HelpAge International

Reducing Income- and Health-Related Vulnerability of Older Persons in Viet Nam project

SOCIAL ASSESSMENT REPORT

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II. ABBREVIATION

APRO	Asia Pacific Regional Office
CMB	Club Management Board
CHS	Commune Health Station
DOH	Department of Health
DOLISA	Department of Labor, Invalids and Social Affairs
EM	Ethnic Minority
FGD	Focus Group Discussion
HAIV	HelpAge International in Vietnam
HelpAge	HelpAge International Health
HI	Health Insurance
IGA	Income Generating Activities
ISHC	Intergenerational Self-help Clubs
MOH	Ministry of Health
MOLISA	Ministry of Labor, Invalids and Social Affairs
NCD	Non-communicable disease
OP	Older People
PC	People's Committee
PWD	Person with Disability
PH	Primary healthcare
SP	Social Pension
VAE	Vietnam Association for the Elderly
VNCA	Vietnam National Committee on Ageing
WB	World Bank
WHO	World Health Organization

III. INTRODUCTION

3.1. Project backgrounds

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

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

Poverty reduction has also been accompanied by broader welfare gains and improved living standards. This is evidenced by the fact that Vietnam achieved most of the Millennium Development Goals faster than targeted—and welfare improvements have continued. From 1993 to 2017, the infant mortality rate decreased from 32.6 to 16.7 (per 1,000 live births)[3], while stunting prevalence fell from 61 percent to 24.2 percent[4]. The net enrollment rate for primary school increased from 78 percent in 1992–1993 to 93 percent in 2014, for lower secondary school from 36.01 percent to 84.4 percent, and for upper secondary school from11.39 percent to 63.1 percent[5]. Access to household infrastructure improved dramatically: by 2016, 99.4 percent of the population used electricity as their main source of lighting (up from 48.6 percent in 1993)[6], 77 percent of the rural population had access to improved sanitation facilities (compared to 33.8 percent in 1993)[7], and 69.9 percent of the rural population had access to clean water (up from 62.9 percent in 1996)[8]. Access to all of these services in urban areas is well above 90 percent.

Vietnam has also closed gender gaps along a wide range of social and economic measures (including bringing female labor force participation within 11 percentage points of that of men)[9], but the high and widening sex ratio at birth (115 in 2018)[10] shows that fundamental gender discrimination persists. The 2018 Human Development Index ranked Vietnam at 116 out of 189 countries, in the

[1] World Bank. 2019. World Development Indicators 2019
[2] Ibid
[3] United Nations Inter-Agency Group for Child Mortality Estimation 2018
[4] GSO of Vietnam. 2017. Statistical Yearbook. Hanoi: Statistical Publishing House
[5] Vietnam Living Standards Survey 1992–1993; Vietnam Household Living Standards Survey (VHLSS) 2014
[6] Vietnam Living Standards Survey 1992–1993; VHLSS 2016
[7] World Bank. 2018. Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam. Washington
[8] Ibid; World Health Organization (WHO)/United Nations Children's Fund (UNICEF). 2015. Joint Monitoring Program for Water Supply and Sanitation. Estimates on the Use of Water Sources and Sanitation Facilities. https://www.wssinfo.org/documents/?tx_displaycontroller[type]=country_files
[9] Vietnam Labor and Employment Survey 2018 (quarter 2)
[10] GSO 2018. Socioeconomic Situation 2018

'medium' category with a score of 0.694 [11], while the World Bank's 2018 Human Capital Index ranked Vietnam 48th out of 157 countries with a score of 0.67 (exceeding the global, regional, and even upper-middle-income country averages) [12].

Looking ahead, Vietnam is expected to go through further social transformation and may face mounting economic and environmental pressures. First, Vietnam is one of the most rapidly aging countries and the 65+ age group is expected to increase 2.5 times by 2050[13]. Second, while the population still largely lives in rural areas (64.8 percent in 2017), it has been steadily urbanizing (at about 0.7 percentage points per year)[14]. Expectations of the population in terms of access to quality public services are also changing because of increasing incomes, access to information, and more spatial integration (global and urban-rural). Risks to development include the fragility of poverty gains, as well as the concentration of poverty in ethnic minority communities and rural, mountainous areas[15]; environmental sources of vulnerability (such as climate change, natural disasters, and unsustainable exploitation of natural resources); rising fiscal pressures, including a growing fiscal deficit [16] and a debt-to-GDP ratio that, although having fallen back from its 2016 high (of 63.7 percent) to 61.4 percent is still close to the 65 percent statutory limit; structural constraints in the growth model, including an overreliance on factor accumulation (compared to productivity growth); and limited private sector development. Balancing economic prosperity with environmental sustainability, promoting equity and social inclusion, and strengthening state capacity and accountability—all within a constantly evolving global and domestic context—will be challenging[17].

3.2. Project development objectives

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

3.3. Project components

To achieve the project objectives, the project will implement the following components:

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

This component has three sub-components:

(i) Sub-component 1.1 Initial establishment and on-going capacity-building of ISHCs: This sub-component includes the activities associated with establishing new ISHCs and providing ongoing capacity-building for the ISHCs, their local partners and government health workers. Examples of

[11] United Nations Development Program (UNDP). Human Development Indices and Indicators. 2018; Statistical Update. New York: UNDP http://hdr.undp.org/sites/default/files/2018_human_development_statistical_update.pdf.
[12] World Bank. 2018. The Human Capital Project
[13] GSO and United Nations Population Fund (UNFPA). 2016. Population Projections for the Period 2014–2049. Hanoi: Thong Tan Publishing House
[14] World Bank. 2019. World Development Indicators 2019
[15] World Bank. 2018. Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam. Washington, DC: World Bank
[16] The fiscal deficit averaged 5.6 percent of GDP during 2011–2015 and 2.2 percent of GDP during 2006–2010
[17] World Bank Group and Ministry of Planning and Investment (MPI). 2016. Vietnam 2035: Toward Prosperity, Creativity, Equity and Democracy. Washington, D.C: World Bank

such activities include project orientation meetings, institutional set-up of clubs, development of training materials, initial and on-going training activities, meetings of the project's advisory committees, regular technical support supervision visits, and small monthly grants (less than US$20) to ISHCs to cover their basic operating and monthly meeting costs during the first 1-2 years.

(ii) Sub-component 1.2 Health promotion and access to community-level healthcare: This sub-component focuses on improving older persons health-related behaviors and use of community-level health care interventions. It will include quarterly health awareness talks (provided by commune health station staff or trained club members) on disease prevention, managing chronic conditions, proper nutrition and other health-related issues relevant to older persons; health promotion through physical exercise and sports and cultural groups, established by the ISHC to promote healthy and active lifestyles; community health awareness campaigns; basic monthly health monitoring (such as measurement of body mass index, blood pressure, sugar levels) in collaboration with the local commune health stations; health check-ups conducted in collaboration with the local district and/or commune health stations to provide more comprehensive check-ups on a semi-annual basis; promoting access of ISHC members to the health insurance benefits to which they are entitled and educating them in how to use them. The costs associated with the development of training materials and the training of those people who will provide these health-related interventions to the elderly will be financed under the first sub-component.

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

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

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

Most of funds in this component will be allocated to the revolving fund. Details of the operation of the fund, including criteria for the selection of beneficiaries of the revolving fund, guidelines on fund management, loan amount, loan terms, exit strategy upon closure (among others) will be described in the project operations manual and also in a user-friendly ISHC revolving fund manual. It is currently anticipated that around 40-50 percent of ISHC members (20-30 people) will participate in the revolving fund. Loan amounts are expected to average around US$250, be repaid over a 12-18-month period, and have a monthly interest rate of 1 percent. The livelihood activities to be funded will typically be small scale husbandry (raising chicken, ducks, fish, goats, pigeons, rabbits and pigs),

agriculture (vegetable and fruits), or small businesses. Training on environmentally friendly livelihood schemes or techniques (suitable to adoption by older person) will also be provided to fund participants as well as to others in the community, with the local AEs facilitating links to the local agricultural sector for technical support where appropriate.

