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Local Health Care Sector Development Program (LHCSDP)

Prepared by the Ministry of Health for the Asian Development Bank

ABBREVIATIONS

ADB – Asian Development Bank

CEMA – Committee on Ethnic Minority Affairs

CHS – Commune health station

CPMU- Central Project Management Unit

HHR – Health human resource

HST – Health security threat

LHC – Local health care

MOH – Ministry of Health

NCD – Noncommunicable disease

PHC – Primary health care

PPMU – Provincial Project Management Unit

RHS – Regional health security

SDG – Sustainable Development Goal

SRH – Sexual and reproductive health

UHC – Universal health coverage

NOTES

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EXECUTIVE SUMMARY

Project description

The proposed Local Health Care Sector Development Program will assist the Government of Viet Nam to implement the Master Plan for Strengthening Local Health Care Services, which sets out reforms to improve access to and the quality of the local health care (LHC) system. The program's impact will be a network of local health facilities to ensure responsive primary health care (PHC) for the entire population is strengthened. The outcome will be improved quality of and access to LHC services for women and men, particularly in disadvantaged and remote areas. The project grant will be implemented in 6 target provinces

Ethnic minority groups in project areas

According to data from the General Statistics Office from the 2019 Population and Housing Census, the total population of 53 ethnic minorities in Vietnam is 14.1 million people (accounting for 14.6% of the country's population). The Northern Midlands and Mountains region has the highest number of ethnic minorities (7.03 million people), the Central Highlands (about 2 million people), the North Central region and the Southwest region have about 1.9 million people. There are differences in the distribution of ethnic groups between regions and provinces.

In general, the proportion of ethnic minority people in the select provinces is relatively high, with an average of 23%, higher than the national average of 14.6%. Ethnic minority groups present in the select provinces include Thai, Kho Mu, Tay, Dao, San Chay (Cao Lan), Nung, Hoa, H'Mong, San Diu, Xo Dang, Khmer, Ba na, Gia Rai, Gie Trieng, Brau, Ro Nam, Hrê, Muong. Factors that limit the access of ethnic minorities to health services include their location in isolated areas with transportation constraints, and relatively low educational levels leading to a lack of knowledge about health care.

Information disclosure and meaningful Consultation

Several consultations were held during project preparation with the participation of stakeholders, including local authorities and representatives of two ethnic minority groups (Khmer and Xo Dang). Consultations were held from 26 to 29 December 2017 in 4 communes (4 districts) in provinces of Soc Trang and Kon Tum to provide the EM people with information on the project and proposed activities, and to get EMs' feedback and comments on the measures to be included in the ethnic minority development plan. Participants included 43 ethnic minority households and 36 staff members of the Department of Health (DOH), District Health Stations (DHSs), Commune Health Stations (CHSs) and Committee on Ethnic Minority Affairs (CEMA) in the provinces/districts. During 2023, a baseline survey had been carried out from 1st April to 30th August, 2023. The survey sample was taken from 48 communes in 12 targeted districts in the 6 targeted provinces of Tuyen Quang, Phu Tho, Quang Nam, Gia Lai, Dak Nong, and Soc Trang. The survey team conducted 163 in-depth interviews with officers/staff of CPMU, PPMUs, DOHs, DHCs and CHSs, and 13 focus group discussions (FGDs), including 12 FGDs of DHSs staffs. The team used 77 data collection forms, 48 checklists, 20 IDI guidelines and 2 FGD guidelines to collect all necessary data mentioned in DMF, GAP, and EMDP, including data on reproductive health care for women and health care for ethnic minority people (see Midterm survey report for more details). In June and July 2024 a monitoring fieldwork had been carried out by a team consisting of the newly recruited Gender and EM consultant, the Training consultant and the M&E consultant to 6 target provinces. The monitoring team had conducted 6 FGDs involving 29 PPMU officers/staff in the 6 provinces, 12 FGDs with 46 staffs of DOHs, and 24 FGDs involving 141 health workers from 24 visited CHSs in the 6 provinces, including 95 females and 32 ethnic minority people. During these FGDs consultations the Gender and EM consultant had provided them with the updated GAP and EMDP and discussed with the participants about GAP and EMDP. An individual IEC consultant has been recruited in 05 August 2024. This consultant is responsible for managing and supervising the Program's IEC activities. The IEC consultant proposed to cancel the marketing package because not enough time and proposed alternative plan to replace this package

to get achieve relevant program targets (T2, T3, T4, T5, A6). On 26 September 2024, the alternative plan was submitted to ADB for no objection. On 02 October 2024, ADB replied to CPMU's proposal that "CPMU needs to prepare a procurement plan (version 8) for ADB's approval. In the updated procurement plan, please indicate the revised amount (should be lower than $250,000) and change CQBS to RFQ. So CPMU submitted the revised TOR for ADB no objection enclosing updated PP. On 20 December 2024, CPMU received NOL from ADB. Therefore, CPMU expects to award this contract in Q1 2025. IEC firm is expected to be recruited in Q1 2025. The IEC team will design the IEC materials in Q2 2025. So all communes in target districts will gain knowledge from the IEC materials on the new services models of LHC in Q3 2025. Hence, it is not enough time, so there will be only IEC material development and TOT for district health center staff. All IEC materials used for health prevention and education activities at local health care level in the target districts will be gender and culturally (EM) sensitive.

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

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

Grievance and redress mechanism

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

Budget for EMDP implementation

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

Implementation Arrangements

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

I. PROJECT DESCRIPTION

1. The proposed Local Health Care Sector Development Program will assist the Government of Viet Nam to implement the Master Plan for Strengthening Local Health Care Services, which sets out reforms to improve access to and the quality of the local health care (LHC) system. The program's impact will be a network of local health facilities to ensure responsive PHC for the entire population is strengthened. The outcome will be improved quality of and access to LHC services for women and men, particularly in disadvantaged and remote areas.

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

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

4. **Output 3:** Local health care workforce development and management strengthened. The program will enhance HHR quality and deployment through reforms to (i) strengthen system for licensing of practitioners and LHC facilities; (ii) enhance competency standards for health personnel; and (iii) strengthen LHC workforce by addressing incentive structures, and gender and ethnic representation. The project grant will support (i) HHR curriculum on managing NCDs, SRH, ageing-related illness, HSTs, and regional cooperation; and (ii) HHR training that ensure access for female and ethnic minority staff. In this regard, seven training courses will be delivered to health staff at the commune and/districts level with specific targets for female and ethnic minority participation.

5. Component I of the Program will be implemented in 16 target provinces; specifically: Ha Tinh, Nghe An, Tuyen Quang, Bac Giang, Phu Tho, Dien Bien, Lai Chau, Quang Nam, Phu Yen, Binh Thuan, Kon Tum, Gia Lai, Dak Nong, Binh Phuoc, Soc Trang, Ca Mau. The aid of the Program (Component II hereinafter referred to as the Project) will be implemented in 6 target provinces including Soc Trang, Quang Nam, Phu Tho, Gia Lai, Tuyen Quang and Dak Nong.

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

II. LEGAL AND POLICY FRAMEWORK

A. National Legal and Policy Framework for Ethnic Minority People

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

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

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

10. Applying socio-economic policies to each region and ethnic group with the needs of ethnic minorities is an essential requirement: Socio-economic development plans and strategies in Vietnam care about ethnic minorities; Key programs for ethnic minorities include Program 135 (Infrastructure for the poor and remote areas) and Program 134 (Elimination of temporary housing for the poor). In addition to education and health policies for ethnic minorities, the legal framework for ethnic minorities includes tools related to regional master planning, Program 135 - phase II and other land management and compensation policy, National target program for socio-economic development of ethnic minority and mountainous areas for the period 2021-2030, phase I: from 2021 to 2025, National target program for building new rural areas for the period 2021-2025, National target program for sustainable poverty reduction for the period 2021-2025. Table 1 includes references to legal instruments.

