

## ETHNIC MINORITY PLANNING FRAMEWORK

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



## Abbreviations

<b>PC</b>	People's Committee
<b>HelpAge</b>	HelpAge International
<b>HAIV</b>	HelpAge International in Vietnam
<b>VAE</b>	Vietnam Association for the Elderly
<b>EM</b>	Ethnic Minorities
<b>EMPF</b>	Ethnic Minority Planning Framework
<b>EMDP</b>	Ethnic Minority Development Plan
<b>GRM</b>	Grievance Redress Mechanism
<b>FGD</b>	Focus Group Discussion
<b>PT</b>	Project Team
<b>PPMTs</b>	Provincial Project Management Teams
<b>IGA</b>	Income Generating Activities
<b>SA</b>	Social assessment
<b>WB</b>	World Bank
<b>GBV</b>	Gender Based Violent
<b>CDD</b>	Community Driven Development
<b>CBDRR &amp;CC</b>	Community-based Disaster Risk Reduction and Climatic Change
<b>PWD</b>	Person with Disability
<b>AE</b>	Association for the Elderly
<b>ISHC</b>	Intergenerational Self-help Clubs
<b>CMB</b>	Club Management Boards
<b>M&amp;E</b>	Monitoring and Evaluation
<b>NCD</b>	Non-Communication Disease
<b>ADLs</b>	Activity for Daily Living
<b>IADLs</b>	Instrument for Activity for Daily Living
<b>DOH</b>	Department of Health
<b>DOLISA</b>	Department of Labor, Invalid and Social Affair
<b>MOH</b>	Ministry of Health
<b>CHS</b>	Commune Health Station
<b>HI</b>	Health Insurance

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## I. INTRODUCTION

### The project background

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)<sup>1</sup>, 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<sup>2</sup>.

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)<sup>3</sup>, while stunting prevalence fell from 61 percent to 24.2 percent<sup>4</sup>. 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 from

11.39 percent to 63.1 percent<sup>5</sup>. 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)<sup>6</sup>, 77 percent of the rural population had access to improved sanitation facilities (compared to 33.8 percent in 1993)<sup>7</sup>, and 69.9 percent of the rural population had access to clean water (up from 62.9 percent in 1996)<sup>8</sup>. Access to all of these services in urban areas is well above 90 percent.

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<sup>1</sup> World Bank. 2019. World Development Indicators 2019

<sup>2</sup> Ibid

<sup>3</sup> United Nations Inter-Agency Group for Child Mortality Estimation 2018

<sup>4</sup> GSO of Vietnam. 2017. Statistical Yearbook. Hanoi: Statistical Publishing House

<sup>5</sup> Vietnam Living Standards Survey 1992–1993; Vietnam Household Living Standards Survey (VHLSS) 2014

<sup>6</sup> Vietnam Living Standards Survey 1992–1993; VHLSS 2016

<sup>7</sup> World Bank. 2018. Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam. Washington

<sup>8</sup> 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](https://www.wssinfo.org/documents/?tx_displaycontroller[type]=country_files)

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)<sup>9</sup>, but the high and widening sex ratio at birth (115 in 2018)<sup>10</sup> shows that fundamental gender discrimination persists. The 2018 Human Development Index ranked Vietnam at 116 out of 189 countries, in the ‘medium’ category with a score of 0.694<sup>11</sup>, 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)<sup>12</sup>.

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<sup>13</sup>. 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)<sup>14</sup>. 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<sup>15</sup>; environmental sources of vulnerability (such as climate change, natural disasters, and unsustainable exploitation of natural resources); rising fiscal pressures, including a growing fiscal deficit<sup>16</sup> 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<sup>17</sup>.

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<sup>9</sup> Vietnam Labor and Employment Survey 2018 (quarter 2)

<sup>10</sup> GSO 2018. Socioeconomic Situation 2018

<sup>11</sup> 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](http://hdr.undp.org/sites/default/files/2018_human_development_statistical_update.pdf).

<sup>12</sup> World Bank. 2018. The Human Capital Project

<sup>13</sup> GSO and United Nations Population Fund (UNFPA). 2016. Population Projections for the Period 2014–2049. Hanoi: Thong Tan Publishing House

<sup>14</sup> World Bank. 2019. World Development Indicators 2019

<sup>15</sup> World Bank. 2018. Climbing the Ladder: Poverty Reduction and Shared Prosperity in Vietnam. Washington, DC: World Bank

<sup>16</sup> The fiscal deficit averaged 5.6 percent of GDP during 2011–2015 and 2.2 percent of GDP during 2006–2010

<sup>17</sup> World Bank Group and Ministry of Planning and Investment (MPI). 2016. Vietnam 2035: Toward Prosperity, Creativity, Equity and Democracy. Washington, D.C: World Bank

## 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.

## Beneficiaries of the project

The project intervention will directly benefit everyone in the 180 target communities, however it will give special focus on targeting people that are poor, ethnic minorities, older people, women and children in vulnerable situations (due to poverty or ill health) in six of Vietnam's 63 provinces. The proposed ISHC model is designed to focus the attention of the community on the neediest people/households (i.e. those in poverty, without proper family support, or facing severe illness and disability), while also providing support to meet the continuum of needs of older persons for livelihoods, health, rehabilitation, assistance with daily living activities, companionship and social inclusion (sports, exercise, social and cultural activities). The project interventions are intergenerational, where young and old are not only beneficiaries of project interventions, but also project contributors by helping others more in need, e.g. through providing assistance with self-help, homecare, resource mobilization, right and entitlement and others. With the largest share of the poorest and older population being women, the project will have a disproportionately positive impact on the well-being of women. The project also has substantial spillover benefits to the beneficiaries' families and the general community in which elderly members live, in the form of support for ensuring livelihoods, assistance with the care-giving burden, and increased knowledge and skills to better care for their frail or sick family/community members living in the target communities.