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

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

Sub-component 3.1 Project management and administration: This sub-component will cover the costs associated with project management and administration, including the management of the project by HelpAge and local partners, the annual mandatory audit, and the project's mandatory Implementation Completion Report. Project management activities will also include activities related to ensuring compliance with the World Bank's fiduciary and safeguards requirements and other project reporting and financial management guidelines. Specific project management functions and key staff roles (including related to project management, procurement and financial management) will be elaborated in the project paper / appraisal document.
Sub-component 3.2 Monitoring and evaluation (M&E): This sub-component will cover the costs associated with project monitoring, project evaluation, and capturing the lessons learned from the project – both to further strengthen implementation of the project and also to demonstrate its results. All assessment and evaluations will be carried out in a participatory manner in order to give voice to beneficiaries concerns and help create a feedback loop from the findings to the interventions in a way that addresses beneficiaries' needs. The main M&E activities will include the development of an annual participatory work plan, annual participatory project assessments (including at baseline), and a mid-term and end-of-project evaluation carried out by an external evaluator. These activities are described further in the JSDF Annex and will be confirmed during the remainder of project preparation and appraisal as well as detailed further in the operations manual. The costs of the regular monitoring and technical support visits and meetings by project staff and/or ISHC consultants will be covered under Component 1.

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

3.4 Demographic, social, health and economic status of older people in the six target communities

The project will be implemented in around 180 communes in six provinces, clustered within three regions and with variation in socio-economic and aging profiles. They are Hoa Binh (elder-child ratio of 37.3) and Thanh Hoa (57.4) in the North, Quang Binh (50.3) and Da Nang (38.5) in the central coast, Khanh Hoa (42.9%) and Ninh Thuan (30.9%) in the South-Central coast.

Thanh Hoa is located in the North Central region, with the area of 11,133.4 km2, 3.5 million

population, the per capital GDP of 1,705 USD. The main income sources are agriculture, forestry and fishery (4.2%); industry and construction (42.4%); services (39.3%). Thanh Hoa has long coast, large farming land, large track of mountainous districts. Ethnic Minority population make up 18.6%. Thanh Hoa has 635 communes, 100% of which have a commune health station (CHS). Of 635 CHSs, 60% meet the national benchmarks, 74% have a physician, 90% have a midwife or obstetric assistant.

Hòa Bình is mountainous province in the Northwest region, with the area of 4,662.5 km2, 976,699 population, the per capital GDP of 1,002 USD. The main income sources are agriculture, forestry and fishery; industry and Construction; services; Ethnic Minority population make up 69.4%. Hoa Binh has 210 communes, 100% of which have a CHS. Of 210 CHSs, 41% meet the national benchmarks, 79% have a physician, 83% have a midwife or obstetric assistant.

Quang Binh is located in the North-central region, with the area of 8,000 km2, 882.505 population, the per capital GDP of 1,287 USD. Ethnic Minority population make up 2.7%. The main income sources are agriculture, forestry and fishery: 18.79%; industry and Construction: 26.75%; services: 54.46%. Quang Binh has 159 communes, 100% of which have a CHS. Of 159 CHSs, 82% meet the national benchmarks, 98% have a physician and 100% have a midwife or obstetric assistant.

Da Nang is is the center of politics and socio-economic of the Central and Highlands, with the area of 1,284.7 km2 and 1.05 million population. Ethnic Minority population make up less than 0.5% of the population. Da Nang has 56 communes, 100% of which have a CHS that meet the national benchmarks and have a physician.

Khanh Hoa is a coastal province in the south central, with the area of 5,217.6 km2, 1,3 million population, the per capital GDP of 1,495 USD. The province makes up of the mainland area and over 200 islands, archipelagoes. Ethnic Minority population make up 5.7%. The main income sources are: agriculture, forestry and fishery (9.81%); Industry and Construction (31.06%); Services (47.4%) and product taxes (11.73%). Khanh Hoa has 140 communes, 98% of which have a CHS. Of 140 CHSs, 86% meet the national benchmarks, 91% have a physician, 95% have a midwife or obstetric assistant.

Ninh Thuan is a coastal province in the south central, with the area of 3,355.2 km2, 601,400 population, the per capital GDP of 1,210 USD. Ethnic Minority population make up 23.1%.; The main income sources are: Agriculture, forestry and fishery (35.77%); Industry and Construction (20.28%); services (38.08%). Ninh Thuan has 65 communes, 100% of which have a CHS. Of 65 CHSs, 72% meet the national benchmarks, 49% have a physician, 95% have a midwife or obstetric assistant.

Most beneficiaries of the project are expected to fall within the age group of 60 to 80, with the proposed ISHC model focused on vulnerable older persons who are in income-based poverty, without proper family support, facing severe illness and disability, or from ethnic minority groups. Some of the project provinces have a high proportion of ethnic minority populations, such as Hoa Binh, Thanh Hoa, and Ninh Thuan.

More demographic, social, health and economic status of older people in the six target communities can be found in the appendix section of the SA.

3.5 Ethnic minorities

Although names of specific beneficiary communities may not be determined by appraisal, it is known that some of the identified project provinces have a high proportion of ethnic minority populations, such as Hoa Binh, Thanh Hoa, and Ninh Thuan. These groups include Muong, Thai, Tay, Dao, Mong, Bru Van Kieu and Chut. Among them, Muong, Thai and Tay generally have a higher level of economic

development and a better command of the Vietnamese language than the remaining groups.

IV. SOCIAL ASSESSMENT METHODS

4.1. Objectives of a social assessment

The objective of a social assessment (SA) is to access the project's potential positive and negative/unintended impacts, and to integrate social assessment relevant findings in project design to minimize negative social impacts and maximize positive social impacts. The SA were conducted in

- Hoa Binh, Thanh Hoa, Khanh Hoa and Ninh Thuận provinces through interview by phone, in depth interview and FGDs
- Da Nang provinces through interview by phone and FGDs
- Quang Binh provinces: interview by phone, e-mail and FGDs.

4.2. Assessment research methods

To collect socio-economic information fully and precisely, the participatory approach is used in this survey. Accordingly, desk review, qualitative methods and direct observation are applied to gather information.

4.2.1 Quantitative method (Desk review)

Based on the available material of national and provincial data from Provincial AE, DoliSA, DoH, VNCA, Provincial People Committees data in recent years, the team reviewed the documents related to the demographic, living arrangement, social, health and economic status of older people in the six target provinces.

4.2.2 Qualitative methods

The qualitative methods included to a wide range of research tools, such as in-depth interviews, focus group discussions (FGDs), and observation of living condition and community where older people are living and their conditions in the project sites.

In-depth interviews and focus group discussions with Provincial AE and key officers from DOLISA and DOH in some provinces. Six in depth interview through phone with the six project Provincial AE (PAE) presidents were conducted to get their input on (1) their interest and commitment in participating in the WB-JFDF proposal (2) gather information on PAE structure, focus, capacity and plan. An additional six FGDs with Provincial AE teams and DOLISA and DOH representative in some provinces were conducted in the six target provinces to get the Provincial AE team feedback and recommendation on the proposed JSDF proposal.

FGDs with older people) In the provinces of Hoa Binh, Thanh Hoa, Ninh Thuan and Khanh Hoa, local people mostly the older people/village elders from Kinh and EM male and female groups, were engaged in FGDs;.The participants included old and near old men and women from urban, rural and EM communities. The contents of the FGDs were related to the project's impacts on target communities, especially on those that are most vulnerable, such as older people, the poor, women and person with disability. Expectations of the participants toward the project's interventions were also asked.