Table 1. Legal Documents Related to Ethnic Minority People

2023	Circular 32/2023/TT-BYT dated December 31, 2023 Detailed regulations on a number of articles of the Law on Medical Examination and Treatment
2023	Decision 4524/QD-BYT dated December 14, 2023 on the publication of amended and supplemented administrative procedures in the field of health finance within the scope of management functions of the Ministry of Health specified in the Decree No. 75/2023/ND-CP dated October 19, 2023 of the Government amending and supplementing a number of articles of Decree No. 146/2018/ND-CP dated October 17, 2018 of the Government detailing and Guidance on measures to implement a number of articles of the Health Insurance Law
2023	Circular 23/2023/TT-BGDDT dated December 11, 2023 regulating the teaching and learning of Vietnamese for ethnic minority children before entering first grade
2023	Decree 75/2023/ND-CP amending and supplementing a number of articles of Decree No. 146/2018/ND-CP dated October 17, 2018 of the Government detailing and guiding measures to implement a number of Articles of the Health Insurance Law
2023	Circular 02/2023/TT-UBDT dated August 21, 2023 amending and supplementing a number of articles of Circular No. 02/2022/TT-UBDT dated June 30, 2022 of the Minister, Chairman of the Committee for Ethnic Minorities Guide the implementation of a number of projects under the National Target Program for socio-economic development in ethnic minority and mountainous areas in the period 2021 - 2030, phase I: from 2021 to 2025
2023	Circular 14/2023/TT-BYT dated June 30, 2023 Regulating the order and procedures for developing bidding packages for the procurement of goods and provision of services in the field of medical equipment at public health facilities
2023	Law on Bidding No. 22/2023/QH15 dated June 23, 2023 takes effect from January 1, 2024
2023	Decree 33/2023/ND-CP dated June 10, 2023 on commune-level cadres, civil servants and non-professional workers at commune level, in villages and residential groups
2023	Circular 12/2023/TT-BYT dated June 6, 2023 amending and supplementing a number of articles of Circular No. 10/2022/TT-BYT dated September 22, 2022 of the Minister of Health guiding implementation Content: Investment and support for the development of precious medicinal herb growing areas under the National Target Program for socio-economic development in ethnic minority and mountainous areas in the period 2021 - 2030, phase I: from 2021 to 2025
2023	Circular 03/2023/TT-BTTTT dated May 30, 2023 guiding the implementation of a number of information and communication contents in Subproject 1 and Subproject 2 under Project 10 of the National Target Program Socio-economic development in ethnic minority and mountainous areas in the period 2021 - 2030, phase I: From 2021 to 2025
2023	Decision 1300/QĐ-BYT dated March 09, 2023 Issuing a set of national criteria on commune health for the period up to 2030

2022	Circular 05/2022/TT-UBDT dated December 30, 2022 regulating the system of statistical indicators for ethnic affairs
2022	Circular 06/2022/TT-UBDT dated December 30, 2022 regulating the reporting regime for ethnic affairs
2022	Decree 95/2022/ND-CP dated November 15, 2022 of the Government stipulating the functions, tasks, powers and organizational structure of the Ministry of Health
2022	Circular 10/2022/TT-BYT dated September 22, 2022 guiding the implementation of investment and support for the development of precious medicinal herb growing areas under the National Target Program for socio-economic development in ethnic minority and mountainous areas in the period 2021 - 2030, phase I: from 2021 to 2025
2022	Circular 12/2022/TT-BNNPTNT dated September 20, 2022 guiding a number of forestry activities to implement the Sustainable Forestry Development Program and the National Target Program for Socio-Economic Development in ethnic minority and mountainous areas in the period 2021-2030, phase I: from 2021 to 2025
2022	Decree No. 66/2022/ND-CP dated September 20, 2022 of the Government on the functions, tasks, responsibilities and organizational structure of the Committee for Ethnic Minorities
2022	Circular 02/2022/TT-UBDT dated June 30, 2022 guiding the implementation of a number of projects under the National Target Program for socio-economic development in ethnic minority and mountainous areas in the period of 2021 - 2030, phase I: from 2021 to 2025
2022	Circular 01/2022/TT-UBDT dated May 26, 2022 regulating the process of monitoring and evaluating the implementation of the National Target Program for socio-economic development in ethnic minority and mountains areas in the period 2021-2030; Phase I: from 2021 to 2025
2022	Decree No. 27/2022/ND-CP dated April 19, 2022 of the Government stipulating the management mechanism and organization of implementation of National Target Programs
2022	Decree 28/2022/ND-CP dated April 26, 2022 on preferential credit policies to implement the National Target Program for socio-economic development in ethnic minority and mountains areas in the period from 2021 to 2030, phase 1: from 2021 to 2025
2022	Circular 15/2022/TT-BTC dated March 4, 2022 regulating the management and use of public funds to implement the National Target Program Socio-economic development in ethnic minority and mountains areas period 2021-2030, phase I: from 2021 to 2025
2022	Decision 263/QD-TTg dated February 22, 2022 Approving the National target program for building new rural areas for the period 2021 - 2025
2022	Decision No. 90/QD-TTg dated January 18, 2022 of the Prime Minister approving the National Target Program for sustainable poverty reduction for the period 2021 - 2025
2022	Decision No. 02/QD-TTg dated January 5, 2022 of the Prime Minister approving the National Strategy on nutrition for the period 2021-2030 and vision to 2045

2021	Decision No. 39/2021/QD-TTg dated December 30, 2021 of the Prime Minister stipulating principles, criteria, norms for allocation of central budget capital and proportion of counterpart capital of local budget for implementation of National Target Program for socio-economic development in ethnic minority and mountains areas for the period 2021 - 2030, phase I: From 2021 to 2025
2021	Circular 32/2021/TT-BGDDT dated November 22, 2021 guiding the implementation of a number of articles of Decree No. 82/2010/ND-CP dated July 15, 2010 of the Government regulating the teaching and learning of ethnic minority languages, writing in general education establishments and continuing education centers
2021	Decision 1719/QD-TTg dated October 14, 2021 Approving the National Target Program for socio-economic development in ethnic minority and mountains areas in the period 2021 - 2030, phase I: from 2021 to 2030. 2021 to 2025
2021	Decision 612/QD-UBDT dated September 16, 2021 approving the list of extremely difficult villages in ethnic minority and mountainous areas for the period 2021 - 2025
2021	Decision 861/QD-TTg dated June 4, 2021 Approving the list of communes in region III, region II, and region I in ethnic minority and mountainous areas in the period 2021 - 2025
2020	Decree 141/2020/ND-CP dated December 8, 2020 regulating the recruitment regime for ethnic minority students
2020	Decree 117/2020/ND-CP dated September 28, 2020, Stipulating administrative sanctions for violations in the health sector
2020	Decision 3532/QD-BYT dated August 12, 2020 of the Ministry of Health Regulations on the development and implementation of the Management Information System for Commune, Ward and Town Health Stations
2019	Circular 37/2019/TT-BYT dated December 30, 2019 Regulating the reporting regime of statistics in the health sector
2019	Decision No. 5349/QD-BYT dated November 12, 2019 of the Ministry of Health Approving the Plan for implementing electronic health records
2018	Decision No. 775/QD-TTg dated June 27, 2018 of the Prime Minister approving the Target Program on Education in mountainous areas, ethnic minority areas, and disadvantaged areas for the period 2016 – 2020.
2017	Circular 58/2017/TT-BTC dated 13 June 2017 guiding policies for financial support for organization, units using ethnic minority laborers in mountainous and especially-difficult areas.
2017	Circular 24/2017/TT-BYT dated May 15, 2017 of the Ministry of Health Regulating the process of receiving, providing medical care, and statistics and reporting for patients who are victims of domestic violence at medical examination and treatment facilities
2016	Decision No. 2085/QD-TTg dated October 31, 2016 of the Prime Minister approving the Special Policy to support socio-economic development in ethnic minority and mountainous areas in the period 2017 – 2020.

2016	Decree No. 109/2016/ND-CP dated 01 July 2016, on issuance of practice certificates to healthcare practitioners and operation licenses to healthcare facilities.
2016	Decision No. 822/QD-BYT dated 10 March 2016 of MOH approving the action plan on gender equity of health sector 2016 – 2020.
2015	Decree No. 75/2015/ND-CP dated 9 September 2015 regarding mechanisms and policies to protect and develop forests, associated with policies on rapid and sustainable poverty reduction and support for ethnic minorities in the period 2015 – 2020.
2015	Decree No. 39/2015/ND-CP dated April 27, 2015 of the Government stipulating support policies for women from poor households who are ethnic minorities when giving birth in accordance with population policy.
2014	Circular 37/2014/TT-BGDDT dated 02 December 2014 issuing the list of essential education equipment for teaching ethnic minority languages in the general education facilities.
2010	Decree No. 82/2010/ND-CP dated 20 July 2010of the Government on learning and teaching in ethnic minority languages at school.

B. Policy and Development Program for Ethnic Minority Groups

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

- National target program for socio-economic development in ethnic minority and mountainous areas for the period 2021 - 2030, phase I: from 2021 to 2025. This is a comprehensive support program for the Socio-economic development in ethnic minority and mountainous areas, including 10 projects related to all important socio-economic fields such as:
    - Project 1: Solve the shortage of residential land, housing, production land, and water for daily life.
    - Project 2: Planning, arranging and stabilizing population in necessary places.
    - Project 3: Developing sustainable agricultural and forestry production, promoting the potential and strengths of regions to produce goods along the value chain.
    - Project 4: Investing in essential infrastructure to serve production and life in ethnic minorities and mountainous areas and public service units in the ethnic sector.
    - Project 5: Developing education and training to improve the quality of human resources.
    - Project 6: Preserving and promoting the fine traditional cultural values of ethnic minorities associated with tourism development.
    - Project 7: Taking care of people's health, improving the physical condition and stature of ethnic minorities; Preventing child malnutrition.
    - Project 8: Implement gender equality and solve necessary issues for women and children.
    - Project 9: Investing in the development of ethnic minority groups with very few people and ethnic groups with many difficulties.

