, village markets where women and men traditionally go to market fair. Communication activities should also be utilized and integrated in local cultural events.
- Involving senior village elders in community participation in health care talks will increase the effectiveness of the media.
- Mass communication should be combined with lectures by physicians in the population groups, especially the dissemination of knowledge to the women about antenatal care. maternity care, nutrition care for children and mothers after childbirth, consultations with regular pediatric health workers.

b) Organize a number of short-term training courses for mothers and village midwives to provide knowledge about delivery and management of some situations that may be encountered when giving birth at home.

c) Many EM women often deliver at home because of habit. Some, for other reasons such as it may be far away from the clinic, when the pain comes, may not have time to come to commune clinic. Midwives, village midwives or some women who provide birth support for their children at home should be trained in basic knowledge about delivery and management of some common situations to avoid unfortunate accidents in delivery.

Training may take 2-3 days. The training should combine both theory and practice, avoiding just providing theoretical knowledge as the ability of the group of village midwives is limited, they need to receive hands - on training. It is necessary to invite the upper-level doctors at the provincial and district levels to participate in the training courses. Examination is required at the end of the course and the certificate of attendance for the midwives in the village.

It is possible to learn more about the model of training ethnic minority women to become village midwives who have supported the health sector in Ninh Thuan province to carry out training activities for women. Support villages in the provinces participating in the project. Training activities for midwives and village mothers will be carried out to improve gender sensitivity in training, while there are currently poor forms of training in village health.

d) Organize a number of media conferences to promote gender equality in ethnic minority groups. There should be a plan to talk periodically and persistently because changing habits and perceptions is not a day-to-day change. In addition, there should be participation of ethnic minority men and women in the talks and discussions on the issue of family sharing and joint decision-making of the work, including the selection of health services when someone in the family is sick.

   Although there are matrilineal populations, the majority of northern ethnic groups are still patriarchal. Women who have to work hard to date without antenatal care can have serious consequences during delivery. As husbands and fathers in the family, men need to be aware of sharing their hard work with their wives so that their wives can have antenatal care. Men who ride motorbikes can take pregnant women for routine antenatal care.

**Promotion of gender equity**: It is essential to increase the participation of women, especially in the EM groups in the project sites, in various project activities and interventions, such as information dissemination and training. It is important to raise awareness for women of their rights and benefits relating to social insurance, health insurance, unemployment insurance and social assistance benefits, their rights to access to the GRM system and how to lodge their complaints when needs arise. It should be recognised that engagement of and awareness raising for women, especially EM women,

is a time-consuming process which should be planned and phased effectively with clear and practical short-, medium- and long-term objectives to make various steps feasible, with lessons reviewed and learnt as well as plans revised after each phase.

Reproductive health care needs for ethnic minority women should be tailored to their cultural and residence characteristics. Efforts should be made to arrange appropriate venues and times for women's participation, and also to promote complementary activities to maximize the participation of women headed households. The provision of training to local managers as well as project staff should consider gender sensitive issues.

Importantly, women from various EM groups should be consulted in good faith throughout the project cycle, from the design to the evaluation steps to ensure their voices to be heard and paid due attention to.There is a risk that female attendance at information workshops and meetings may be low. Specific measures may therefore be necessary to enhance women's current access to information and their associated engagement in MOH. Efforts will be needed to arrange a location and time suitable for the participation of women, and additional promotional activities may also be necessary to maximise attendance by female householders. Training provided to local administrators as well as project staff should take into account gender sensitivity.

During the monitoring of the EMDP implementation, the key indicators of gender actions will be monitored and reflected in monitoring reports.

### 3.5. Procedure for review and approval of an EMPF

Once an EMDF for a subproject is completed by the PMU, or its consultants, the EMDP needs to be submitted to the World Bank for prior review and comments before implementation of the subprojects for which the EMDP is associated. The Bank may request revision of the EMDP, based on the quality of the EMDP. When there is doubt or need for technical support in preparing an EMDP, the Bank's task team should be contacted for timely support.

## IV. IMPLEMENTATION OF AN EMDP

### 4.1. Implementation arrangements

There would be one PMU at the central level (known as the PMU in this document). This PMU has the overall responsibility for the overall implementation of EMDP(s), including monitoring and evaluation of the results of the EMDP implementation. The PMU will assign a qualified member of staff to work on social safeguards in the project. S/he will support local and stakeholders with preparing materials in implementing EMDP(s) and in monitoring progress. S/he will ensure that EMDP(s) is implemented and delivered as per work plan and quality.