4.2.3 Survey sites and samples

Table 1: Sample

Type	Hoa Binh (Mountainous (EM)	Thanh Hoa (rural and mountainous)	Khanh Hoa (Urban, rural, coastal and mountainous)	Ninh Thuan (costal, EM, rural)	Da Nang (urban, rural, costal)	Quang Binh (rural, costal)	Amount of consultations/FGD/in depth interviews
In depth interview through phone	Hoa Binh provincial AE chair	Thanh Hoa provincial AE chair	Khanh Hoa provincial AE chair	Ninh Thuan provincial AE chair	Da Nang provincial AE chair	Quang Binh provincial AE chair	6
FGDs at provincial level	Hoa Binh Provincial AE, DOLISA, DOH	Thanh Hoa Provincial AE	Khanh Hoa AE, DOLISA, MOH	Ninh Thuan AE, DOLISA, DOH	Da Nang AE	Quang Binh AE	6
FGD with older women and men including district and commune AE	Mostly Ethnic minority group	Rural and EM group	Urban, rural, coastal and EM Groups	Rural group	None	None	4 FGDs

V. MAIN FINDINGS

5.1 Possible project's positive impacts

Consultation with Provincial, district, commune and village AEs as well as older men and women from the six target provinces have spoken very positively about the project, appreciated its benefits, and demonstrated their support for the project. The following are likely positive impacts from the project intervention:

Table 5.1 Project's positive impacts: Output and outcome level

Sector	Output level	Outcome level
Social and Cultural	• Having social and cultural performance groups in each ISHC will increase social and cultural activities and performance in the target communities and during the ISHC monthly meeting • More exchange among social and cultural performance groups within ISHCs and with ISHCs and other clubs/groups in the locality • Social and cultural activities will enable older people to help keep local stories, history and custom alive.	• Increased understanding interaction and solidarity • It gives each generation a sense of purpose. • Reduce conflict within the families and communities • People especially older people are stronger, both physically and mentally • Reduced the gender gap which expect women especially in EM areas to stay at home and do the housework only, by encouraging older women go out from their home and have more social

		interaction • Local fine tradition, culture and even EM language are preserved and transferred to the younger generation • People are happier
Healthy and active ageing	• Through regular health awareness talk and community campaign which will greatly increase the health and self-care awareness of ISHC and community members • Having physical exercise and sport teams will increase ISHC and community members participation in regular physical exercise & sport	• Improve healthy and active behaviors • Improve health status • Reduce health expenditure • People are healthier • Reduce morbidity
Health access	• Increased access to monthly health screening (BMI, BP and blood sugar) • Increased access to health checkup (by professional) • Increased number of dialogues and partnership with CHS and district and provincial hospital	• Reduce severe complication (early diagnosis and proper treatment) • Improve health status • People are healthier • Reduce mortality
Health insurance (HI)	• Increased understanding of the improvement of having HI • Increased in # and % of ISHC members have HI • Increased usage of HI	• Increase early diagnosis and treatment • Reduce financial burden on the family • Reduce mortality
Community-based care	• Increase in number of community-based care providers in the target communities • Large number of home bound and bed bound people have access to community-based care services, which include (1) social, (2) personal, (3) living support and (4) health cares	• More caring communities • The care burdens of the disadvantaged families are reduced • No one is left behind – inclusion of the most excluded groups
Livelihood	• Increased access to age and environmentally friendly livelihood schemes • Increased access to simple and age friendly revolving funds • Increased access to ongoing technical support from the economic volunteers	• Club members livelihood schemes are more diversed and have less risk • Higher and more regular household incomes • Less dependent, feel more purposeful, more confident, especially for older women, who are hard to access other micro credit fund • More caring communities/mutual support among people • Wealthier
Right and entitlement	• Increased awareness on right and entitlement • Increased access to legal service provided by the ISHCs	• Increased access to right and entitlement • Improved social protection in the target communities, especially for older women who are home and bed bound and live alone • Improved accountability of local

		government in realizing their people's right & entitlement
Resource mobilization	• Increased local resource mobilization activities in the ISHC and communities • More number of ISHC and communities become contributors/donors • Increased success in resource mobilization	• ISHC has more resources to support those most in need in their communities • Increased and sustainable social and development funds
Self-help and community support	• Increased self-help activities in the target communities • Large number of ISHC and communities joining in monthly self-help activities	• Large number of the poorest and most needy HHs received self-help support from the ISHC • Increased mutual support spirit and solidarity • More caring communities • Improve the quality of life in the target communities • Better image on ISHCs and older people (as change agents)
Life-long learning	• Increased cross learning and sharing activities in the ISHC and communities • Large number of ISHC and community members participate in monthly life-long learning talks and or training	• More informed, active and opened communities • Increased application of life-long learning to the daily life of ISHC and community members • ISHCs members, majority of them are older people, have updated information and skills to continue to participate in social -economic activities effectively
Voice and dignity	• Increased awareness of the ISHC model and its benefits in the local communities and authorities • Increased dialogue between the ISHC, local communities and authorities	• Increased interaction and partnership between ISHC, local communities and authorities • Grassroots democracy is better realized • Increased respect, image of older people and understanding between ISHCs, local communities and authorities

5.2 Potential project's negative/unintended impacts

As the project does not require land acquisition, construction and resettlement, its negative impact is negligible. There may be some potential social effects of the project activities on local people and communities, which will be reflected in the session VI below.

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VI. Other Social Risk and Mitigation Measures

Despite the positive impacts that the project may bring to elderly beneficiaries, there may be some implementation risks. The following are some possible social risks and mitigation actions that will be taken to reduce the possible risks.

6.1. Possible Social Risks of the project to the beneficiaries

As the project does not require land acquisition, construction and resettlement, its social risks are negligible. There may be some potential social risks of the project activities on local people and communities

Possible Social Risks	Probability	Impact	Mitigation measures
The province is large while only about 30 villages are supported in each province to establish. Other neighbouring communities might want the ISHCs and it is beyond the project capacity to support and there might be some unmet expectation.	Medium	Low	To address this, the project will work with the provincial AE and local authority to mobilize local funding to establish more ISHCs to meet the local demand.
The Club Management Board (CMB) members might complain that they have to work hard to achieve all the club 8 areas of activities and management.	Low	Medium	Selecting the right people to work for the CMB. Criteria for CBM members will be mentioned in the project manual/guideline on ISHCs establishment and management. Only those who has time, capacity, reputation, commitment, enthusiastic, have community experience and healthy enough will be selected. In addition, there will be 5-6 group leaders to support the CMBs to conduct club activities and management. Moreover, the partnership with other government service providers will be promoted to reduce the hardship of the CMBs, if any.
The existing barriers against the ethnic minority older persons to participate in and benefit from the project's activities to improve their quality of life and well-being may be related to languages, cultural practices, institutional arrangements, and religious or spiritual beliefs.	Medium	Medium	Different needs and preferences of older men and women from ethnic minority groups in the project communes will be considered in the design of the project's activities and organization of consultations. An engagement process with older persons from the ethnic minority groups in the project communes will be undertaken, including stakeholder analysis and engagement planning, disclosure of information, and meaningful consultation, in a culturally appropriate and gender and inter-generationally inclusive manner. On a basis of the findings from this SA and the engagement process, an EMPF has been

			prepared prior to appraisal. This EMPF provides guidance on how an Ethnic Minority Development Plan should be prepared during implementation to set out the measures or actions proposed with a clear time frame.
Livelihood components: older members may not be able to pay back their loans to the revolving fund if they fail to generate incomes for various reasons, which may undermine their self-esteem and self-confidence and add to their socioeconomic vulnerability.	Low[18]	Medium	• The revolving fund schemes also have risk fund policy which is to require at least 50% of the monthly interests be allocated for risk fund. With this risk fund policy, the revolving fund schemes will greatly increase as the ISHCs grow older. • The ISHC will also have self-help and local resource mobilization components which will be very useful to support ISHC members that face repayment problem due to emergency, health or environment. • The ISHC will also have regular age friendly and pro-poor livelihood talks, technical monitoring visit and economic volunteer support service which will improve self-esteem and self-confidence. • All of the above will be included in the project manuals/guidelines.
Health components: For activities focused on the health of older persons, there may be risks of failure to familiarize older persons from remote rural areas and from ethnic minority groups with the proposed health promotion models given their cultural differences.	Low[19]	Medium	• The new and improve ISHC development model will allow and encourage target communities to adopt and adapt the ISHC model into local social and cultural context of each community. • The activities will be introduced to the champions first, then spread into the communities • Health IEC materials will be age and user friendly
Homecare component: • For activities focusing on personal care, it is concerning that it may be impossible to mobilize enough volunteers who can work on a part-time and unpaid basis to meet the	Low[20]	Medium	• . • The ISHCs will recruit the home care volunteers from their members who are the good neighbors of the people in need of care. The work of volunteers will be reported in the ISHC monthly gatherings to increase acknowledgment, transparency and

[18] Over the past 10 years, HAI and local partners have implemented similar revolving fund schemes in thousands of communities throughout Vietnam. The revolving fund schemes repay rate of past projects has been very high at 99.6%.