- Project 10: Communication, propaganda, and advocacy in ethnic minorities and mountainous areas.

- National target program for sustainable poverty reduction and social security for the period 2021-2025. This program includes the following 7 important projects:
    - Project 1: Support investment in socio-economic infrastructure development in poor districts and especially difficult communes in coastal and island areas.
    - Project 2: Diversifying livelihoods, developing poverty reduction models.
    - Project 3: Supporting production development and improving nutrition.
    - Project 4: Developing vocational education and sustainable employment.
    - Project 5: Housing support for poor and near-poor households in poor districts.
    - Project 6: Communication and information poverty reduction.
    - Project 7: Capacity building and program monitoring and evaluation.
- The national target program for building new rural areas for the period 2021-2025 includes 10 components, of which component 4 is about sustainable poverty reduction, especially in ethnic minorities, mountainous and rural areas. coastal and islands areas; Component number 5 is about improving the quality of education, health and health care for rural people; Component number 6 is about improving the quality of cultural life of rural people; preserve and promote traditional cultural values in a sustainable manner associated with rural tourism development; and component number 7 on improving environmental quality; building a bright - green - clean - beautiful and safe rural landscape; preserve and restore the traditional landscape of rural Vietnam;

12. In addition to specific programs/policies for ethnic minorities and areas with ethnic minorities, ethnic minorities also benefit from other development programs and policies for people in general, including ethnic minorities. In the field of health care, there is a number of important policy documents such as Decision 155/QD-TTg dated January 29, 2022 Approving the National Plan to prevent non-communicable diseases and mental health disorders period 2022-2025, Decision 4485/QD-BYT dated September 20, 2021 approving the Implementation Plan of Decision No. 1929/QD-TTg dated November 25, 2020 of the Prime Minister on approval of the community-based social support and rehabilitation program for mentally ill people, autistic children and people with mental disorders for the period 2021-2030, Decision 5658/QD-BYT dated December 11 In 2021, the Plan to implement the national strategy on gender equality in the health sector for the period 2021-2030, and many other policy documents.

In addition to the national target programs and policies mentioned above, ethnic minority groups also benefited from many programs and policies of the Government in the past, many of which are still in effect to this day. Noteworthy are the following programs/policies:

- The program is invested in accordance with Resolution 30a/2008/NQ-CP dated December 27, 2008 of the Government on support for seedlings, working tools and capital sources.
- National target program on rural sanitation and clean water supply.
- National target program on population and family planning.
- National target program for preventing dangerous social diseases, epidemics and HIV/AIDS.
- National target program on education and training.

- Policy on granting health insurance cards to ethnic minorities in the following groups: poor households, near-poor households, people living in areas with difficult socio-economic conditions, people living in areas with especially difficult socio-economic conditions according to the Health Insurance Law.
- Policy to support medical examination and treatment costs (including food, self-transportation, emergency transportation and home death) for the poor and ethnic minorities living in difficult socio-economic conditions who receive inpatient medical examination and treatment at district-level medical facilities according to the levels specified in Decision No. 14/2012/QD-TTg dated March 1, 2012 of the Prime Minister amending Decision 139/2002/QD- TTg for medical examination and treatment for the poor.
- Policy to support poor women who are ethnic minorities when having children according to population policy according to Decree No. 39/2015 / ND-CP dated April 27, 2015 of the Government.
- Policy on training human resources for disadvantaged and mountainous areas according to recruitment level in Decision No. 1544 / QD-TTg dated November 14, 2007 of the Prime Minister approving the Project on human resource training for health care cadres for difficult areas, the Northern and Central mountainous areas, the Mekong Delta and the Central Highlands, according to the nomination system.

C. ADB Safeguard Policy for ethnic minority people

13. The objectives of the indigenous peoples safeguard as set out in the ADB Safeguard Policy Statement (SPS) 2009 are to ensure that projects are designed and implemented in a way that fosters full respect for indigenous people identity, dignity, human rights, livelihood systems, and cultural uniqueness as they define them. This is so that indigenous peoples: i) receive culturally appropriate social and economic benefits; ii) do not suffer adverse impacts as a result of projects, and iii) can participate actively in projects that affect them. Per the ADB SPS, The term Indigenous Peoples is used in a generic sense to refer to a distinct, vulnerable, social and cultural group possessing the following characteristics in varying degrees: (i) self-identification as members of a distinct indigenous cultural group and recognition of this identity by others; (ii) collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories; (iii) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and (iv) a distinct language, often different from the official language of the country or region. In considering these characteristics, national legislation, customary law, and any international conventions to which the country is a party will be taken into account. A group that has lost collective attachment to geographically distinct habitats or ancestral territories in the project area because of forced severance remains eligible for coverage under this policy.

D. Principles of ADB SPS 2009 for indigenous peoples:

(i) Screen early on to determine (i) whether indigenous peoples are present in, or have collective attachment to, the project area; and (ii) whether project impacts on indigenous peoples are likely.

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

(iii) Undertake meaningful consultations with affected indigenous people communities and concerned indigenous people organizations to solicit their participation (i) in designing, implementing, and monitoring measures to avoid adverse impacts or, when avoidance is

not possible, to minimize, mitigate, or compensate for such effects; and (ii) in tailoring project benefits for affected Indigenous Peoples communities in a culturally appropriate manner.

(iv) Ascertain the consent of affected Indigenous Peoples communities to the following project activities: (i) commercial development of the cultural resources and knowledge of Indigenous Peoples; (ii) physical displacement from traditional or customary lands; and (iii) commercial development of natural resources within customary lands under use.

(v) Avoid, to the maximum extent possible, any restricted access to and physical displacement from protected areas and natural resources. Where avoidance is not possible, ensure that the affected indigenous peoples communities participate in the design, implementation, and monitoring and evaluation of management arrangements for such areas and natural resources and that their benefits are equitably shared.

(vi) Prepare an Indigenous Peoples Plan (IPP) that is based on the [assessment of social impacts] with the assistance of qualified and experienced experts and that draw on indigenous knowledge and participation by the affected Indigenous Peoples communities. The IPP includes a framework for continued consultation with the affected indigenous peoples communities during project implementation; specifies measures to ensure that indigenous peoples receive culturally appropriate benefits; identifies measures to avoid, minimize, mitigate, or compensate for any adverse project impacts; and includes culturally appropriate grievance procedures, monitoring and evaluation arrangements, and a budget and time - bound actions for implementing the planned measures.

(vii) Disclose a draft IPP, including documentation of the consultation process and the results of the [assessment of social impacts] in a timely manner, before project appraisal, in an accessible place and in a form and language(s) understandable to affected Indigenous Peoples communities and other stakeholders. The final IPP and its updates will also be disclosed to the affected Indigenous Peoples communities and other stakeholders.

(viii) Prepare an action plan for legal recognition of customary rights to lands and territories or ancestral domains when the project involves (i) activities that are contingent on establishing legally recognized rights to lands and territories that indigenous peoples have traditionally owned or customarily used or occupied, or (ii) involuntary acquisition of such lands.

(ix) Monitor implementation of the IPP using qualified and experienced experts; adopt a participatory monitoring approach, wherever possible; and assess whether the IPP's objective and desired outcome have been achieved, considering the baseline conditions and the results of IPP monitoring. Disclose monitoring reports.

III. SOCIAL IMPACT ASSESSMENT

A. Methodology

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

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

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

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

B. General Information of Ethnic Minority in Viet Nam

17. According to data from the General Statistics Office from the 2019 Population and Housing Census, the total population of 53 ethnic minorities in Vietnam is 14.1 million people (accounting for 14.6% of the country's population). The Northern Midlands and Mountains region has the highest number of ethnic minorities (7.03 million people), the Central Highlands (about 2 million people), the North Central region and the Southwest region have about 1.9 million people. The distribution of ethnic groups also has many differences between regions and provinces. Each ethnic group lives in different places and each village usually includes several ethnic groups. The distribution of ethnic groups has changed due to migration, especially in the Central, Central Highlands and Southern regions.

18. Ethnic distribution in the provinces is uneven, in which each region has specific ethnic groups. For example, in the Northern mountainous region there are ethnic groups belonging to patriarchy such as Hmong, Dao, Tay, Nung, Thai, etc. In the Central Highlands and Southwestern provinces there are ethnic groups belonging to matriarchy such as Ede, Ba Na, Gia Rai, Xo Dang, Mnong, Khmer, ... In some provinces, there are ethnic minorities that are among the specially protected groups in the ethnic policy of the Government of Vietnam. Some ethnic groups have very small populations such as O Du (441 people, Nghe An province); Si La ethnic group (592 people, Lai Chau province); Mang ethnic group (4,501, Lai Chau province); Brau and Ro Mam ethnic groups (Kon Tum province), …

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

[1] (i) Pre-Feasibility Report - FS, (ii) Health Yearbook 2015, (iii) Database of the Department of Personnel Organization, MOH, 2016 and report on 53 ethnic groups conducted by the Committee for Ethnic Minority Affairs in 2016.