**Ageing Profiles of the target provinces:** The project will be implemented in around 180 communes in six provinces, with two from each of the three regions of Vietnam, 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, and Khanh Hoa (42.9) and Ninh Thuan (30.9) in the Mekong Delta.

**Table 1 Number of beneficiaries expected to be reached by different types of interventions**

No	Target groups	Expected number	Their needs	The action will address the needs by:
1	ISHC leaders, local partners and commune health staff	1,260	Capacity building	Providing ongoing 5-day TOT training, ongoing capacity building training, networking and regular one to one technical support visit
2	DoH, DoLISA, PC, media, policy makers and others	60	Awareness	Providing ongoing information on the ISHC model and site visit to for local and national service providers and policy makers
3	Older people and people with disabilities	900	Community-based care service	Setup community-based care service in the 180 ISHCs with at least 1,800 homecare volunteers and 180 healthcare providers
4	ISHC members	4,200 households	Income security	Providing revolving funds, regular awareness on age and environmentally friendly livelihood and ongoing technical supports

5	ISHC and community members	117,000	Health Awareness	Conducting quarterly health talks in ISHCs monthly meetings (ISHC members: 9,000); and community health awareness session during community events (36,000) and on the community loudspeakers (72,000)
6		7,200	Physical exercise and sport	Organising regular (at least 3 times per week) physical exercise or sport events in each ISHC and promotion of individual practice
7		7,650	Access to regular health check-up	Monthly health screening and bi-annual health check-up in partnership with Commune Health Stations
		8,100	Access to regular basic health monitoring	Monthly health screening and bi-annual health check-up in partnership with Commune Health Stations
8		8,000	Awareness on right & entitlement	Conducting regular talks and training on Right and Entitlement in each ISHC
9		1,800	Access to legal support	Setting up right and entitlement monitoring system and provide awareness and legal service as needed in each ISHC
10		37,800	Social and cultural	Set up social and cultural group in each ISHCs; monthly activities during monthly club meetings and in other community events
11		4,320 individual cases, while 28,800 people will benefit from the broader community support activities	Self-help	Organising monthly self-help activities in each ISHC to help those in most need and to support the development of the communities, like village clean up and environmental day.

The total expected number of direct beneficiaries of the ISHCs' interventions are 117,000 people across the 180 target communities.

### 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



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. 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 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.

## **The Objectives of an Ethnic Minority Planning Framework**

Bank's ESS7 of the new Environment and Social Framework requires the Borrower/recipient to prepare a time-bound plan, such as an Indigenous Peoples plan (in this project it is Ethnic Minority Development Plan), setting out the measures or actions proposed.

As at this stage, the presence of EM in the project area could not be determined until the project are identified during project implementation, the project owner has to prepare an Ethnic Minority Planning Framework (EMPF). This EMPF provides guidance on how an Ethnic Minority Development Plan (EMDP) for a project should be prepared. It helps, on the basis of consultation with affected EM in the project areas, ensure (a) affected EM peoples receive culturally appropriate social and economic benefits; (b) when there are potential adverse effects on EM, the impacts are identified, avoided, minimized or mitigated.

This EMPF is prepared by HelpAge in accordance with Bank's ESS7. It was developed on the basis of a) social assessment report (conducted during project preparation), b) consultation exercises conducted by HelpAge with the various project stakeholders, and ethnic minorities residing in the project area. This EMPF will be applied to all investments identified during project implementation of the project.

## **II. ETHNIC MINORITIES IN VIETNAM AND IN PROJECT PROVINCES**

### **General information on EM groups in Vietnam**

Vietnam is a multi-ethnic country with 54 different ethnic groups who have formed the language, lifestyle and cultural characteristics of their nation for a long time. The Kinh people (also known as the Viet ethnic group) are the majority group, accounting for 85.3% of the population in the country. According to the 2019 census, the total population of 53 EMs is 14,123,255 people, accounting for 14.7% of the population in the country. Among the EMs in Viet Nam, the majority live in low lands and high mountains in the North and Central Highlands, with 56.2% in the North midland and mountains, 37.7% in Central Highland, 10.3% in the North Central region and Central coastal region, and less than 8% in other areas.

Some EM groups have a population of over one million people, such as Tay, Thai, Muong, Khmer, and Hmong. As many as 14 EM groups have a population of over 100,000 people; 34 EM groups have a population of less than 100,000, of which 16 EM groups have a population of less than 10,000 and five have less than 1,000 people, such as Si La, Pu Peo, Brau, Ro Mam, and O du. EM groups, especially those with small populations, mostly live in the mountainous and highlands areas with very limited access to infrastructure, health care and education (World Bank, 2009; Phung & Do, 2014). Despite rapid economic growth in recent decades, poverty remains prevalent and high in mountainous and highlands areas where many EM groups live. While EMs in total account for 14% of the total population, they also account for as high as 50% of the total poor population (World Bank, 2013). In order to raise income level, reduce poverty and improve access to basic services for EMs, the Government has implemented the National Target Programme on Sustainable Poverty Reduction (2012-2015). In addition, many international organizations have implemented programs and projects to support EM people. These support programs are, however, unable to eradicate chronic poverty, which remains prevail. Housing, hygiene and clean water conditions of EMs are generally much worse than those of Kinh and other relatively large ethnic groups.