[19] The finding over the past 10 years have found that the CDD model was most successful and easier to introduce in ethnic minority and low-land rural communities than in urban

[20] HAIand local partners have introduced community-based homecare components in Vietnam since 2003 in thousands of communities which is highly appreciated by older people, communities and authorities. Recruitment of at least 10 community-based homecare volunteers per ISHC is similar target in past HelpAge and local partners' projects so it should not be a big issue for this project

increasing demand for basic personal care from older persons. • The project community-based care approach may result in weak commitment and poor services provided by volunteers to the project's beneficiaries. • Home care volunteers may not have adequate skills to support PWD • Home care volunteers could pose a risk to beneficiaries if they are neglectful or abusive. There may be some GBV risks, especially those relating to economic, emotional and physical violence, when older persons are involved in the project's livelihood programmes and expected to receive personal care from community volunteers.			accountability • The volunteers will be trained, acknowledged by the ISHCs as appropriate. • There will be one member in the CMB to be in charge of home care component. • The project will build on existing homecare training package and homecare case management system which has been tested and improved since 2003. • CMBs will work closely with local health centers and AE to address the issues emerged with the people in need that is beyond their capacity • Home care volunteers, once recruited, will be introduced to the beneficiaries by CMB. They will provide care only when the beneficiaries accept their service • There will be at least 2 home care volunteers to support one case • CMB and project staff pay monitoring visits to home care beneficiaries to discover risks if any for timely solutions;

6.2. Other social risks to the project objective achievements and mitigations measures

Risk	Probability	Impact	Mitigation measures
Physical: The project and local AE may find it challenging to work in 180 spread out over six provinces throughout the country	Low	Medium	• Assign or recruit strong and experienced staff/consultants currently working or used to work in HelpAge and Provincial AE to work for the project • Train and work closely with district and commune AE and AE branches in the 180 target communities, who will provide on-going technical support to the ISHCs • Work with local communities, service providers and authorities to carry out project activities
Pro Poor: Poor and disadvantaged people may find it difficult to attend all the ISHC activities because of time, mobility, distance constraints	Low	Low	• ISHC is required to be formed at village level- closest to the living place of the club members • Provide a wide range of activities based on local interests, including smaller neighbourhood-based self-help groups and activities • Have activities for those with mobility constraints (esp. home care, simple physical exercise, culture, fund raising, right and entitlement and self-help) • All ISHCs activities (what, where, when, how) will be discussed and agreed with the members; This principle will be included in the ISHC establishment guideline.
Environmental: • Natural disasters (flash flood and landslide, typhoon, drought….) may affect livelihoods	Low	Medium	• Provide training on Climate Change Adaption livelihood during CMB training. • Mainstream CBDRR and CCA in the ISHC regular activities. • Implement 10 criteria of aged and environmentally

• Environmental impact from small household livelihoods • Project implementation might be delayed because of the natural disasters.			friend livelihood – on allocation of revolving funds • Localize the project activities. When possible, avoid to plan the project activities, mostly training, during the disaster season.
Political: LAs may not be receptive to participatory development model like ISHCs	Low	High	• Have regular and close linkage and cross sharing with local authorities and community leaders. • Organize field visit for LAs • Select the target villages and communes with most demonstrable political support to ISHC model
Economic: Agricultural or livestock disease may lead to loss due to the possibility of an outbreak of livestock or agricultural disease.	Medium	Medium	• Set up self-help groups, where IGA loss will be paid back by other group members that were not affected by the loss • Diversified livelihood schemes to reduce risk • Local link with local agriculture extension offices to provide ongoing technical support to the ISHCs
Social: ISHC leaders may not have the skills to grasp training quickly	Low	Medium	• Train many ISHC leaders (5 per ISHC instead of a single leader) • Use easy to understand materials & methodologies • Make the ISHC intergenerational (30% ISHC members should be younger old or near old) for mutual support • The project will also train local AE staff who will provide continuous technical support to ISHCs
Others: Exclusion of the poorest and most marginalised: home and bed bounded and the poor	Low	Medium	• Ensure most of the ISHC members as well at least one of their leaders are from the disadvantaged group. This will be stipulated in the ISHC members and CMB members' selection criteria in the guideline • Activities of the ISHCs are inclusive of the poorest. This will be mainstreamed in most of ISHC activities and will be included in the ISHC establishment, operation and management manual/guideline

6.3. Preconditions and assumptions

The **main preconditions** are: **(1)**The project is contracted on time with WB and regulations pertaining to Vietnam are clear, **(2)** Local Authorities and government service providers welcome and facilitate the start-up of activities in their areas, **(3)** Competent staff and consultants available and will work with the poor, older people, women, ethnic minorities and PwD, **(4)** Communities, service providers and authorities will contribute time, labour, funding (co-funding for ISHC self managed revolving fund) and material for project activities, **(5)** Health staff will participate and support the ISHCs' health activities, and **(6**) Funding and additional support is available to support additional activities of the ISHCs and its replication.

The **main assumptions** are: **(1)** ISHC members and local communities willing to take ownership of the ISHC model throughout the project and beyond, **(2)** there is no major change in AE structure and leadership, **(3)** No major natural disasters, pandemics or major slow-down in the local economy, **(4)** Local service providers willing to cooperate and involve ISHCs in local health, poverty reduction and

welfare initiatives**, (5)** Authorities willing to partner with the ISHCs and have funds to allocate to ISHCs (direct and/or indirect funding to the ISHCs) for local development initiatives, and **(6)** Local and international donors have funding to support the replication of ISHCs in needy communities.

VII. CONCLUSIONS AND RECOMMENDATIONS

The project has a number of very positive impacts and only few minor negative/unintended impacts as well as some social risks as mentioned above. All the negative social impacts and risks can be minimized and controlled. To reduce social risks during the implementation of the project, the following are conclusions and recommendations

- Right at the beginning, the project should develop a manual on ISHC establishment, operation and management, which will guide the CMB members selection to make sure that the ISHCs can recruit right people to be in CMB as this is the key for ISHCs success. The manual should also have the section on membership structure to allow self-help principles and how to prioritize the most disadvantaged people to avoid exclusion. Criteria for selection of project sites should be provided in the manual, such as at the village level, having strong support from LA, having communal house for monthly gathering, acceptance from communities, ect… to avoid possible risks relating to mobility and participation of the local people, as well as support of the LA. Establishing linkage and partnership with local service providers such as health, social work, agricultural extension, Red Cross, ect… should also be guided to leverage the ISHC impact as well as reduce the hardship of the CMB members.
- A part from the above manual, the project should develop other manuals to guide ISHC activity components (revolving loan fund/livelihood, health, home care, right & entitlements, fund raising, necessary knowledge and skills for CMBs…) to make sure that the ISHCs can conduct their activities, operate and manage properly and the measures to minimize the risks as described above will be included.
- Having only manuals/guidelines are not enough, the project also need to develop age friendly IEC materials on health, home care, IGAs and rights &entitlements for the ISHCs to use to teach their members during their learning sessions in the ISHC monthly gatherings.
- To minimize the impact of unmet need for more ISHCs, the project would need to sensitize and advocate for more local and international funding for new ISHCs in non project communities, through organizing field visits for local authorities and organizations, sharing ISHC impacts in local and national events, as well as in the portal, organize training for new ISHCs established by local partners, ect
- Building capacity for CMBs and AE staff is very crucial, to ensure the proper implementation of ISHCs activities, operation and management. Given the nature of the ISHC model and the main target groups (mainly older people in the community), the project would need to allocate a due resources (funding and time) for capacity building activities. The role of AE at all levels is very important to ensure continuous technical support for ISHCs during and after the project.
- The project will address the gender related issues in poverty, health, voice, abuse & violence and social participation (women are more vulnerable in most of these aspects, especially in EM areas) by: 1) ensure 60-70% ISHCs members are women so that they can benefit from ISHC income generating activities, health care and other activities 2) ensure 2-3 women members in the ISHC management of 5 members to make sure that the club activities are in need of and appropriate for the women members ; 3) having smaller groups by neighborhood in ISHCs to allow older women to be more confident/can share/speak out; 4) establish ISHCs at village level and recruit ISHC management members from the same village to facilitate the ISHC activities which would help older women especially EM ones, have no language, culture and physical distance problem; 5) organize health check up at the nearest possible place to allow older women to participate in; 6) having at least 2 volunteers to provide home care and support to those in need, most of them are older women, to: a) reduce partly the hardship of family carers most of them are also women; b) prevent and discover gender-based violence if any, c) avoid any possible abuse by the volunteer during the caring process; 6) having rights & entitlement component as one of the ISHC 8 areas of activities, to raise awareness on laws and policies relating to older people, as well

as setting up community based monitoring system to monitor the realization of older people rights and entitlements.