20. In terms of household size, ethnic minority households range from 3.4 to 5.6 members. On average each household has 4.4 people. Ethnic minorities with less than 4 members per household include Brau, Hre, Ro Mam, Ngai, Gie Trieng, and Tay. Ethnic minorities with 5 or more members per household include Pa Dam, Ha Nhi, La Chi, H'Mong.

21. The proportion of ethnic minorities using health insurance cards for medical examination and treatment is not high. According to regulations, ethnic minorities enjoy preferential policies in medical examination and treatment, are granted free health insurance cards by the state and are entitled to 100% of medical examination and treatment costs under health insurance. Results of the 2019 Survey of 53 Ethnic Minorities showed that the proportion of ethnic minorities with health insurance cards was 93.5%[2]; This rate in urban areas is 86.6% and in rural areas is 94.4%; There is no significant difference between men and women in the rate of health insurance participation. However, the average rate of medical examination and treatment using health insurance cards among ethnic minorities is only 43.7% (lower than in 2015, 44.8%); The rate of ethnic minority women using health insurance for medical examination and treatment is 46.8% and the rate of ethnic minority men using health insurance cards for medical examination and treatment is 40.5%. There are 17/53 ethnic groups with the rate of medical examination and treatment using health insurance below 40%. The Lo Lo ethnic group has the lowest rate of medical examination and treatment using health insurance, only 28.8% (men 26.1% and women 31.6%)[3].

22. On June 4, 2021, the Prime Minister issued Decision 861/QD-TTg approving the list of communes in region III, region II, and region I in ethnic minority and mountainous areas in the period of 2021-2025; Next, the Committee for Ethnic Minorities issued Decision No. 612/QD-UBDT dated September 16, 2021 approving the list of extremely difficult villages in ethnic minority and mountainous areas for the period 2021-2025. These two decisions have caused many ethnic minority people and many ethnic minority families in localities that were previously classified as communes of Region II, Region III, and extremely difficult villages (those people who are eligible for state health insurance support) but are now not in this category, so they are no longer supported by the state as before. This causes the proportion of ethnic minorities with health insurance cards to decrease sharply. Faced with that situation, based on the proposals of localities, on October 19, 2023, the Government issued Decree No. 75/2023/ND-CP amending and supplementing a number of articles of Decree No. 146/2018 /ND-CP dated October 17, 2018 of the Government detailing and guiding measures to implement a number of articles of the Law on Health Insurance deciding to support at least 70% of health insurance premiums for people Ethnic minorities who are living in communes of Region II, Region III, and extremely difficult villages in ethnic minority and mountainous areas in the 2016-2020 period and these communes are no longer on the list of communes of Region II, Region III, extremely difficult villages in ethnic minority and mountainous areas in the period of 2021-2025; The support period is 36 months from November 1, 2023. The promulgation of Decree No. 75/2023/ND-CP has partly reduced difficulties for ethnic minorities in affected areas in access to health insurance.

23. Regarding the low rate of use of health insurance cards, some surveys conducted by CEMA in 2016 have indicated that the situation is due to: (i) use of alternative methods of treatment including self-treatment based on traditional methods (medicine folklore, superstitions). Ethnic minority community members only go to the commune or district health station when the disease has become too serious, while the capacity and conditions for treatment at the commune and district are weak; (ii) inadequate understanding of the benefits of health insurance cards; (iii) difficult economic conditions; (iv) the distance to medical facilities is very far: difficulties with transportation (limited vehicles, road conditions) combined with fears of travelling too far. The surveys by CEMA show that the distance

[2] The proportion of the population in general with health insurance in 2019 was only 89.1% (Health Statistics Yearbook 2019-2020).

[3] Committee for Ethnic Minorities (2021). Data on women and men of ethnic groups in Vietnam in the period 2015-2019. Hanoi, UN Women.

from home to medical facilities is relatively far away, especially for some ethnic groups such as Mu, Cong, Lo Lo, La Hu. On average, homes are 3.8 km from clinics and 16.7 km from the hospital, with some ethnic groups living further away from hospitals such as: O Du - 72km, Ro Mam - 60.1km, Ha Nhi - 53.8km, Chut - 48km. In addition, 7 there are about 24 ethnic groups where the distance from home to hospital ranges from 20 km to 40 km.

24. The 2023 Health Work Summary Report of the Kon Tum Department of Health also shows that although the number of medical examinations and treatment in the first 11 months of 2023 increased by 18% over the same period last year, the bed capacity usage in many hospitals and medical centers are quite low compared to the assigned plan: 53.4% at Ngoc Hoi regional general hospital; 33% in Traditional Medicine and Rehabilitation Hospital; 47.7% at Dak Glei District Medical Center; 64.7% at Dak Ha District Medical Center; 47.9% at Dak To District Medical Center, 28.4% at Ia H'Drai District Medical Center; 18.6% at Kon Plong District Medical Center; 27.1% at Kon Ray District Medical Center; 58.7% at Sa Thay District Medical Center, and 31.6% at Tu Mo Rong District Medical Center. According to the Kon Tum Department of Health, there are 3 main causes of this situation, including: (1) some communes meet new rural standards, so many people are not granted free health insurance cards and are not provided with medical examination and treatment by the Fund for the poor as before, forcing them to pay for all travel and medical examination and treatment expenses themselves, reducing the attraction of people to the province's medical facilities; (2) people with good economic conditions tend to go for medical examination and treatment at higher levels, not trusting the quality of services at the district and commune levels, where there are many limitations in facilities and lack of experienced staff; and (3) implementing medical examination and treatment using traditional medicine methods and rehabilitation at commune health stations faces many difficulties due to insufficient human resources and equipment.

25. In Soc Trang, according to the 2022 Statistical Yearbook of Soc Trang province, in that year there were 1,123,551 people out of a total population of 1,197,823 people with health insurance (accounting for 98%), and there were 2,403,243 person-times of using medical services covered by health insurance. Thus, on average, each person with health insurance will receive 2.1 times of health insurance support.

Table 2. Distribution of ethnic minority people by provinces

	Tay	Thai	Muong	Nung	Mong	Dao	San Chay	Kho mu	San Diu	EM with small population
Tuyen Quang	205624	798	1579	16902	21310	105359	70636	34	15440	1258 (Pa Then)
Bac Giang	59008	2252	2234	95806	498	12379	30283	51	33846	
Phu Tho	5229	1830	218404	1375	1267	15702	4278	62	329	
Dien Bien	1683	213714	1292	908	228279	6659	182	19785	42	Khang (5224) Ha Nhi (4555) Phu La (247) Cong (1145) Sila (243)
Lai Chau	1793	142898	1707	334	110323	58849	146	7778	80	Ha Nhi (15.952) La Hu (12002) Lu (6693)

	Tay	Thai	Muong	Nung	Mong	Dao	San Chay	Kho mu	San Diu	EM with small population
										Mang (4501) Cong (1513) Si la (592)
Nghe An	1068	338559	1247	511	33957	120	31	43139	38	O du (411)
Ha Tinh	258	801	776	99	9	43	15	9	6	
Quang Nam	697	291	815	425	22	73	Xo dang	Co tu	Gie Trieng	Co
							47268	55091	23222	6479
Phu Yên	2349	298	231	2283	192	1031	E de	Ba Na	Cham	Hre
							25225	4680	22813	164
Binh Thuan	5978	230	788	2529	2	47	Hoa	Co ho	Cham	Raglai
							9917	13531	39557	17382
Kon Tum	3552	8905	8114	2830	14	545	Gia Rai	Ba Na	Xo Dang	Gie Trieng
							25883	68799	133117	39515
Gia Lai	11412	5440	8283	12420	3386	4825	459738	189367	964	70
Dak Nong	24751	11250	5446	31063	34976	19786	E De	Mnong	Ma	Hoa
							6726	50718	8087	5779
Binh Phuoc	24862	1536	3286	23917	823	3104	Khmer	Mnong	Xtieng	Hoa
							19315	10879	96649	8049
Soc Trang	54	48	98	49	3	16	362029	0	0	62389
Ca Mau	148	119	198	59	11	11	26110	5	7	6343

Source: General Statistical Office, Population and Housing Census 1 April 2019.