One of the barriers to accessing health care services for EM groups is their customs and limited awareness of health care practices. On the other hand, the infrastructure and quality of primary care services at the grassroots level are poor. According to MoH's assessment of the quality of medical examination and treatment services at the grassroots level, although Viet Nam has gained some achievements in older people care after 30 years of the renovation process, the inequalities in the health outcomes in EM ethnic minorities areas are still very different from those of the majority population. According to MoH's statistics in 2014, the grassroots health network in the northern

mountains was facing many difficulties. Out of more than 2,560 CHSs, 78 are housed in temporary houses; over 2,200 CHSs have been degraded. The percentage of doctors working at CHSs was lower than that in the lowlands. To improve the quality of grassroots health services for mountainous areas to meet health care needs of EM communities is one of the key priorities of the sector health. According to 53 ethnic minorities survey (2015), literacy rate among EMs remains low, with some ethnic groups in which more than half of the population are illiterate. The literacy rate of men is higher than that of women in all EM groups, although the differences vary among the groups (86.3% for males compared to 73.4% for females). Though there is no data available on literacy rate among EM older people, it is observed that the illiteracy rate among older people is higher. Data on 53 ethnic minorities survey (2015) also shows that EMs have lower life expectancies, higher child mortality, lower average incomes, more difficulties accessing social services such as health care, education, and infrastructure, higher poverty and near-poverty rates, more disadvantages for women, etc. Most EMs have not yet met SDG, including ethnic groups which are considered to be the most developed. In particular, some indicators are far behind and are difficult to achieve. Language barriers, customs, poor infrastructure, unfavourable natural conditions, small area of arable land and divided terrain as some of the reasons for the shortcomings.

### Ethnic minorities in project provinces

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. For more information, please see below table.

**Desktop data demographic of the six target provinces as of 2018  
(Provincial GSO, PC and AE data)**

#	Description	Province						TOTAL
		Hoa Binh	Thanh Hoa	Da Nang	Quang Binh	Khanh Hoa	Ninh Thuan	
<b>A</b>	<b>General information</b>							
<b>A1</b>	<b>Region</b>	<b>North West</b>	<b>North Central</b>	<b>Central</b>	<b>North Central</b>	<b>South Central</b>	<b>South Central</b>	
A2	Population	832,543	3,600,000	1,215,000	936,607	1,326,500	608,000	<b>8,518,650</b>
<b>A3</b>	<b>% of OP</b>	10.9	12.5	9.2	11.2	9.3	8.5	<b>10.9%</b>
A4	# of OP	90,747	450,000	111,780	104,900	123,365	51,680	<b>932,472</b>
<b>A5</b>	<b># of District</b>	11	27	8	8	8	7	<b>69</b>
A6	# of ward/commune	210	635	56	159	137	65	<b>1,262</b>
A8	% of EM	69.40%	18.60%	0.50%	2.70%	5.70%	23.10%	<b>17.5%</b>
<b>A9</b>	<b># of EM</b>	577,785	669,600	6,075	25,288	75,611	140,448	<b>1,494,807</b>
<b>A10</b>	<b>EM groups</b>	Muong, Thai, Tay & Dao	Muong, Thai, Tho, Dao & H'mong	Co-tu & Tay	Bru-Vân Kiêu, Chút & Tày	Raglai, Hoa, Koho	Chăm, Ra Glai, Cơ Ho, Hoa	<b>13 EM groups</b>

### III. THE LEGAL AND POLICY FRAMEWORK

This section describes a legal framework for ensuring that the affected ethnic minorities (equivalent to the indigenous peoples as defined in ESS7) have equal opportunities to share the project benefits, that free, prior and informed consultation will be conducted to ensure their broad-based community access and support to the project are obtained, and that any potential negative impacts are properly mitigated and the framework will be applied to all the projects. It provides guidance on how to conduct preliminary screening of ethnic minorities, social assessments, and identification of mitigation measures given due consideration to consultation, grievance redress, gender issues, and monitoring. An outline of the EMDP report is provided in Annex 1.

#### **Key legislative documents relating to ethnic minorities**

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

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

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

In terms of the national legal framework, equality and rights of ethnic people was stipulated clearly in the Vietnam Law. Article 5 in the Vietnam Constitution (1992) is as follows: the Socialist Republic of Vietnam is a united nation having many nationalities. The State implements a policy of equality and unity and supports the cultures of all nationalities and prohibits discrimination and separation. Each nationality has the right to use its own language and characters to preserve their culture and to improve its own traditions and customs. The State carries out a policy to develop thoroughly and gradually improve the quality of life of ethnic minorities in Vietnam physically and culturally.

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

- To implement the EM policy on the principles of equality, solidarity, respect and mutual assistance for development;
- To assure and implement the policy on comprehensive development and gradual improvement of material and spiritual life for EM people;
- To assure preservation of the language, scripts and identity, and promotion of fine customs, habits, traditions and culture, of each EM group; and

- An EM group shall respect customs and habits of other groups, contributing to building an advanced Vietnamese culture deeply imbued with the national identity.

The document of the Government on the local democracy and citizen participation is directly related to EMPF. Ordinance No. 34/2007/PL-UBTVQH11 dated April 20th, 2007 of the Standing Committee of the National Assembly, of the 11<sup>th</sup> National Assembly on exercise of democracy in communes, wards and townships had provided the basis for the participation of the community in preparing the development plans and the supervision of community in Vietnam. Decision No.80/2005/QĐ-TTg of the Prime Minister dated April 18th, 2005 on investment supervision by the community.

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

The Government's Decision No.135/1998/QĐ-TTg, dated July 31st, 1998 approved "*The socio-economic development programme for the extremely difficult mountainous and remote communes*". Accordingly, those people who live in the extremely difficult area in mountainous and remote areas will receive adequate support in health examination and treatment.

Resolution No. 18/2008/QH12, issued by the National Assembly, stipulated the acceleration of the performance of socialization policies and laws to promote the quality of health care service for the people. The National Assembly made a directive to increase the rate of annual budget expenses for health care, ensuring that the rate of increase of expenses for health care is higher than the average expense increase of the national budget. At least 30% of the health budget should be spent on preventive health. It also includes a budget line for health care for the poor, farmers, EM groups and the people in the regions with difficult and extremely difficult socio-economic conditions.