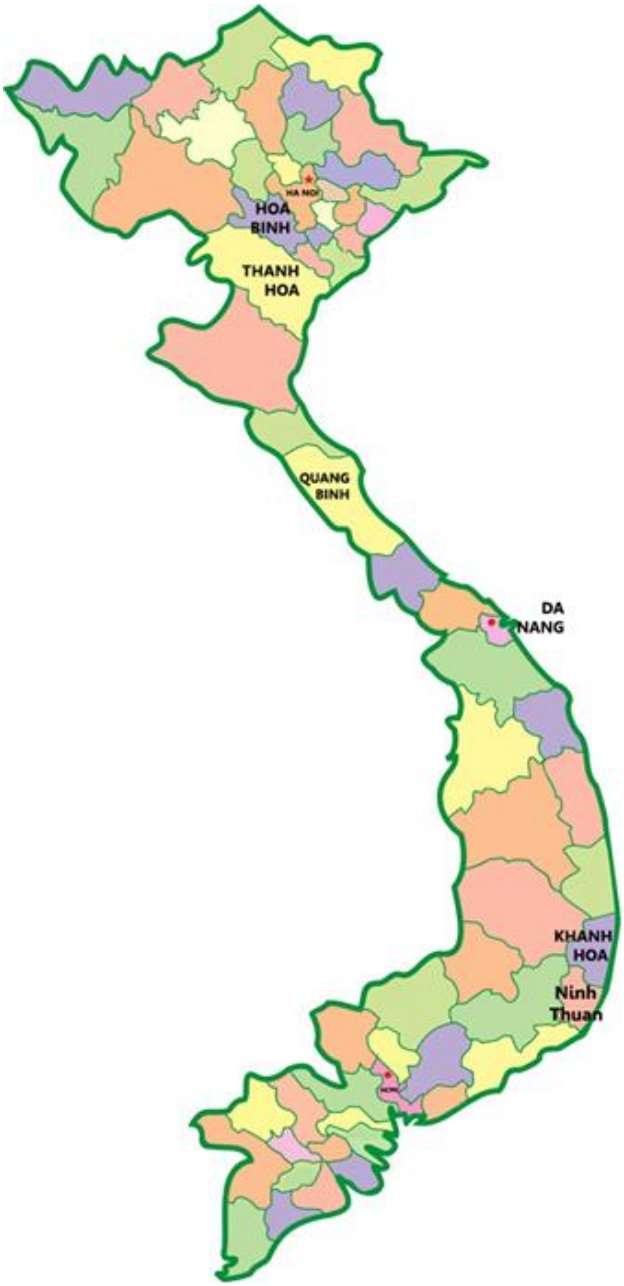
- Other cross cutting issues such as inclusion, accountability, climate change adaptation….will be taken into account while developing these manuals/guidelines.

The nature of the model is self help or community driven development approach. Thus this approaches should be specified in the project manuals/guidelines, as mitigation measures to potential risks relating to micro credit payment, reluctance to participate in the ISHC activities, ect. Regular monitoring and technical support to ISHC and local AE is important, to enable the project to manage the risks better. The project should allocate due resources for this activity.

The below table will summarize the project key recommendations for risk mitigation			
Key mitigation measure for risk identified	**Responsibility**	**Timeline**	**Estimated cost and budget source**
Develop ISHC establishment, operation and management to guide CMB members selection, membership structure, project site selection, linkage and partnership with local service providers, ISHC activities and targets, and ISHC CDD approach and management	PT, with support from HAI	First 3 months and update when necessary	Part of JD of project Staff/consultant
Develop health, care, IGAs, right& entitlements… manuals to guide ISHC activities	PT, with support from HAI	First 3 months and update when necessary	Part of JD of project Staff/consultant
Develop age friendly IEC materials on health, home care, IGAs and rights &entitlements for the ISHCs to use to teach their members during their learning sessions in the ISHC monthly gatherings.	PT, with support from HAI	First 3 months and on going	Part of JD of project Staff/consultant
To sensitize and advocate for more local and international funding for new ISHCs in non project communities	PT and HAI	Through out the project life	Combining with project monitoring and technical support trips, field visits, annual review meetings
Building capacity for CMBs and AE staff to ensure the proper implementation of ISHCs activities, operation and management.	PT with support from HAI	Through out the project life	Combining with project on-going training, technical support trips
The project will address the gender related issues in poverty, health, voice, abuse & violence and social participation, as well as inclusion, accountability, climate change adaptation as described	PT with support from HAI	Through out the project life	Combining with project on-going training, technical support trips
Ensure ISHCs will practise CDD approach	PT and HAI	Through out the project life	Mainstreaming in the project capacity building activities and combined with project on-going monitoring and technical support trips

VIII. APPENDICE

8.1. Annex 1: Map of Six Project Provinces



8.1. Annex 4: Social and Economic Data of Six Target Provinces

#	Description	Province						TOTAL
		Hoa Binh	Thanh Hoa	Da Nang	Quang Binh	Khanh Hoa	Ninh Thuan	
A	**General information**							
A1	**Region**	**North West**	**North Central**	**Central**	**Central**	**South Central**	**South Central**	
A2	Population	832,543	3,600,000	1,215,000	936,607	1,326,500	608,000	**8,518,650**
A3	% OP	10.9	12.5	9.2	11.2	9.3	8.5	**10.9%**
A4	#OP	90,747	450,000	111,780	104,900	123,365	51,680	**932,472**
A5	# of District	11	27	8	8	8	7	**69**
A6	# of commune/ward	210	635	56	159	137	65	**1,262**
A7	AE provincial staff	8	7	5	5	4	2	**31**
A8	% of EM in the province	69.4%	18.6%	0.5%	2.7%	5.7%	23.1%	**17.5%**
A9	# of EM in the province	577,785	669,600	6,075	25,288	75,611	140,448	**1,494,807**
A10	EM groups in the province	Muong, Tay Thai & Dao	Muong, Thai, Tho, Dao & H'mong	Co-tu & Tay	Bru–Van Kieu, Chut & Tày	Ragalai, Hoa, Co ho	Cham, Ragalai, Co Ho, Hoa	**13 EM groups**
A11	% of PWD	8.04%	10.22%	8.84%	9.10%	8.25%	6.99%	**9.2%**
A12	# of PWD	66,936	367,920	82,796	110,565	109,436	42,499	**780,153**
B	**Assessing AE organization capacity**							
B1	AE's staffing in the province	450	1,331	133	338	295	147	**2,694**
B2	% of village/community have AE	100%	100%	100%	100%	100%	100%	**100%**
B3	% of OP that are	96%	98%	84%	88%	85%	78%	**92%**

	members of AE							
B4	% of OP that are members of AE	87,117	441,000	93,895	92,312	104,860	40,310	**859,495**
B5	Relationship with DoH and DoLISA	Very good	Very good	Very good	Good	Very good	Good	**100% have good or very good relationship**
B6	Support from PC to AE work	Very good	Very good	Very good	Good	Very good	Good	**100% have good or very good support**
B7	Has experience working with HelpAge	Yes	Yes	No	Yes	Yes	No	**4/6 have worked with HelpAge**
C	**Health and Social Pension Assessing**							
C1	% of Commune or Ward have CHS	100%	100%	100%	100%	100%	100%	**100%**
C2	% OP have health Insurance	90%	85%	91%	85%	85%	80%	**80% to 91%**
C3	SP amount	270,000	270,000	350,000	270,000	300,000	270,000	