C. Ethnic Minorities in the Program provinces

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

Table 3. Information of Ethnic Minority People in Selected Provinces

No	Province	Population	EM	% EM	% poor EM	% near poor EM
1	Tuyen Quang	784,811	445,504	57%	24.3%	17.4%
2	Bac Giang	1,803,950	252,273	14%	18.2%	13.3%
3	Phu Thọ	1,463,726	249,564	17%	14.7%	13.2%
4	Đien Bien	598,856	494,795	83%	46.9%	11.6%
5	Lai Chau	460,196	386,963	84%	31.5%	13.8%
6	Nghe An	3,327,791	491,295	15%	29.2%	26.1%
7	Ha Tinh	1,288,866	3,112	0.24%	10.2%	4.4%
8	Quang Nam	1,495,812	140,590	9.4%	47.3%	5.0%
9	Phu Yen	872,964	60,134	6.9%	38.4%	20.1%
10	Binh Thuan	1,230,808	97,006	7.9%	12.7%	16.0%
11	Kon Tum	540,438	296,866	55%	31.0%	11.4%
12	Gia Lai	1,513,847	699,791	46%	21.2%	17.9%
13	Dak Nong	622,186	202,360	33%	28.6%	9.9%
14	Binh Phuoc	994,679	195,659	20%	9.6%	6.3%
15	Soc Trang	1,199,653	424,846	35%	13.6%	15.5%
16	Ca Mau	1,194,476	33,624	2.8%	16.7%	5.9%
	Total	**19,393,059**	**4,474,382**	**23%**		
	Whole country	**96,575,342**	**14,100,000**	**14.6%**	**22.3%**	**13.2%**

Source: General Statistics Office, Population and Housing Census, April 1, 2019; Committee for Ethnic Minorities and General Statistics Office (2020), Results of the survey collecting information on the socio-economic situation of 53 ethnic minorities in 2019. Hanoi, Statistics Publishing House.

Table 4. Population, % EM and CHSs in 6 targeted provinces and 12 targeted districts in 2023

	Population	% EM	CHSs	CHSs with doctor
Phu Tho	1551033	27	225	201
Doan Hung	127208	5.2	22	22
Yen Lap	100005	78.1	17	2
Tuyen Quang				
Son Duong	210469	46.9	28	28
Yen Son	160880	57.1	27	24
Quang Nam				
Hiep Duc	45760	11.3	11	3
Que Son				
Gia Lai	1613895	45.8	220	179
Ia Pa	60508	78.7	9	7
Krong Pa	93345	72.2	14	12
Dak Nong	197011	31.3	19	19
Dak R'Lap	94146	12.1	8	8
Cu Jut	102865	48.8	11	11
Soc Trang	1296995		109	95
Long Phu	93435	50.6	11	11
Cu Lao Dung	57713	8	8	7

Source: PPMUs

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

a) Health Human Resource in Kon Tum Province

27. In Kon Tum province, by the end of 2023, there are 2,739 civil servants, public employees and workers working in the health sector, of which 266 have postgraduate degrees in medicine and pharmacy (9.7%), 939 people with university degrees in medicine and pharmacy (34.3%), 888 people with college degrees in medicine and pharmacy (32.4%), 399 people with intermediate degrees in medicine and pharmacy (14.6%), and 247 people with primary health and/or pharmacy education and other staff (9%)[4]. In 2023, Kon Tum Department of Health sent 10 doctors working in extremely difficult areas and border areas to participate in specialty training I at Hue University of Medicine and Pharmacy according to Project 585 of the Ministry of Health and organized recruitment of 93 health sector specialists. The number of doctors per 10,000 people is 10.5 doctors (the national average is 12.5 doctors per 10,000 people[5]). 100% of communes, wards and towns have doctors. About half of the medical staff and doctors work in provincial hospitals (1,244 employees including 253 doctors). The remainder of the health workforce works at district and commune levels.

[4] Department of Health of Kon Tum province (2023). Report No. 4622/BC-SYT dated December 17, 2023 Summary of medical work in 2023; Main tasks and solutions in 2024. Kon Tum.

5 Ministry of Health (2024). Report No. 11/BC-BYT dated January 4, 2024 Summary of health work in 2023 and tasks and solutions in 2024. Hanoi.

28. Ethnic minority health workers account for 20% of the total workforce at district and commune levels. This scale is far below the 53% of ethnic minorities among the total provincial population. However, the representation of ethnic minorities among medical doctors is quite impressive, with 54% of medical doctors being ethnic minority people for the total district and commune health care levels—the scale that is compatible with the share of ethnic minority in the general population. At district level, ethnic minority doctors account for 34% (54 out of 161 doctors), but at the commune health stations ethnic minority doctors account for as high as 90% total number of medical doctors at commune level (84 out of 93 medical doctors working in CHSs). The high scale of ethnic minority medical doctors at commune level is perhaps the result of the government policy giving priority and favorable conditions for recruitment of EM from difficult areas for medical training (they do not need to take university entry examination) according to Decision 1544/QD-TTg by the Prime Minister on 14 November 2007. For other qualifications, the scales of ethnic minority people are far below the share of EM among general population. Please see the table below for more information on EM health workers in Kon Tum province.

b) **Health Human Resource in Soc Trang Province**

29. According to the 2022 Soc Trang Province Health Statistics Yearbook, the total number of medical human resources in Soc Trang province is 4,017 people, including 1,088 doctors, 895 physicians, 1,399 nurses, 372 midwives, and 263 technicians; Pharmaceutical workforce has 548 people, including 251 pharmacists and 297 college/intermediate pharmacists. Among the health sector workforce in ethnic minority communes, doctors account for 10.5%, doctor assistants/primary nurses/nurses account for 54.1%, midwives account for 14.6%, pharmacists account for 15%, primary pharmacists account for 0.7% and 5% are other employees[6]. The proportion of ethnic minorities in the health workforce is only 21.8% (21.7% are permanent employees and 0.1% are working on a contract basis), much lower than proportion of ethnic minorities in the general population.

30. According to the 2022 Soc Trang Provincial Statistical Yearbook, 93.5% of communes/wards/towns have doctors, 100% have midwives or obstetricians and pediatricians. The number of medical staff at commune health stations ranges from 8 to 12 people/health station depending on the commune's population size: Target of 8 medical staff for health stations for communes with less than 10 thousand people; 9 medical staff for health stations for communes with 10 to 12 thousand inhabitants; 10 medical officers for communes with 12-14 thousand inhabitants; 11 medical officers for communes with 14-16 thousand inhabitants; and 12 medical officers for communes with more than 16 thousand inhabitants. In 2020, Soc Trang has 97.3% of villages/hamlets with active medical staff (Health Statistics Yearbook 2019-2020).

[6] Committee for Ethnic Minorities and General Statistics Office (2020). Results of the survey collecting information on the socio-economic situation of 53 ethnic minorities in 2019. Hanoi, Statistics Publishing House.

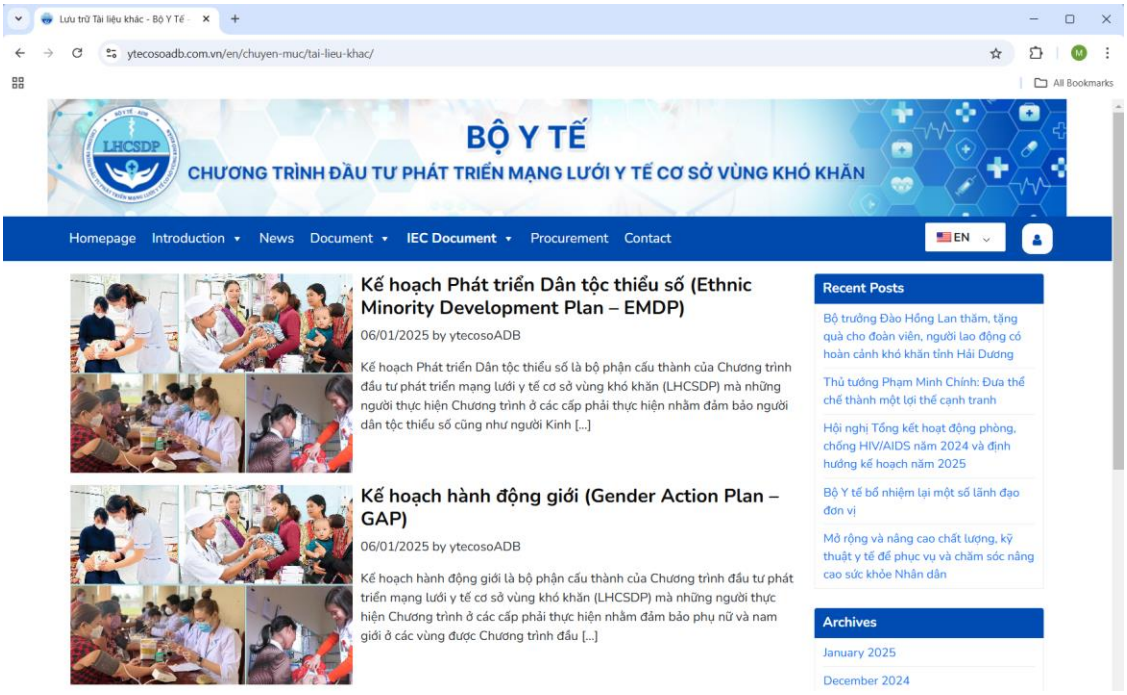
E. Information Disclosure and Meaningful Consultation

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

32. During 2023, a baseline survey had been carried out from 1st April to 30th August, 2023. The survey sample was taken from 48 communes in 12 targeted districts in the 6 targeted provinces of Tuyen Quang, Phu Tho, Quang Nam, Gia Lai, Dak Nong, and Soc Trang. The survey team conducted 163 in-depth interviews with officers/staff of CPMU, PPMUs, DOHs, DHCs and CHSs, and 13 focus group discussions (FGDs), including 12 FGDs of DHSs staffs. The team used 77 data collection forms, 48 checklists, 20 IDI guidelines and 2 FGD guidelines to collect all necessary data mentioned in DMF, GAP, and EMDP, including data on reproductive health care for women and health care for ethnic minority people (see Midterm survey report for more details).