For areas where EM groups reside, the PMU would coordinate with provincial and other stakeholders which would provide support to the former in the implementation and monitoring the implementation process of EMDP(s).

Provincial and other stakeholders would provide guidance to district VSS and other stakeholders in the implementation and monitoring the implementation process of EMDP(s).

### 4.2. Disclosure of EMPF

Once preparation of an EMPF is completed, it needs to be disclosed to affected EM people and their communities. The EMPF needs to be disclosed in an appropriate manner to ensure affected EM people and their community can conveniently access and can fully understand. In addition to public disclosure of the EMPF, meetings need to be given at the community where EM people are affected by the subproject. Where needed, meetings should be conducted using the language of the EM affected to ensure they fully understand the EMPF objective and can provide feedback.

Please note that all EMPFs prepared during project implementation must be disclosed locally in a timely manner, before appraisal/approval of these subprojects. The EMDPs need to be disclosed in an accessible place and in a form and language understandable to affected EM as well as key stakeholders, including the Bank's InfoShop.

### 4.3. GRM

GRM will be applied to persons or groups that are directly or indirectly affected by the project, as well as those that may have interests in a project and/or have the ability to influence its outcome -- either positively or negatively. At the commune level, MOH representatives regularly organize meetings with local people. Therefore, grievances can be redressed through annual meetings with voters and PMU's annual meetings with local people.

If the affected EM people are not satisfied with the process, resolutions, or any other issues, the EM themselves or village leaders can lodge their complaints to the CPC or to the PMU following GRM described in the EMPF. All grievances will be addressed promptly, and in a way that is culturally appropriate to the affected EM peoples. All costs associated with EM's complaints are exempt to EM complainants. The PMU is responsible for monitoring the progress of resolution of EMs' complaints. All cases of complaints must be recorded in the PMU's project files.

***Procedures to settle cases within PMU's jurisdiction***

GRM is established on the basis of the Vietnam's laws. MOH has a GRM from the national to district levels (see Annex A2), which will be followed during project implementation. The project will provide training and support to strengthen these existing structures for effectively dealing with grievances that may arise during the course of the project implementation. In addition, the PMU will be responsible for considering and settling cases within their jurisdiction. Complaints on project-related issues will be settled as follows:

- Individuals can lodge first-time complaints at district-level, or make a suit at the People's Court according to the existing legislation on civil proceedings.
- If individuals do not agree with first-time resolutions of district-level, they can submit their complaints to the provincial, or make a suit at the People's Court according to the existing legislation on civil proceedings.
- If individuals do not agree with second-time resolutions of the provincial VSS, they can make a suit at the People's Court according to the existing legislation on civil proceedings.

The project will establish an unit in charge of comments and complaints, including those EM groups regarding the implementation of the project. In addition, it is encouraged that grivances will be settled through informal institutions that are available in communities, such as heads of villages, extended family networks, mediation panels, and chief monks (in Khmer pagodas). At the village level, the project will coordinate with the existing grievance mechanisms that may be chaired by elder and/or spiritual leaders, which are acceptable to local communities, particularly the EM groups.

Some forms of comments and complaints may include written documents submitted, emails or direct communication (such as through telephones).People can send written texts or present their issues to village elderly, village heads or commune officials. Complaints will be handled in a timely manner, and written responses will be provided to complainants. District-level will record and document complaints and resolutions, which will be attached to bi-annual progress reports to the PMU for synthesis and submit to the WB.

To ensure that the grievance mechanism is practical and acceptable by EMs affected by the project, this will be consulted with local authorities and local communities taking into account of specific cultural attributes as well as traditional, cultural mechanisms for raising and resolving complaints/conflicts. If the EM objects, efforts will be made to identify and determine ways to resolve that are culturally acceptable to them. The information on GRM will be included in the POM. Local administrators and people in the project sites will be informed of this GRM.

## V. MONITORING AND EVALUATION

The responsibility for overall monitoring and implementing the EMPF and EMDPs rests with the PMU. In case of necessity, the PMU may hire a qualified consultant for external monitoring of the implementation of EMDP(s). During monitoring of EMDP implementation, the key indicators, including those of gender actions, will be monitored and reflected in monitoring reports.

## VI. BUDGET

The budget for the implementation of EMDP(s) comes from the counterpart funds. MOH will allocate and provide funds sufficiently and timely to ensure that EMDP(s) will be implemented successfully. The implementation budget for EMDP(s) will be estimated on a basis of activities proposed in EMDP(s).