8.2. Annex 2: Stakeholder/Target Group Analysis

Stakeholder		Position			Reason for Position	Strength& Weakness	Engagement Strategy
		+	0	-			
1	Local Communities	+			The local communities' representatives have visits the ISHCs in neighboring districts or know about ISHCs and have expressed great interest in establishing similar ISHCs in their communities. They are aware of the benefit of the ISHC as well as the commitment and resources required to ensure the ISHCs are effective and sustainable	**Strengths:** • Are elected representatives of the target communities • Have in-depth knowledge of the target communities • Are respected in the target communities • Able to mobilize local communities and resources to help keep the ISHC be more effective and sustainable **Weaknesses:** • Lack financial resource to set up the ISHC in their communities • Lack capacity to set and manage the ISHC • Lack effective lobby and fund-raising skills	**The project will:** • Provide initial start grant to the target communities to set up the ISHCs • Provide ongoing capacity building training to local partners and ISHCs' leaders to effectively manage the ISHCs • Work closely with local partners and the ISHCs to improve their capacity in lobbying and local fund raising through both informal training and hand on technical support.
2	Vietnam Association for the Elderly (VAE)	+			VAE is mandated to provide care and promote the role of older people. ISHCs are found is a good model for VAE to realize their mandate. VAE has also be one of the founding members in the development of the ISHC model in Vietnam. Nationally, HelpAge has supported VAE to develop a National Proposal for the replication of the ISHC model nationally which is approved by the Prime Minister. VAE will conduct 3 year implementation of the ISHC replication project by end of 2019 the findings of which will inform the second phase of the project VAE has been assigned by the GoV to take led in replicating the ISHC nationally	**Strengths:** • The second largest mass organization in the country with 8.5 million members and around 10,000 staff throughout the country • Actively involved in the replication of the ISHC model in VN • Has successfully replicated more than 1,000 ISHCs in 18 provinces in the country. • Has good access to senior policy makers • Has access to local funding opportunities for age related programs **Weaknesses:** • Staff has uneven capacity • Effective lobby and advocacy skills are still low • Fund raising skills are low	**The project will:** • Continue to strengthen the partnership between HelpAge and VAE in the areas of fund raising, policy advocacy and replication of the ISHC widely. • Promote cross learning and sharing between VAE offices/teams at all levels (national, provincial, district and commune levels)
3	People Committees (provincial,	+			The PC is the highest and main government administrative body at provincial, district and	**Strengths:** • Highest government body at provincial, district and commune levels.	**The project will:** • Provide ongoing IEC materials on the ISHC model

	district and commune levels) (PC)		commune levels. Provincial PC has given approval for the replication of the ISHC model in their province and has the authorities to allow local partner to raise funds for the wider replication of the ISHC model in the province. The PC is tasked to provide support to ISHCs including creating favorable conditions for ISHCs to operate. ISHCs activities contribute to the implementation of social security – the focus of the PC.	• Are aware of the ISHC model and is supportive in the replication of the ISHC model in the province • Have access to government funding • Are influential seeking funding from local private donors **Weaknesses:** • Ageing is not one of the main focus of the PC • Still limited awareness on Ageing and Gender • Local fund-raising initiatives for older people is still limited • Lack system to monitor the well-being of older people in the locality	• Regularly invite PCs representatives to visit the project and participate in the ISHC activities. • Work closely with the PC to increase funding from local fund raising. • Provide regular information on the status of older people in their locality
6	Ministry of Health (MoH and DoH, CHS)	+	In provinces that have existing ISHCs, DoH has been support in organizing mobile health clinics and also provided volunteer health educators to the target communities to provide regular health awareness sessions and promotions. They are tasked by PM in Decision 1533 to provide support to ISHCs in term of health and care	**Strengths:** • Largest health care providers in the locality • Large number of highly trained health providers located in both project districts and communes. **Weaknesses:** • Lack regular outreach health programs • Focus more on treatment then prevention • Limited knowledge, skills and resources and capacity to meet the increasing needs of health care especially of older people	**The project will:** • The project staff and ISHC representatives to link with the local DoH to organize annual mobile health check in all project communities. • The ISHCs will be encouraged to build up their relationship with the local DoH (health station and district hospital) to increase their members access to both curative and preventative health care.
7	Ministry of Labor, Invalid and Social Affair (MoLISA and DoLISA)	+	MoLISA/DoLISA is the main Government agency assigned to cover the area on Ageing in Vietnam. In provinces that have existing ISHCs, DoLISA has provided right and entitlement experts to give talks on various topic relating to rights and entitlement during the ISHC monthly meeting They are tasked by PM in Decision 1533 to support AE in ISHC replication.	**Strengths:** • Main government agency overseeing ageing in the province • Has large number of social workers throughout the province • Are assigned to ensure the poor and needy have access to their rights and entitlements **Weaknesses:** • Lack outreach staff to cover all communities in the province • Ageing has low priority due to lack of awareness on Ageing • Focus more on handout instead of promoting the role of communities to help themselves	**The project will:** • Provide ongoing capacity building training for both project staff and ISHC representatives to link with the local DoLISA to ensure that all needy people have access to their rights and entitlement • Provide regular information on the ageing and on the ISHC model to local DoLISA staff and office • Support local partners and ISHCs to start up regular dialogs with local DoLISA

8.3. Annex 3: Target Group Analysis

Target Group	Interests, Motives	Characteristics	Potentials	Conclusion

Target Communities	**Interests:** want to set up the strong and effective ISHCs in their communities **Motivations:** Want to improve the well-being of the people in their communities, especially for those that are poor and disadvantaged **Attitudes:** Very positive and supportive	• Local knowledge • Are respected by others • Focus on the long-term development of their communities • Has the human resources • Lack capital investment • Lack management and facilitation skills	• Take lead in establishing the ISHC in their communities • Become ISHC leaders, volunteers or members • Become motivator or trainers • Conflict negotiator • Help Others	• Should be main targets for being • Help set up the ISHC • ISHC leaders, members or volunteers • Be advisor to the project and or ISHCs

8.4. Appendix 4 Needs, Priority, Gender an EM Analysis

Table 4.1 Respondents information by gender, ethnicity and province

No	Province	Total			EM			Ethnicity	
		Total	Male	Female	Total	Male	Female	Kinh	EM
1	Hoa Binh	49	19	30	41	11	30	8	41
2	Thanh Hoa	62	23	39	11	4	7	51	11
3	Khanh Hoa	56	14	42	8	2	6	48	8
Total		**167**	**56**	**111**	**60**	**17**	**43**	**107**	**60**

Table 4.2 Ranking of Priority of Need of Older People with respect to Older Men and Older Women

No	Areas of Need	Total		Male		Female		Variance		Are the identify needs include in the ISHC development model intervention
		Rank	Score	Rank	Score	Rank	Score	Rank	Score	
1	Income security - revolving funds	1	8.63	1	8.61	1	8.65	20	0.01	Yes. Livelihood component
2	Social and cultural	2	8.14	5	7.21	2	8.60	1	0.47	Yes, Social and cultural component
3	Income security – Awareness	3	8.10	2	8.32	7	7.98	16	-0.11	Yes. Livelihood component
4	Health - screening	4	7.96	4	7.50	4	8.19	10	0.23	Yes, health component
5	Health – checkup	5	7.82	6	7.07	3	8.20	5	0.38	Yes, health component
6	Health - awareness	6	7.63	8	6.80	5	8.05	3	0.42	Yes, health component
7	Health - exercise & sport	7	7.59	8	6.80	6	7.99	4	0.40	Yes, health component
8	Health – insurance	8	7.56	7	7.05	8	7.82	9	0.26	Yes, health component
9	Life-long learning	9	7.22	3	7.93	12	6.86	6	-0.36	Yes, life-long learning component
10	Resource mobilization	10	7.21	10	6.77	9	7.43	12	0.22	Yes. resource mobilization component