33. In June and July 2024 a monitoring fieldwork had been carried out by a team consisted of the newly recruited Gender and EM consultant, the Training consultant and the M&E consultant to 6 target provinces. The monitoring team had conducted 6 FGDs involving 29 PPMU officers/staff in the 6 provinces, 12 FGDs with 46 staffs of DOHs, and 24 FGDs involving 141 health workers from 24 visited CHSs in the 6 provinces, including 95 females and 32 ethnic minority people. During these FGDs consultations the Gender and EM consultant had provided them the updated GAP and EMDP and discussed with the participants about GAP and EMDP. The results of these discussions are used to update GAP monitoring table (see GAP monitoring table updated to 30 September 2024).

34. In Q4 2024 updated GAP and EMDP (both English and Vietnamese versions) had been posted on the website of the Program: https://ytecosoadb.com.vn/chuyen-muc/tai-lieu-khac/



35. An individual IEC consultant has been recruited in 05 August 2024. This consultant is responsible for managing and supervising the Program's IEC activities. The IEC consultant proposed to cancel the marketing package because not enough time and proposed alternative plan to replace

this package to get achieve relevant program targets (T2, T3, T4, T5, A6). On 26 September 2024, the alternative plan was submitted to ADB for no objection. On 02 October 2024, ADB replied to CPMU's proposal that "CPMU needs to prepare a procurement plan (version 8) for ADB's approval. In the updated procurement plan, please indicate revised amount (should be lower than $250,000) and change CQBS to RFQ. So CPMU submitted the revised TOR for ADB no objection enclosing updated PP. On 20 December 2024, CPMU received NOL of ADB. Therefore, CPMU expects to award this contract in Q1 2025. IEC firm is expected to be recruited in Q1 2025. The IEC team will design the IEC materials in Q2 2025. So all communes in target districts will gain knowledge from the IEC materials on the new services models of LHC in Q3 2025. Hence, it is not enough time, so there will be only IEC material development and TOT for district health center staff. All IEC materials used for health prevention and education activities at local health care level in the target districts will be gender and culturally (EM) sensitive.

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

a) Characteristics of the Xo Dang and Khmer Ethnic Groups

Xo Dang Ethnic Groups

37. The Xo Dang ethnic group is concentrated in Kon Tum province, with some members also residing in the mountainous regions of Quang Ngai and Quang Nam. The Xo Dang people have close relationships with the Gie Trieng, Co, Here and Ba Na people. According to the 2019 Population and Housing Census, the Xo Dang population in Vietnam has 212,277 people and is present in 41/63 provinces and cities. The Xo Dang people live mainly in the North Central and Central Coast (67,385 people), and in the Central Highlands (143,991 people). In Kon Tum province, the Xe Dang population accounts for nearly a quarter of the entire province's population.

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

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

40. Since the communication campaigns have been implemented quite well for Xo Dang ethnic minority people, Xo Dang people have also had changes in health perception, and Xo Dang people always go to the CHS instead of asking the shaman. Besides, village health staffs periodically inform and remind households to vaccinate at the station, therefore, most of Xo Dang people have their children vaccinated.

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

Khmer Ethnic Groups

42. The Khmer people in Vietnam (also known as Khmer Krom, Khmer-Crom and Khmer-ha) are an ethnic group living mainly in the Mekong Delta, such as Soc Trang, Tra Vinh, Bac Lieu, Ca Mau, Kien Giang, An Giang, Hau Giang, Can Tho, Vinh Long, Dong Thap, Long An, and Tien Giang.

43. According to the 2019 Population and Housing Census, the Khmer population in Vietnam has 1,319,652 people and is present in many provinces in the South, mainly in the Mekong Delta (1,141,241 people), South-East region (172,477 people), Central Highlands (23,058 people), and North Central and Central Coast (16,616 people). The Khmer population in Soc Trang province accounts for about 30% of the province's population.

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

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

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

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

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

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

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

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

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

50. A communication strategy will be developed and implemented during project implementation based on the specific characteristics of ethnic minorities in the project area. The communication strategy is built on local communication experience and on the analysis of factors that limit access to basic medical care services. This strategy includes integrating information dissemination activities with village meetings; develop simple, easy-to-understand communication materials in ethnic minority

languages; and the participation of village heads, village elders or reputable people in the ethnic minority community. Special:

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

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

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

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

Table 5. Status of Health Human Resource in 12 target districts in 6 target provinces in 2024

No	Province	CHS staff	CHS female staff	% female	EM staff	% EM staff	CHS doctors	CHS female doctors	% female doctors
1	Tuyen Quang	719	515	71.6	360	50.1	57	26	45.6
2	Phu Tho	238	149	62.6	68	28.6	44	13	29.5
3	Quang Nam	139	116	83.5	83	60.0	5	3	60.0
4	Gia Lai	143	89	62.2	61	42.7	20	9	45.0
5	Dak Nong	560	432	77.0	278	49.6	20	12	60.0
6	Soc Trang	126	63	50.0	21	16.7	19	5	26.3
	Whole 6 provinces	**1,925**	**1,364**	**68.5**	**871**	**45.2**	**165**	**68**	**41.2**

Source: Reports by PPMUs, August 2024.

Table 6. Project Outputs and Proposed Measures to Enhance positive Impacts

No negative effect expected; therefore, there is no need to have a column on anticipated negative effects.

Project outputs	Anticipated Positive Effect	Beneficiaries	Proposed Measures to Enhance positive impact (by output and sub – output)	Performance Indicators
Output 1: Public investment management for local health care strengthened				
Improve the capacity of the grassroots health system. **Activities:** (i) Supplement equipment, including medical equipment, communications, IT, epidemic prevention, mobile medical examination and treatment, monitoring equipment, rapid warning system... for 2-function district health centers, including targeted 12 district health centers where there are key commune health stations invested in new construction, upgrading and repairing facilities from the loans of Component I, ensuring that immediately after the investment, they will have the conditions and capacity to deploy the family health care model in the local area; ensuring no overlap with the	Ethnic minority people have better access to health services, Reduce travel costs and other related expenses when ethnic minorities access health centers.	Health workers, especially ethnic health workers in the 12 target districts will benefit from improved equipment and facilities. Local people, including ethnic minority people will benefit from better quality of services of the local health care system.	CPMU to hire an IEC firm in Q1 2025 to develop IEC strategy and materials and provide TOT to use the materials to staff from PPMU and 12 target districts in the 6 target provinces Awareness-raising strategy and communication materials are gender- and ethnic minority-sensitive TOT organized for staff of PPMUs and 12 districts in the 6 target provinces in Q3 2025. PPMUs to carry out communication campaigns to disseminate project activities	Gender and ethnicity are intergrated into all communication materials (Q3/2025). EMDP is clearly placed in the homepage of the Project website (Q4 2024) Proportion of ethnic minority staff participating in TOT in Q3 2025 for using communication materials no less than their representation in the work force at the local health care system (see Table 6 for reference). DHCs and CHSs in 12 districts in the 6 target provinces will carry out the project communication strategy and activities in their routine visits to ethnic minority villages starting from Q4 2025.

Project outputs	Anticipated Positive Effect	Beneficiaries	Proposed Measures to Enhance positive impact (by output and sub – output)	Performance Indicators
investment from ADB's "Health Security in the Greater Mekong Subregion" Project, meeting the needs of people in the region. (ii) Implement basic medical service package for primary health care (according to the Vietnam Health Program issued by the Ministry of Health). (iii) Equip the vehicle project management units to monitor project implementation.			Disseminate project activities and basic health services through village meetings, or through village elders, village heads, or reputable people in the village	
Output 2: Service models of local heath care network improved				
Reforming the operation mechanism of the grassroots health system, improving the quality of health services at the commune health stations **Activities:** (i) Providing additional health equipment for commune health stations in 12 districts of 6 pilot provinces to meet the requirements for the activities of the commune health stations in disease prevention, health care,	Improved access to basic health services for ethnic minority people Enhanced capacity of ethnic minority health staff	Health workers, especially ethnic health workers in the 12 target districts will benefit from improved equipment and facilities. Local people, including ethnic minority people will benefit from better quality of services of the local health care system.	Medical records contain information on ethnic group. Through village meetings, or through the village patriarch, village chief or a reputable person, to disseminate information on project activities and enhanced health services at the commune health stations: CHSs work closely with village health workers to	Most of electronic medical records, including health insurance, HIS, and other health records, such as tuberculosis, HIV, non-communicable diseases, communicable diseases, population and reproductive health care programs, accidents and injuries, etc. contain information on ethnic minority as mentioned in Circular 37/2019/TT-BYT dated 30 December 2019. Increase the proportion of ethnic minority users of local