On October 15th, 2002, the Government enacted Decision No.139/QĐ-TTg on "*health check-up and treatment for the poor*" applicable to all people who are the poor and who live in extremely difficult regions under Program 135, and EM groups. They will be entitled to free health check-up and treatment. The fund of this program will come from national and local budgets (accounting for 75%) and organizations and individuals's contributions.

Thank to enforcement of Decision 139, health care for the poor and EM peoples has been greatly improved. Relevant provinces established funds for check-up and treatment for the poor. In extremely difficult provinces in the North Central Region, due to a high rate of EM people and people living in the areas under Program 135, the number of beneficiaries of Policy 139 is high. As the performance of health check-up and treatment for the poor has improved, the number of patients visiting health facilities has been increasing significantly. This becomes a great challenge for poor provinces in the North Central Region because of limited state budgets in the context of increasing demand for health check-up and treatment from the poor in the region.

Decision 139 has significantly improved healthcare conditions for the poor, especially those in mountainous areas and from EM groups. However, access to health care services of the poor and EM groups in the Northern Central Region is still difficult. The poor cannot go to health care facilities because they cannot afford transport costs or caring costs for patient, or they cannot access modern health care services at central and provincial health care establishments. Meanwhile, at the district level, medical equipment and facilities are inadequate, and human resources are not satisfactory in both quantity and quality to provide adequate examination and treatment for local people in general, and for the poor, older people and EM people in particular.

The Vietnamese Government has made considerable efforts to improve access to health care services for poor EMs and people in EM areas including older people. Health care policies have been comprehensive, covering health care infrastructure, human resources, education, and communication (to raise awareness of preventive health), and provision of insurance cards.

In his Decision No. 122/QĐ-TTg, dated January 10, 2013, the Prime Minister approved the National Strategy for Protection, Care and Improvement of Public Health for the 2011- 2020 Period, with Vision

to 2030. The Strategy states the objective to “ensure that all people, especially the poor, EMs, under-six children, people entitled to preferential treatment, people living in disadvantaged and remote areas and vulnerable groups can access to quality basic healthcare services”.

In her Decision 7618/QĐ-BYT, dated 30 Dec, 2016, the health Minister approved Health care Project for older people, period 2017-2025 in all 63 provinces/cities, of which the priority will be given the those in far and remote areas and having EMs.

Resolution No. 20/NQ-TW, dated October 25, 2017, issued by the Central Party Committee, 12<sup>th</sup> tenure, stipulated the strengthening of the protection, care and improvement of public health in the new situation. Under this resolution, one of the tasks to renovate grassroots healthcare service is to deliver activities to prevent and combat non-communicable diseases (NCDs), with due attention to preventive healthcare and capacity building for screening and early detection and control of diseases as well as strengthened management and treatment of NCDs, chronic diseases and long-term care at the grassroots level.

### **3.3 The policies relating to poverty reduction for EM and mountainous areas:**

The most prominent program is the socio-economic development program for the most vulnerable communes in ethnic minority and mountainous areas, also shortly referred to as the 135 program, which is approved by Decision No.135/1998/QĐ-TTg of July 31,1998. For the first 2 phases, the program's target is to: 1) Promote production and increase living – standard for ethnic minority households; 2) Develop infrastructure and develop public essential public service in the localities such as electricity, schools, health clinics, small irrigation system, roads, clean water providing systems; and 3) Enhance the people's awareness for better living standards and quality of life; For the 3<sup>rd</sup> phase, the program consists of three main components, namely: (a) support for infrastructure investments; (b) support for production development and livelihood diversification; and (c) strengthening the capacity for community and grassroots-level officers.

Another important program is Program 30a, focused on 64 poor and 23 near-poor districts and coastal areas with specific sub-components in district infrastructure, coastal infrastructure, production development and labor export, aiming to improve the living conditions of ethnic minorities

A part from these, there are program 132 and 134 which targeted mainly at the Central Highlands to increase access to land and improve housing conditions.

These programs and policies have increased the opportunities for poor households to secure the benefits of economic growth, resulting in improve living standards and increased chances to escape to poverty. Such programs impact many facets of households, including infrastructure investment (roads, irrigation, schools, health clinics, electricity), capacity building, skills upgrading, ensuring access to basic social services such as clean water and latrines, health services, primary and secondary enrolment. However, due to ageism, the older people are hard to access to this preferential credit, and thus, according to the AE, the poverty rate among EM older people is still high.

### **3.4 The World bank’s policy toward the ethnic minorities (ESS7)**

The WB’s “Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities,”(ESS7) aims to ensure that Indigenous Peoples (in this project it is EM) present in, or with collective attachment to, the project area are fully consulted about, and have opportunities to actively participate in, project design and the determination of project implementation arrangements. The policy objectives, among others, are: (a) To ensure that the development process fosters full respect for the human rights, dignity, aspirations, identity, culture, and natural resource based livelihoods of EM; (b) To avoid adverse impacts of projects on EM, or when avoidance is not possible, to minimize, mitigate and/or compensate for such impacts; (c) To promote sustainable development benefits and opportunities for EM in a manner that is accessible, culturally appropriate and inclusive;

(d) To improve project design and promote local support by establishing and maintaining an ongoing relationship based on meaningful consultation with the EM affected by a project throughout the project's life cycle, and (e) To recognize, respect and preserve the culture, knowledge, and practices of EM, and to provide them with an opportunity to adapt to changing conditions in a manner and in a timeframe acceptable to them.

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

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

### **3.5 Consultation and participation of EMs people at each stage of the project**

This section provides a framework for ensuring that the affected EMs (equivalent to the indigenous peoples as defined in ESS7) has equal opportunity to share the project benefits, that free, prior and informed consultation will be conducted to ensure their broad-based community access and support to the project are obtained, and that any potential negative impacts are properly mitigated and the framework will be applied to all the projects. It provides guidance on how to conduct preliminary screening of EMs, and identification of mitigation measures given due consideration to consultation, grievance redress, gender-sensitivities, and monitoring. An outline of the EMDP is provided in Annex One.