11	Self-help - community development	11	6.93	13	6.48	10	7.16	10	0.23	Yes, self-help component
12	Right and entitlement - awareness	12	6.68	11	6.64	13	6.69	17	0.02	Yes, right and entitlement component
13	Intergenerational bonding	13	6.62	15	6.05	11	6.91	8	0.29	Yes, intergenerational approach
14	Right and entitlement - legal service	14	6.50	14	6.11	14	6.70	13	0.20	Yes, right and entitlement component
15	Voice and inclusion - local development	15	6.46	12	6.50	15	6.43	17	-0.02	Yes, dialog with LA
16	Homecare	16	6.13	16	5.54	16	6.42	7	0.30	Yes, homecare component
17	Environmental protection &CCA	17	6.04	17	6.00	18	6.05	17	0.02	Yes, livelihood and life-long learning component
18	Domestic violence (including gender-based violence) and abuse	18	5.74	20	4.89	17	6.16	2	0.43	Yes, Life-long learning and right and entitlement components
19	Income security - Pension	19	5.49	19	5.11	19	5.68	14	0.19	Yes, right and entitlement component
20	Disaster preparedness	20	5.48	18	5.25	20	5.59	15	0.12	Yes, life-long learning component
	Average score		**7.00**		**6.63**		**7.18**		**0.18**	OW in general responded with higher needs than OM
Number of Respondents		**169**	**100%**	**56**	**33.1%**	**111**	**65.7%**			

Table 4.3 Ranking of Priority of Need of Older People with respect to Kinh and EM groups

No	Areas of Need	Total		Kinh		EM		Variance		Are the identify needs include in the ISHC development model intervention
		Rank	Score	Rank	Score	Rank	Score	Rank	Score	
1	Income security - revolving funds	1	8.63	1	8.60	1	8.70	11	0.10	Yes. Livelihood component
2	Social and cultural	2	8.14	2	8.13	2	8.15	17	0.02	Yes, Social and cultural component
3	Income security – Awareness	3	8.10	3	8.07	3	8.13	15	0.06	Yes. Livelihood component
4	Health - screening	4	7.96	4	7.96	4	7.95	18	-0.01	Yes, health component
5	Health – checkup	5	7.82	5	7.82	5	7.82	18	-0.01	Yes, health component
6	Health - awareness	6	7.63	6	7.61	7	7.68	13	0.08	Yes, health component
7	Health - exercise & sport	7	7.59	8	7.49	6	7.78	3	0.30	Yes, health component
8	Health – insurance	8	7.56	7	7.50	7	7.68	6	0.19	Yes, health component
9	Life-long learning	9	7.22	9	7.27	10	7.12	7	-0.15	Yes, life-long learning component
10	Resource mobilization	10	7.21	10	7.18	9	7.27	12	0.09	Yes. resource mobilization component
11	Self-help - community development	11	6.93	11	6.98	11	6.85	8	-0.13	Yes, self-help component
12	Right and entitlement - awareness	12	6.68	12	6.67	14	6.68	18	0.01	Yes, right and entitlement component

13	Intergenerational bonding	13	6.62	13	6.55	12	6.75	5	0.20	Yes, intergenerational approach
14	Right and entitlement - legal service	14	6.50	15	6.37	13	6.73	1	0.36	Yes, right and entitlement component
15	Voice and inclusion - local development	15	6.46	14	6.50	15	6.38	10	-0.11	Yes, dialog with LA
16	Homecare	16	6.13	16	6.04	16	6.28	4	0.25	Yes, homecare component
17	Environmental protection &CCA	17	6.04	17	5.99	17	6.12	8	0.13	Yes, livelihood and life-long learning component
18	Domestic violence (including gender-based violence) and abuse	18	5.49	18	5.71	18	5.78	14	0.07	Yes, right and entitlement and life-long learning components
19	Income security - Pension	19	5.48	20	5.36	19	5.72	1	0.36	Yes, right and entitlement and life-long learning components
20	Disaster preparedness	20	4.96	18	5.50	20	5.45	16	-0.05	Yes, Life-long learning and self-help components
	Average score		**6.96**		**6.96**		**7.05**		**0.09**	EM in general responded with a little higher need than Kinh group
Number of Respondent		**169**	**100%**	**107**	**63.3%**	**60**	**35.5%**			

Table 4.4: EM respondent information

No	Ethnicity	#	%
1	Muong	35	58.3%
2	Thai	10	16.7%
3	Tai	5	8.3%
4	Dao	5	8.3%
5	Raglai	5	8.3%
Total		**60**	**100.0%**

Table 4.5: Ranking of Priority of Need of Kinh Older Women and EM Older Women

No	Areas of Need	W Total		Kinh W		EM W		Variance		Are the identify needs include in the ISHC development model intervention
		Rank	Score	Rank	Score	Rank	Score	Rank	Score	
1	Income security - revolving funds	1	8.63	1	8.50	1	8.88	8	0.38	Yes. Livelihood component
2	Social and cultural	2	8.14	2	8.47	2	8.81	10	0.34	Yes, Social and cultural

										component
3	Income security – Awareness	3	8.10	7	7.81	5	8.26	3	0.45	Yes. Livelihood component
4	Health - screening	4	7.96	4	8.09	3	8.35	13	0.26	Yes, health component
5	Health – checkup	5	7.82	3	8.10	3	8.35	14	0.25	Yes, health component
6	Health - awareness	6	7.63	5	7.97	6	8.19	16	0.22	Yes, health component
7	Health - exercise & sport	7	7.59	6	7.87	6	8.19	11	0.32	Yes, health component
8	Health – insurance	8	7.56	8	7.66	8	8.07	6	0.41	Yes, health component
9	Life-long learning	9	7.22	11	6.78	13	6.98	17	0.20	Yes, life-long learning component
10	Resource mobilization	10	7.21	9	7.28	9	7.67	7	0.40	Yes. resource mobilization component
11	Self-help - community development	11	6.93	10	7.18	11	7.14	20	-0.04	Yes, self-help component
12	Right and entitlement - awareness	12	6.68	13	6.59	14	6.86	12	0.27	Yes, right and entitlement component
13	Intergenerational bonding	13	6.62	12	6.74	10	7.19	3	0.45	Yes, intergenerational approach
14	Right and entitlement - legal service	14	6.50	14	6.46	12	7.09	2	0.64	Yes, right and entitlement component
15	Voice and inclusion - local development	15	6.46	15	6.40	16	6.49	18	0.09	Yes, dialog with LA
16	Homecare	16	6.13	16	6.28	15	6.65	9	0.37	Yes, homecare component
17	Environmental protection &CCA	17	6.04	18	5.85	17	6.37	1	0.52	Yes, livelihood and life-long learning component
18	Domestic violence (including gender-based violence) and abuse	18	5.49	17	6.07	18	6.30	15	0.23	Yes, right and entitlement and life-long learning components
19	Income security – Pension	19	5.48	20	5.50	19	5.95	3	0.45	Yes, right and entitlement and life-long learning components
20	Disaster preparedness	20	4.96	19	5.57	20	5.63	19	0.05	Yes, Life-long learning and self-help components
	Average score		**6.96**		**7.06**		**7.37**		**0.31**	EM OW in general responded with higher needs than Kinh OW
	Number of Respondent	**111**	**100%**	**68**	61.3%	**43**	38.7%			

Table 4.6 Ranking of Priority of Need of Older People with respect to Kinh Older Men and EM Older Men