Project outputs	Anticipated Positive Effect	Beneficiaries	Proposed Measures to Enhance positive impact (by output and sub – output)	Performance Indicators
reproductive health care, health care for the elderly at the local. (ii) Plan for development of family medicine model; (iii) Guidance on replicating pilot models to innovate grassroots health service delivery activities and financial mechanisms in primary health care. In it, some activities will be performed such as: - Implement models to improve the quality of grassroots healthcare operating according to family medicine principles at commune health stations in 6 provinces representing the North, Central, and South (including screening and care activities, primary health care); - Awareness communications to enhance health information collection and management and evidence-based planning; - Deploy a pilot model to innovate grassroots medical activities			disseminate information of project activities. Ensure fair participation of ethnic minority staff in training/capacity building activities. In 2022 CPMU organized 5 3-day training courses on family medicine principles for 198 medical staff in Tuyen Quang, Phu Tho, Quang Nam, Soc Trang and Gia Lai (Dak Nong did not participate because it was trained at the HPET project), of which 65.6% are female and 31.3% are ethnic minorities. In 2023, train 331 people (50.5% female and 31% ethnic minorities) on epidemic prevention, disease and biosafety. Training on prevention of high blood pressure and diabetes in the community for 207 students, including 113 female students (accounting	health care services among all users by 10% by the end of the project. Proportion of ethnic minority health workers participating in capacity training no less than their representation in the work force at the local health care system (see Table 6 for reference).

Project outputs	Anticipated Positive Effect	Beneficiaries	Proposed Measures to Enhance positive impact (by output and sub – output)	Performance Indicators
according to family medicine principles ; - Carry out behavior change communication activities, increase awareness about prevention, care and health promotion. (v) Training on family medicine principles for medical staff at CHSs and hospitals in the project area.			for 55%), 52 ethnic minority students (accounting for 25%).	
Technical assistance for the Ministry of Health on developing and promulgating the policies for the development of the Grassroots health system in the new situation **Activities:** (i) Organize a workshop to develop and promulgate policy documents on reforming the financial mechanism and operating mechanism of grassroots healthcare as follows: Integrating the family doctor clinic model and payment plans	Improvement of policy making in MOH	Policy makers in MOH Health care workforce will benefit indirectly through better policies and guidelines.	N/A	(i) Policy workshop organized; (ii) Instructions on technical and professional processes, improve service quality, management regulations, and quality assurance issued. (iii) Policy advocacy activities are carried out.

Project outputs	Anticipated Positive Effect	Beneficiaries	Proposed Measures to Enhance positive impact (by output and sub – output)	Performance Indicators
for insurance services and health management records. (ii) Issue instructions on technical and professional processes, improve service quality, management regulations, and quality assurance. (iii) Support for policy advocacy activities: mobilize the Party, National Assembly, and Government to support new mechanisms and policies to improve the effectiveness of grassroots health activities.				
Output 3: Local health care workforce development and management strengthened				
Improving the capacity of the health staff **Activities:** (i) Training on family medicine principles applied to district-level medical staff to implement the family medicine model, applying available training frameworks and materials approved by the	Increased capacity of EM staff, increased health care services in remote areas where EM live far from the CHSs	Ethnic minority health workers will benefit from training and/or other capacity building activities.	Fair participation of EM health workers in all capacity development activities – proportions of ethnic minority health workers participating in trainings/other capacity development activities will be no less than representation in the local health care workforce	Proportion of ethnic minority health workers participating in capacity training no less than their representation in the work force at the local health care system (see Table 6 for reference).

Project outputs	Anticipated Positive Effect	Beneficiaries	Proposed Measures to Enhance positive impact (by output and sub – output)	Performance Indicators
Ministry of Health (such as the HPET Project). (ii) Training on epidemic prevention, infectious disease prevention and biosafety standards. (iii) Training on management of non-communicable diseases in the community, focusing on intervention contents of the Program. (iv) Training classes on grassroots healthcare network management skills (communication skills, TTB management, financial management, project management,...). (v) Organize workshops to deploy, guide, evaluate and summarize the model of CHCs operating according to family medicine principles. (vi) Support the Ministry of Health and provinces to visit and study abroad about primary				

Project outputs	Anticipated Positive Effect	Beneficiaries	Proposed Measures to Enhance positive impact (by output and sub – output)	Performance Indicators
health care models and health screening for people.				
Technical support and project management **Activities :** (i) Establish and operate the activities of the Central Program Management Unit and the Provincial Project Management Units. (ii) Recruit consulting companies and experts to support project implementation. (iii) Monitor and annually evaluate project activities and service quality of CHS. (iv) Project audit activities	Ensure the participation of ethnic minority communities and receive benefits from the project	Ensure management activities are sensitive with interest of women and ethnic minority people	Arrange staff with knowledge of ethnic minorities and issues related to ethnic minorities. Encourage ethnic minorities to participate in project support activities	A new gender and EM consultant had been recruited in December 2023 to support CPMU to implement EMDP.

V. GRIEVANCE REDRESS MECHANISM

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

55. The complaint resolution mechanism will be established based on Law on Complaints No. 02/2011/QH13 and Decree No. 124/2020/ND-CP guiding the implementation of the Law on Complaints as follows :

a. **Complain to the Commune People's Committee (CPC)** - An affected ethnic minority person can complain to any member of the Commune People's Committee, through the Chairman or directly to the Commune People's Committee, in writing or orally. In case the complainant comes to complain directly, the person receiving the complaint instructs the complainant to write a complaint or the person receiving the complaint records the complaint in writing according to Form No. 01 issued with Decree 124. /2020/ND-CP. The time limit for resolving the first complaint is no more than 30 days from the date of acceptance ; For complicated cases, the resolution time may be longer but must not exceed 45 days from the date of acceptance. In remote and remote areas with difficult access, the time limit for resolving complaints shall not exceed 45 days from the date of acceptance ; For complicated cases, the resolution time limit may be longer but must not exceed 60 days from the date of acceptance (Article 28, Law on Complaints 2011). During the process of resolving the complaint, the person resolving the complaint must hold a dialogue. The person in charge of the dialogue must conduct a direct dialogue with the complainant, the complained person and people with related rights and interests. The dialogue is recorded in minutes, clearly stating the time, location, and participants (specify attendees and absent persons ; in case the complainant does not participate in the dialogue, clearly state whether or not there is a reason), content, opinions of participants, agreed contents, issues with different opinions and signed by the parties. The minutes are made in at least three copies, each party keeps one copy. The minutes of dialogue are made according to Form No. 14 issued with Decree 124/2020/ND-CP. The Commune People's Committee will meet with households with complaints to resolve them and is responsible for documenting and retaining all complaints they handle.

b. **Complain for the second time to the District/Town People's Committee (DPC)** - Within 30 days from the date of expiration of the time limit for resolving complaints specified in Article 28 of the Law on Complaints, if the first complaint is not resolved or from the date of receiving the decision to resolve the first complaint, if you do not agree with the complaint, you have the right to complain to the person with authority to resolve the complaint a second time; For remote areas with difficulty in traveling, the time limit may be longer but must not exceed 45 days (Article 33 of the Law on Complaints 2011 and Article 4 of Decree 124/2020/ND-CP). Households with complaints may bring the case, in writing or orally, to any member of the District People's Committee. The time limit for resolving a second complaint is no more than 45 days from the date of acceptance ; For complicated

cases, the time limit for resolving complaints may be longer but must not exceed 60 days from the date of acceptance. In remote areas with difficult access, the time limit for resolving complaints shall not exceed 60 days from the date of acceptance ; For complicated cases, the time limit for resolving complaints may be longer, but must not exceed 70 days from the date of acceptance (Article 37 of the Law on Complaints 2011). During the process of resolving the second complaint, the person resolving the complaint must hold a dialogue. The person in charge of the dialogue must conduct a direct dialogue with the complainant, the complained person and people with related rights and interests. The dialogue is recorded in minutes, clearly stating the time, location, and participants (specify attendees and absent persons ; in case the complainant does not participate in the dialogue, clearly state whether or not there is a reason), content, opinions of participants, agreed contents, issues with different opinions and signed by the parties. The minutes are made in at least three copies, each party keeps one copy. The minutes of dialogue are made according to Form No. 14 issued with Decree 124/2020/ND-CP. The District People's Committee is responsible for resolving complaints and documenting and retaining all processed complaints. The District People's Committee must ensure that their decision is notified to the complainant in accordance with the law.

c. Second complaint to the Provincial People's Committee (PPC) – If the authority to resolve a second-time complaint is the Provincial People's Committee, then within 30 days from the expiration of the time limit for resolving complaints specified in Article 28 of the Law on Complaints, the first-time complaint shall not be resolved or from the date of receipt of the decision to resolve the first complaint, if the complainant does not agree, he or she has the right to complain to the person competent to resolve the second complaint; For remote areas with difficulty in traveling, the time limit may be longer but must not exceed 45 days (Article 33 of the Law on Complaints 2011 and Article 4 of Decree 124/2020/ND-CP). During the process of resolving the second complaint, the person resolving the complaint must hold a dialogue. The person in charge of the dialogue must conduct a direct dialogue with the complainant, the complained person and people with related rights and interests. The dialogue is recorded in minutes, clearly stating the time, location, and participants (specify attendees and absent persons; in case the complainant does not participate in the dialogue, clearly state whether or not there is a reason), content, opinions of participants, agreed contents, issues with different opinions and signed by the parties. The minutes are made in at least three copies, each party keeps one copy. The minutes of dialogue are made according to Form No. 14 issued with Decree 124/2020/ND-CP. The Provincial People's Committee is responsible for resolving and documenting and maintaining records of all complaints they handle. The Provincial People's Committee must ensure that their decision is notified to the complainant in accordance with the law.

d. **Administrative lawsuit at the local People Court** - After the time limit for resolving complaints specified in Article 28 of this Law expires, if the second-time complaint is not resolved or the complainant does not agree with the decision to resolve the second-time complaint, he or she has the right to initiate an administrative lawsuit at the local court. Court according to the provisions of the Administrative Procedures Law (Article 33 of the Law on Complaints 2011).