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

- (a) EM and the community they belong to are consulted at each stage of project preparation and implementation,
- (b) Socially and culturally appropriate consultation methods will be used when consulting EM communities. During the consultation, special attention will be given to the concerns of EM young and older people, especially women and their access to development opportunities and benefits; and
- (c) Affected EM and their communities are provided, in a culturally appropriate manner at each stage of project preparation and implementation, with all relevant project information (including information on potential adverse effects that the project may have on them).

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

The process of consultation should be two-way, i.e. both informing and discussing as well as both listening and responding. All consultations should be conducted in good faith and in an atmosphere free of intimidation or coercion, i.e. without the presence of those people who may be intimidating to respondents. It should also be implemented with gender inclusive and responsive approaches, tailored



to the needs of disadvantaged and vulnerable ones in EM groups, especially older people, enabling incorporation of all relevant views of affected people and other stakeholders into decision making.

#### IV. INITIAL CONSULTATIONS AND SOCIAL ASSESSMENT

**Objectives of the SA.** In the context of the Bank’s ESS7, SA is a study that aims to explore how planned project activities under a Bank financed project would affect the life of poor and disadvantaged people in the target communities, such as the poor, OP, women, EM and PWD present in the project areas. The purpose of the SA is to ensure if there is any potential adverse impact as a result of the project, appropriate measures are in place (in advance of project implementation) to avoid, mitigate, minimize such potential adverse impacts for affected population, if unavoidable. The SA also aims to explore, based on the understanding of local cultural, socio-economic characteristics of the target communities, possible development activities that the project can implement (in relation to the project goal/objectives) to ensure the poor, OP, Women, EMs and PWD in the project area receives socio-economic benefits that are culturally appropriate to them.

Between August to November 2019 January, some initial consultations and social assessment were conducted in project provinces, both with people and relevant provincial departments including DOH, DOLISA and AE including those in Hoa Binh province - the provinces that has the highest rate of EM among the 6 project provinces . Among the consultations, there was an exercise conducted in Thanh Hoa, Hoa Binh and Khanh Hoa to understand types of social, economic, health and care needs, prioritizing those needs and find any gaps between the Kinh and EM groups, Male and Female groups and between Female Kinh and Female EM groups. Relevant information has also been collected regarding demographics of target provinces, socio-economic status and prioritizing the top twenty highest needs for old and near old in the target provinces were also collected. A part from consultations with provincial agencies, a total of 167 community representatives (OP, Women, and EM) were consulted. 35.9% of the respondents were from EM groups and of which 72.2% of EM respondents were female EM.

#### Respondent detail: During the need and priority assessment

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
<b>Total</b>		<b>167</b>	<b>56</b>	<b>111</b>	<b>60</b>	<b>17</b>	<b>43</b>	<b>107</b>	<b>60</b>
<b>%</b>		<b>100.0%</b>	<b>33.5%</b>	<b>66.5%</b>	<b>100%</b>	<b>28%</b>	<b>72%</b>	<b>64.1%</b>	<b>35.9%</b>

#### Main findings of the initial consultations and SA.

The findings of the initial consultations and SA in the target provinces and EM area show that generally, the project will bring positive benefits in social, economic, health and care aspects to the local people in the EM project sites, especially poor and disadvantaged people. The SA demonstrates the broad support to the project benefits from various stakeholders and communities, including those from the EM groups. Following are the main findings:

- **Respondents value the important role of ISHC in having very wide range of community-led interventions that would meet the needs of their communities,** especially older people,

women and people with disability, such as on social and cultural, income security, health living, health, care, right and entitlement, resource mobilization and life-long learning.

- **As ISHC is the community led organization, all the activities will be designed by the local people responding to their needs and relevant to their local context. What the respondents like most is these multi-functional ISHCs are in their own villages**, very near to their house so there is no distance problem. Also, all the ISHC activities are designed by the club management board members, most of whom are senior older people in the community, in agreement with the club members, so they find it is easy for them to participate in, as the board members will use their own local language, they understand the local customs and practices and therefore there are no barriers. **They said that they have strong confidence that if the project is implemented in their provinces that the people and authorities would warmly welcome and support project initiatives.** In addition, they also confirmed that they are ready to contribute at least 15,000,000 VND (equivalent to more than 600 USD) per each community, totally about 100,000 USD co-funding requirement (of all 180 ISHCs) of the ISHC self-managed revolving loan fund. **The EM respondents also said that if the ISHCs can link/partner with commune health stations to provide health check-up and provide self-care awareness and basic health screening for them in their village it would be very good.** Though there is medical doctor in the commune health center, but in many cases the center is very far from their house (6 km for example in the village that the team consulted), thus it is very difficult for them, especially older people, to travel there for regular basic health screening or consultation, in the context that most of them do not travel by motorbike and depends on their children to take them there. Thus, if the club management boards members can be trained on how to measure blood pressure or monitor weight, as well as simple health and care topics to provide this knowledge back to the people than it would be great as the EM older people health and care knowledge is very limited. Or if the ISHC can use the retired doctors or village health volunteers or anyone having health background to be in the CMB to be in charge of club health and care activities, then the people will be benefited greatly.
- **The respondents also want to have basic vital signs (blood pressure, weight) monitored regularly by the ISHCs and commune health center, based on the results they want to receive medication and advice including appropriate diet from health professional.** Experience from existing ISHCs in EM areas show that the CMB, being trained, can do basic health monitoring properly, and can refer the cases of abnormal results to the CHS for further examination. In addition, they want to have periodical health check organized jointly by ISHCs and CHS, as this would reduce their waiting time, (as the club will be in charge of inviting the members to come and do all the arrangement while the CHS will be in charge of professional part including the check up and consultation). However, they expressed that as there is only one medical doctor in the CHS, it is a need to invite doctor from district and/or provincial level to come and support to reduce the waiting time more and ensure the quality. T
- **There is a need for joint planning between health sector, local AE and ISHCs and some financial support for health check up to provide better benefits for EM people.** The leader from Hoa Binh Health Department shared that to organize the health check-up for older people, they need at least 5 people, so only CHS alone cannot manage. To invite people from district or provincial level to come, there should be budget to cover some of their travel and equipment cost. Also these joint activities should be discussed between local AE and health sector to be put in the annual plan of the health department. **In term of social care, there is almost nothing provided in the community for home bound and bed bound older people, except some voluntary, irregular and unorganized home care services, as the practice in the good neighborhood.** Very common that in each of EM villages, there are about 4-5 home bound and bed bound older people, most of them are older women. Most of the care will be provided by their family members who lack of care knowledge and skills. The situation is more difficult when the older people live alone. **In term of income, many correspondents reported they have the need to borrow small loans from ISHCs.** While asking why they have not