No	Areas of Need	M Total	Kinh M	EM M	Variance	Are the identify needs include in

		Rank	Score	Rank	Score	Rank	Score	Rank	Score	the ISHC development model intervention
1	Income security - revolving funds	1	8.61	1	8.24	1	8.77	13	0.53	Yes. Livelihood component
2	Income security – Awareness	2	8.32	2	7.82	2	8.54	6	0.71	Yes. Livelihood component
3	Life-long learning	3	7.93	3	7.47	3	8.13	7	0.66	Yes, life-long learning component
4	Health - screening	4	7.50	4	6.94	4	7.74	3	0.80	Yes, health component
5	Social and cultural	5	7.21	7	6.47	5	7.54	1	1.07	Yes, Social and cultural component
6	Health – checkup	6	7.07	7	6.47	6	7.33	2	0.86	Yes, health component
7	Health – insurance	7	7.05	6	6.71	7	7.21	15	0.50	Yes, health component
8	Health - awareness	8	6.80	9	6.41	9	6.97	11	0.56	Yes, health component
9	Health - exercise & sport	9	6.80	5	6.76	10	6.82	19	0.06	Yes, health component
10	Resource mobilization	10	6.77	10	6.24	8	7.00	4	0.76	Yes. resource mobilization component
11	Right and entitlement - awareness	11	6.64	10	6.24	10	6.82	9	0.59	Yes, right and entitlement component
12	Voice and inclusion - local development	12	6.50	12	6.12	12	6.67	12	0.55	Yes, dialog with LA
13	Self-help - community development	13	6.48	12	6.12	13	6.64	14	0.52	Yes, self-help component
14	Right and entitlement - legal service	14	6.11	14	5.82	14	6.23	16	0.41	Yes, right and entitlement component
15	Intergenerational bonding	15	6.05	15	5.65	14	6.23	10	0.58	Yes, intergenerational approach
16	Environmental protection &CCA	16	6.00	16	5.47	14	6.23	4	0.76	Yes, livelihood and life-long learning component
17	Homecare	17	5.54	17	5.35	17	5.62	18	0.26	Yes, homecare component
18	Disaster preparedness	18	5.25	19	5.00	18	5.36	17	0.36	Yes, Life-long learning and self-help components
19	Income security - Pension	19	5.11	18	5.12	19	5.10	20	-0.02	Yes, right and entitlement and life-long learning components
20	Domestic violence (including gender-based violence) and abuse	20	4.89	20	4.47	20	5.08	8	0.61	Yes, right and entitlement and life-long learning components
	Average score		**6.63**		**6.24**		**6.80**		**0.56**	EM Men make in general responded with higher needs than Kinh Men
	Number of Respondent	**56**	**100%**	**39**	69.6%	**17**	30.4%			

Table 4.7: Ranking of Priority of Need of Older People with respect to EM Older Men and Older Women

No	Areas of Need	EM Total		EM M		EM W		Variance		Are the identify needs include in the ISHC development model intervention
		Rank	Score	Rank	Score	Rank	Score	Rank	Score	
1	Income security - revolving funds	1	8.70	1	8.24	1	8.88	15	0.65	Yes. Livelihood component
2	Social and cultural	2	8.15	7	6.47	2	8.81	1	2.34	Yes, Social and cultural component
3	Income security - Awareness	3	8.13	2	7.82	5	8.26	19	0.43	Yes. Livelihood component
4	Health - screening	4	7.95	4	6.94	3	8.35	8	1.41	Yes, health component
5	Health – checkup	5	7.82	7	6.47	3	8.35	2	1.88	Yes, health component
6	Health - exercise & sport	6	7.78	5	6.76	6	8.19	7	1.42	Yes, health component
7	Health - awareness	7	7.68	9	6.41	6	8.19	4	1.77	Yes, health component
8	Health – insurance	8	7.68	6	6.71	8	8.07	9	1.36	Yes, health component
9	Resource mobilization	9	7.27	10	6.24	9	7.67	6	1.44	Yes. resource mobilization component
10	Life-long learning	10	7.12	3	7.47	13	6.98	18	-0.49	Yes, life-long learning component
11	Self-help - community development	11	6.85	12	6.12	11	7.14	12	1.02	Yes, self-help component
12	Intergenerational bonding	12	6.75	15	5.65	10	7.19	5	1.54	Yes, intergenerational approach
13	Right and entitlement - legal service	13	6.73	14	5.82	12	7.09	11	1.27	Yes, right and entitlement component
14	Right and entitlement - awareness	14	6.68	9	6.24	14	6.86	16	0.63	Yes, right and entitlement component
15	Voice and inclusion - local development	15	6.38	12	6.12	16	6.49	20	0.37	Yes, dialog with LA
16	Homecare	16	6.28	17	5.35	15	6.65	10	1.30	Yes, homecare component
17	Environmental protection &CCA	17	6.12	16	5.47	17	6.37	13	0.90	Yes, livelihood and life-long learning component
18	Domestic violence (including gender-based violence) and abuse	18	5.78	20	4.47	18	6.30	3	1.83	Yes, right and entitlement and life-long learning components
19	Income security - Pension	19	5.72	18	5.12	19	5.95	14	0.84	Yes, right and entitlement and life-long learning components
20	Disaster preparedness	20	5.45	19	5.00	20	5.63	16	0.63	Yes, Life-long learning and self-help components

	Average score		**7.05**		**6.24**		**7.37**		**1.13**	EM OW in general responded with much higher needs than EM OM
Number of Respondent		**60**	**100%**	**17**	28.3%	**43**	71.7%			

Table 4.8 Ranking of Priority of Need of Older People with respect to Kinh Older Men and Older Women

No	Areas of Need	Kinh Total		Kinh M		Kinh W		Variance		Are the identify needs include in the ISHC development model intervention
		Rank	Score	Rank	Score	Rank	Score	Rank	Score	
1	Income security - revolving funds	1	8.60	1	8.77	1	8.50	16	-0.17	Yes. Livelihood component
2	Social and cultural	2	8.13	5	7.54	2	8.47	5	0.59	Yes, Social and cultural component
3	Income security - Awareness	3	8.07	2	8.54	7	7.81	7	-0.46	Yes. Livelihood component
4	Health - screening	4	7.96	4	7.74	4	8.09	14	0.22	Yes, health component
5	Health – checkup	5	7.82	6	7.33	3	8.10	6	0.49	Yes, health component
6	Health - awareness	6	7.61	9	6.97	5	7.97	3	0.63	Yes, health component
7	Health – insurance	8	7.50	7	7.21	8	7.66	11	0.29	Yes, health component
8	Health - exercise & sport	7	7.49	10	6.82	6	7.87	2	0.67	Yes, health component
9	Life-long learning	9	7.27	3	8.13	11	6.78	1	-0.86	Yes, life-long learning comp.
10	Resource mobilization	10	7.18	8	7.00	9	7.28	15	0.18	Yes. resource mob. component
11	Self-help - community development	11	6.98	13	6.64	10	7.18	9	0.34	Yes, self-help component
12	Right and entitlement - awareness	12	6.67	10	6.82	13	6.59	18	-0.15	Yes, right and ent. component
13	Intergenerational bonding	13	6.55	14	6.23	12	6.74	10	0.32	Yes, intergenerational approach
14	Voice and inclusion - local development	15	6.50	12	6.67	15	6.40	17	-0.17	Yes, dialog with LA
15	Right and entitlement - legal service	14	6.37	14	6.23	14	6.46	19	0.14	Yes, right and entitlement component
16	Homecare	16	6.04	17	5.62	16	6.28	8	0.42	Yes, homecare component
17	Environmental protection &CCA	17	5.99	14	6.23	18	5.85	13	-0.24	Yes, livelihood and life-long learning component
18	Domestic violence (including gender-based violence) and abuse	18	5.71	20	5.08	17	6.07	3	0.63	Yes, right and entitlement and life-long learning components
19	Disaster preparedness	20	5.50	18	5.36	19	5.57	19	0.14	Yes, Life-long learning and self-

										help components
20	Income security - Pension	19	5.36	19	5.10	20	5.50	12	0.25	Yes, right and entitlement and life-long learning components
	Average score		**6.96**		**6.80**		**7.06**		**0.16**	Kinh OW in general responded with higher needs than Kinh OM
Number of Respondent		**0**	**107**	100%	39	**36.4%**	68	**63.6%**		

8.5. Annex 5: Photos