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

VI. IMPLEMENTATION ARRANGEMENTS

A. Executing agency (EA)

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

B. Central Program Management Unit (CPMU)

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

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

59. Provincial People's Committees had set up provincial project management Unit (PPMU) in 6 provinces with ADB's non-refundable aid. The PPMU is responsible for project implementation, monitoring, and periodic reporting on project progress.

D. Project implementation support consultants (PIC)

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

VII. MONITORING AND REPORTING

A. Reporting

61. Implementing units (PPMUs) is responsible for internal monitoring of implementation of the Ethnic Minorities Development Plan. Semi-annual monitoring reports will be prepared and submitted to the Central Management Unit/Ministry of Health until project completion. Gender and ethnic minority consultants are responsible for synthesizing and developing monitoring reports every 6 months with the support of the Central Management Unit/Ministry of Health.

62. Monitoring reports will summarize progress in implementing the Ethnic Minorities Development Plan, compared with monitoring indicators; and when required, recommend changes to ensure that the objectives of the EM development plan are met. The Central Program Management Unit/Ministry of Health, after approving the monitoring report every 6 months, will send the monitoring report to ADB for publication on the ADB website.

B. Monitoring Indicators

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

Table 7. Monitoring indicators in EMDP

Monitoring and Evaluation Issues	Basic indicators
1. The progress of EMDP implementation	- The plan has been shared with the community: The updated EMDP and GAP (in Vietnamese language) had been shared with PPMUs in 6 targeted provinces and 12 targeted district health centers in these 6 provinces during the fieldwork in June and July 2024. - The plan is suitable with the implementation conditions of ethnic minority people and the EM people have participated during EMDP implementation. - The plan is relevant to the progress of other project activities. - Adequate human resources available to implement the plan. Each PPMU assigned a member to serve as a focal person on implementation of GAP and EMDP. - Sufficient funding for implementing the plan.
2. Hire a communication consultant	- The individual IEC consultant has been recruited in 05 August 2024. This consultant is responsible for managing and supervising the Program's IEC activities..
3. Implementing community consultations and local people's participation	- According to the original plan, an IEC consulting firm will be recruited by CPMU in Q4 2024 to Implement gender-sensitive marketing and awareness-raising activities to ensure women and men of all ages and ethnic groups in the communities of the target districts know about and understand the new service models of the LHC system. However, the IEC consultant proposed to cancel this package because there is not enough time to implement the original

Monitoring and Evaluation Issues	Basic indicators
	plan and proposed alternative plan to replace this package to get achieved relevant program targets (T2, T3, T4, T5, A6). The IEC consultant proposed to cancel the marketing package because not enough time and proposed alternative plan to replace this package to get achieve relevant program targets (T2, T3, T4, T5, A6). On 26 September 2024, the alternative plan was submitted to ADB for no objection. On 02 October 2024, ADB replied to CPMU's proposal that "CPMU needs to prepare a procurement plan (version 8) for ADB's approval. In the updated procurement plan, please indicate revised amount (should be lower than $250,000) and change CQBS to RFQ. So CPMU submitted the revised TOR for ADB no objection enclosing updated PP. On 20 December 2024, CPMU received NOL of ADB. Therefore, CPMU expects to award this contract in Q1 2025. IEC firm is expected to be recruited in Q1 2025. The IEC team will design the IEC materials in Q2 2025. So all communes in target districts will gain knowledge from the IEC materials on the new services models of LHC in Q3 2025. Hence, it is not enough time, so there will be only IEC material development and TOT for district health center staff. All IEC materials used for health prevention and education activities at local health care level in the target districts will be gender and culturally (EM) sensitive.
4. Implementation of specific developmental interventions for local ethnic minority people	- All activities that support the EM development as set out in the EMDP are implemented effectively. - Various sectors and branches effectively collaborate in implementing activities described in the EMDP.
5. Grievance Mechanisms	- Ethnic minority community has a clear understanding of the grievance mechanism. -District Health Centers, commune-level social organizations and commune people's committee have a clear understanding of grievance mechanism and are able to assist EM people to implement such mechanisms.

VIII. BUDGET FOR EMDP IMPLEMENTATION

64. The budget for the implementation of the Ethnic Minority Development Plan including (i) communication strategy development and (ii) health human resource training and supervision is included in the overall project budget according to the following items:

a) Trainings and Workshops

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

- Training on family medicine principles applied to district-level medical staff to implement the family medicine model, applying available training frameworks and materials approved by the Ministry of Health (such as the Project HPET).
- Training on epidemic prevention, infectious disease prevention and biosafety standards.
- Training on management of non-communicable diseases in the community, focusing on intervention contents of the Program.
- Training classes on grassroots healthcare network management skills (communication skills, medical information management, financial management, project management,).
- Organize workshops to deploy, guide, evaluate and summarize the model of CHCs operating according to family medicine principles.
- Support the Ministry of Health and provinces to visit and study abroad about primary health care models and health screening for people.

b) System development

- Community communication and advocacy, gender and ethnic minority strategies.
    - The Provincial Project Management Board, District Health Center and Commune Health Center need to have social marketing activities for medical examination and treatment services, including updating information on the list of services, drugs and medical products, and contraceptives, providing information, even for people living in villages far from the station. This can be done through the use of social networks (such as Facebook, Zalo) or through direct communication when commune health staff periodically visit the village.
    - Provincial Project Management Board, District Health Center and Commune Health Center need to have communication and awareness raising activities appropriate to each ethnic group (for example, do not talk about child marriage in ethnic groups that do not have child marriage), prioritize investment for ethnic groups in priority villages (for example, have communication and awareness materials translated into the languages of the target priority ethnic groups).
    - Integrate the promotion of voluntary health insurance into other health care communication activities in areas where people do not receive health insurance support from the government due to the new rural classification.
    - The Provincial Project Management Board's Gender and Ethnicity Focal Point should work with the District and Commune Health Centers and the Ethnic Minority Development Focal Point to lead the implementation of the Provincial Project's Action Plan on Ethnic Minority Development.
- Integrate gender and ethnic minority issues in seminars and training activities;
- Support medical facilities in the project area in integrating gender and ethnic minority issues in the regular operations of medical facilities (communication to raise awareness of gender and ethnic minorities, improving the quality of responsive gender and ethnic minorities in service provision, improving the quality of statistics and management that are sensitive to gender and ethnic minorities).

- The Provincial Project Management Board, District Health Center and Commune Health Center need to amend reporting practices to have regular health statistics disaggregated by gender and priority ethnic groups (such as Khmer people in Soc Trang or Xo Dang people in Kon Tum) to track progress in implementing health programs for these priority ethnic groups over time.

IX. INDICATIVE IMPLEMENTATION SCHEDULE

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

Table 8. Indicative Implementation Schedule

Activities	Indicative Dates
Update EMDP and disseminate it to project provinces	Quarter III/2024 (done)
IEC firm is expected to be recruited in Q1 2025. The IEC team will design the IEC materials in Q2 2025. TOT for district health center staff. All IEC materials used for health prevention and education activities at local health care level in the target districts will be gender and culturally (EM) sensitive.	Quarter I/2025 Quarter II/2025 Quarter III/2025
Develop communication strategy	Quarter II/2025
Implement communication strategy	Quarter III/2025– onward
Capacity development activities	Continuous
Monitoring and evaluation (annual 6-month monitoring report)	January and July every year

Photo1: Discussion in DOH Soc Trang

Photo 2: Discussion in Krong Pa DHC, Gia Lai

Photo 3: Visiting Dak Wer CHS in Dak R'lap District, Dak Nong

Photo 4: Discussion in Bang Doan CHS, Doan Hung District, Phu Tho

Photo 5: Discussion in Phuc Lai CHS, Doan Hung district, Phu Tho

Photo 6: Ultrasound room in Son Duong DHC with the notice of not providing consutation on sex of fetus (blue plate hanging on the wall).