accessed to the government loan provided by the bank/mass organization like Women's Union or Farmers' Union, the common response is that these channels have either complicated paper works (for older people), or too big amount (older people just want to borrow some hundreds USD to invest in simple planting and husbandry), and many reported that they are hard to access to the loans due to ageism. In some cases, older women are not confident to borrow due to their low self-esteem and/or lack of age friendly income generating activities. Also, they wish to receive information and techniques about the age friendly techniques how to improve their income generating activities.

To address the above, the project will have various components on ISHC establishment and capacity building, health and social care and livelihood/income security to enable the ISHCs to provide community based health and social care services as well as small loans together with access to age friendly income generating activities information and techniques for their members in need.

**Ranking of Priority of Need of the Poor, Older People, Women and PWD with respect to Kinh and EM groups and how the project will address**

No	Areas of Need	Total		Kinh		EM		Variance		Mitigation: Inclusion of identified needs in ISHC interventions
		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	Gender Based Violent	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
	<b>Average score</b>		<b>6.96</b>		<b>6.96</b>		<b>7.05</b>		<b>0.09</b>	EM in general had a little higher need than Kinh group
	<b>Number of Respondent</b>	<b>169</b>	<b>100%</b>	<b>107</b>	<b>63.3%</b>	<b>60</b>	<b>35.5%</b>			35.5% of the respondents were from EM groups.

Scoring: 10 high need, 1 low need

#### Ranking of Priority of Need of Poor, Older People, Women and PWD with respect to EM men and EM Women

No	Areas of Need	EM Total		EM M		EM W		Variance		Mitigation: Inclusion of identify needs include in ISHC 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	Gender-based violent	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
	<b>Average score</b>		<b>7.05</b>		<b>6.24</b>		<b>7.37</b>		<b>1.13</b>	Female EM W had much in much higher needs than EM Male EM
	<b>Number of Respondent</b>	<b>60</b>	<b>100%</b>	<b>17</b>	28.3%	<b>43</b>	71.7%			71.7% of the EM group respondents were female.

Scoring: 10 high need, 1 low need

## V. PROCEDURES TO IDENTIFY EM COMMUNITIES AND NECESSITY FOR EMDP

*The following are the procedure taken to identify EM communities*

- The project will develop guideline on the project community selection criteria
- Based on the guideline, the provincial AE will work with district AEs to come up with a tentative short list of potential project communes, based on their local knowledge and or after consultation with relevant stakeholders, including the Committee for Ethnic Minorities Affairs (CEMA), if there are EM communes.
- Orientation meeting(s) will be conducted for the potential communes and district AEs to fully understand the project model and requirement.
- After the orientation meeting(s), if still interested in joining the project, the potential commune AE then will have consultation with the commune authority to identify the community in the project commune that can meet the selection criteria.
- The commune AE, in collaboration with village AE, will have some consultation with EM older people representative and community leaders to introduce the project model and requirement, to see whether they are interested in, if yes, what are their concerns and preferences, and to verify whether they meet the selection criteria.

### ***Necessity of EMDP***

As the selected EM communities might have different social economic situation, it is important to develop the EMDP to have a better understanding about the communities, identify any potential impacts, both positive and negative to the beneficiaries and their preferences. Based on this information the project will come up with the plan of actions to ensure that the target population can receive social and economic benefits that culturally appropriate to them.

## VI. PREPARATION OF AN EMDP

An EMDP should be developed on the basis of consultation with EMs in the project areas. Consultation is important to preparation of an EMDP since it provides EMs groups (both potentially affected and not affected by projects) with opportunities to participate in planning and implementation of projects. More importantly, it helps identify potential adverse impacts, if any, as a result of project, on EMs groups, thereby enabling devising of appropriate measures as to how adverse impacts could be avoided, minimized, and mitigated. Consultation also aims to ensure EMs people, especially older

people, have opportunities to articulate, on the basis of their understanding of project/ project objectives, their needs for support from the project in relation to the project goal/project activities. The whole exercise of developing an EMDP is grounded on a study that is referred to, in the Bank-funded projects, as a Social Assessment (SA).

### 6.1 Methodology for preparing an EMDP

To prepare an EMDP, consultations will be conducted with various stakeholders mainly at the local levels in the project provinces having a good number of EM population, specifically Hoa Binh, Ninh Thuan and Thanh Hoa. A number of conventional qualitative research instruments are employed, including focus group discussions, in-depth interviews, note-taking, and photographing, and non-participant observation.

- **Focus group discussions (FGDs):** Each FGD includes 5-7 participants who are recommended and invited by local guides following the requirements of the project team (PT) study team. Gender-disaggregated data are paid attention through the establishment of gender sensitive FGDs. Local guides are the chiefs of the selected villages or AE who have a very good understanding of the community. In order to understand likely different impacts and their responses to the project, a variety of respondent groups are selected, including administrators from Local and VAE at provincial, district, commune and village levels and target beneficiaries at community level including local poor/near-poor, other disadvantaged groups and representatives from local OP, EM, and Women groups.
- **Consultation with local partners:** The study team may organize consultations with local AE partners. The local partners are selected in two respects: the local AE is representative of their community members and will be involved in the planning, implementation and monitoring of the project intervention at community level.
- **Gathering available information:** Collecting and distilling from existing information at various level, including DEMA, health, DOLISA and AE, where available.

### 6.2 Suggested steps in developing an EMDP

The following steps should be followed by the Project Team (PT), both national, and provincial in each province and their counterpart at district, commune and community levels, to contribute to the development of the EMDP for the project. The PT and PPTs should comply with the suggestion steps for preparing an EMDP for the project.

Step	Implementation plan	Monitoring the implementation
1	<b>EMDP objectives</b> For ensuring: (1) Avoiding, minimizing, mitigating potential negative impacts (if yes) and (2) Receiving the benefits for EM groups that are suitable to their cultures.	Monitor whether community consultation is organized or not.
2	<b>Consultation and Data Collection</b>  The data to be collected can be both quantitative and qualitative regarding: <ul style="list-style-type: none"> <li>• Socio-economic conditions: the population of the selected project sites, the EM populations; economic structures, etc.);</li> <li>• Project beneficiaries preceded needs and prioritizing the needs</li> </ul>	Factors to monitor (whether they are in accordance with the plan)  The data both quantitative and qualitative) collected (whether they are relevant and reliable;

	<p>Secondary data can be collected from organizations and individuals involved: Local People’s Committee, commune health centers and AE.</p> <p>They can collect qualitative data through conventional qualitative methods, such as group discussions, in-depth interviews, observation and photographing. Such direct consultations will be conducted with representatives from local AE at all levels as well as EM older people including women.</p> <p>The team leaders should communicate regularly with a focal point at the central level to report emerging issues, consult necessary issues and report the progress to make the study to be followed. The focal point would provide adequate supervision and guidance to the teams as needed.</p>	<p>any discrepancies found)</p> <p>Methods used to collect the data (whether they are relevant and effective)</p>
3	<p><b>Review and analysis the data:</b></p> <ul style="list-style-type: none"> <li>• Compilation and aggregation of the data from the focus group meetings and participant groups in each location;</li> <li>• Based on this type of aggregation it is possible to begin analyzing patterns in the data according to the frequency with which certain responses occur. This is where triangulation of the responses and recommendations made by different participant groups becomes important. The purpose of this is to identify areas of commonality in which there is a high degree of consensus and also areas in which there are major differences of opinion between one or more groups</li> <li>• Iterative analysis of the data and in-depth knowledge of the local situation is required to interpret and assess the relevance and implications of this type of information; and</li> <li>• It is important to verify the findings and the main conclusions with participants and other stakeholders, where possible, to ensure that the analysis has not somehow drifted away from what people were trying to say.</li> </ul> <p>Some data should be tabulated properly and placed either in the main text or annexes, whichever is more relevant depending on the specific report structure of each province.</p>	<p>The approaches employed to analyze the collected data (whether they are relevant and effective; identify any constraints)</p>

4	<p>Based on the data collected and findings from public consultation, the study team should determine:</p> <p>(a) The factors from the project activities that may cause potential positive and negative impact (if any) and</p> <p>(b) Assess the needs of the related EMs groups (with clear targets and priority strategy). It is important to prioritize their needs based on the sources (human resources, technology, finance, and institutions) available to the project.</p> <p>On a basis of the identified factors, the team should discuss and propose what specific measures the project can do to avoid, minimize and mitigate the negative impacts, specifying who should do what and how given the available resources.</p>	<p>Check whether beneficiaries and impacts on them have been identified appropriately.</p> <p>Check whether all the existing resources have been sought to address to maximize positive impacts and minimize potential negative impacts.</p> <p>The expectation of beneficiaries and whether the project objectives can be met.</p>
5	<p><b>Writing up an EMDP</b></p> <p>An EMDP should be structured to address the important social safeguards issues relating to the EM groups in the project sites</p> <ul style="list-style-type: none"> <li>• Background information on the project sites and a profile of the related EM groups in the project sites (the related socio-economic and political conditions as well ethnic cultures and customs);</li> <li>• Key activities/mitigation measures that should be implemented locally, as identified on a basis of the assessment of specific needs from the public consultation with the related EM groups in each study site;</li> <li>• Key stakeholders who will implement these activities;</li> <li>• Resources needed (finance and human resources) for these key stakeholders to implement these activities.</li> <li>• A timeframe (frequency) to implement these activities;</li> <li>• An GRM mechanism (in addition to the existing government structure);</li> <li>• An institutional arrangement for implementing the identified activities;</li> <li>• Disclosure of EMDP;</li> </ul>	<p>Determining the implementation plan can be successful or not, and how the - HelpAge senior management team perceive the effectiveness of this plan.</p> <p>The implementation and monitoring plan should be developed with the HelpAge senior management team to make it easier to them to adopt it.</p>
6	<p><b>Meaningfully consult on the EMDP</b></p> <ul style="list-style-type: none"> <li>• The project EMDP will promote meaningfully consult with key stakeholders with local partners and target communities throughout the project implementation with enhance long-term buy-in of the project intervention.</li> <li>• Their feedback will be incorporated into the EMDP (as needed)</li> <li>• Regular monthly monitoring (consultation) with the target communities to ensure meaningful implementation of the EMDP and others project requirement.</li> </ul>	<p>Mainstream/include EMDP in project:</p> <ul style="list-style-type: none"> <li>• reports</li> <li>• project feedback system and</li> <li>• monitoring and technical support activities</li> </ul>

### 6.3 The proposed measures for an EMDP

Based on the initial consultation and social assessment with target community representatives, some



possible measures in the EMDP, or integrated into the EMDP may include:

- a) Develop a communication strategy to raise awareness among EM communities in general and women in particular about the Intergenerational Self-help Club development model.
  - Implement communication activities to raise awareness of EM communities about ISHC model including its objective, activities, as well as the various benefits from joining and supporting ISHC in their communities as well as obligations.
  - It is important to use spoken languages that are close and relevant to the culture and cognitive ability of EM communities and people; avoid the use of many documents and documents on paper. In addition, communication activities should be conducted in places that people visit on certain occasions, such as village community cultural houses. Communication activities should also be utilized and integrated in local events.
  - Involving senior village elders club management boards in life-long learning talks will increase the effectiveness of the communication sessions
- b) Involving senior village elders, half of which will be older women, in the club management boards which will enable the designed club activities relevant to the needs of the club and community members.
- c) Organize monthly life-long learning talks (during ISHC monthly meetings) that will promote greater and long lasting learning and sharing between the ISHC and community members.
  - ISHC should conduct monthly life-long learning for their members. To ensure it is balance with respect to the need of the members these are the recommended number of life-long learning by topics
    - 4 livelihood topics per year
    - 4 health and care topic per years
    - 2 right and entitlement topics per years
    - 2 others topics (CBDRR, CCA, GBV and others)
  - Involving senior village elders club management boards in life-long learning talks will increase the effectiveness of the communication sessions
  - Provide regular ongoing networking and capacity building for CMB and local partners on topics such as trainer faciliation skills, livelihood, health, care, right and entitlement, environmental, gender andGBV, and CBDRR to enable the CMB and local partners to become effective communicators.
  - The training materials should be age friendly (big letter, with pictures to demonstrate...)
- d) ISHCs will be guided to have activities to reach more community members who are not ISHC members, through their activities including health care, self help and community support; right& entitlements, home care, and income generating activities, ect....In addition, each ISHC member will be responsible to share what they have learnt from ISHCs to at least 2 more members.
- e) Gender issues should be paid due attention during the project implementation
  - It is essential to engage women, especially those from the EM groups in the project sites, in various project activities and interventions.
  - Basic health and care needs for and by women (especially EM women) should be tailored to their cultural and ethnic characteristics. Efforts should be made to arrange appropriate venues and times for women's participation, and to promote complementary activities to maximize the participation of women-headed households. The provision of training to local managers and project staff should be gender sensitive.
  - Activities to promote women's confidence and participation will be designed in the ISHC model, such as organizing ISHC members into smaller groups or having cultural performance activity relevant to their culture, to attract and build their confidence.

- Women from various EM groups should be consulted in good faith throughout the project cycle, from the design to the evaluation steps to ensure their voices to be heard and paid due attention to. There is a risk that female attendance at information workshops and meetings may be low. Specific measures may therefore be necessary to enhance women’s current access to information and their benefits from the project’s activities.
  - During the monitoring of the EMDP implementation, the key indicators of gender actions will be monitored and reflected in monitoring reports.
- f) The grievance redress mechanism (GRM): Many EM respondents preferred direct communication, rather than through news letters or help-line service. They trust the role of the village elderly and ISHC and community leaders in settling grievances. Meanwhile, some respondents argued that grievances can be redressed through the ISHC monthly meetings with ISHC members and annual community meetings with local people.
- Organise monthly ISHC meetings in each ISHC
  - Allocate times for ISHC and community members to bring up grievance issues and work together to redress the grievance
  - Set up monthly meeting minutes to ensure the grievance is recorded and follow-up action are taken.

#### **6.4 Procedure for review and approval of an EMDP**

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

### **VII. IMPLEMENTATION OF AN EMDP**

#### **Implementation arrangements**

The PT is in charge of the overall implementation of all EMDPs prepared under the project. The PT will make sure all PPTs understand the objectives of the EMPF and know how to apply it during the project life.

At the HelpAge national level - The HAIV is responsible for providing technical support to PT and PPTs in preparing EMDP for the project. The PT will assign a qualified member of staff to be focal point for ESF issues in the project. S/he will support local stakeholders with preparing materials in implementing EMDP and in monitoring progress. S/he will ensure that EMDP is implemented and delivered as per work plan and quality. At the outset of the project implementation, PT will provide training to its social staff – at national and provincial levels, to enable them to undertake screening (of EM presence in the influence area of the projects) to determine when an EMDP is needed, and on the basis of the screening result, conduct social impact assessment, and prepare EMDP. Where local capacity is insufficient to prepare an EMDP, HelpAge Regional Office may be mobilized to assist PT and PPTs in development an EMDP for the project in accordance with the EMPF.

At provincial level - The PPTs are responsible for implementing the EMDP. Appropriate staff and budget – sufficient to achieve the objective of an EMDP, need to be included in the EMDP for Bank’s prior review and approval, and comments before implementation of the projects for which the EMDP is associated. The Bank may request revision of the EMDP, based on the quality of the EMDP. When

there is doubt or need for technical support in preparing an EMDP, the Bank's task team should be contacted for timely support.

The PT, with technical support from HAIV, would coordinate with Provincial AE/PPTs which would provide support in the implementation and monitoring the implementation process of EMDP. Provincial AE/PPT would provide guidance to district, commune AEs and Club Management Boards (CMB) in the implementation and monitoring the implementation of EMDP.

### **Disclosure of EMDPs**

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

Please note that the EMDP prepared must be disclosed locally in a timely manner, before the implementation of any of activities for which the EMDP is associated for. The EMDP need to be disclosed in an accessible place and in a form and language understandable to affected EMs as well as key stakeholders and at the Bank's Portal.

### **Grievance Redress Mechanism (GRM).**

If a affected EM person or group who are not satisfied with the process, resolutions, or any other issues of the ISHCs/project, they can raise their concerns. There are some options for them to do so, depending on which one is more culturally relevant or appropriate for them.

**First, raise their concerns/queries to the Club Management Boards (CMB):** As the ISHC is a Community Driven Development (CDD) model where local people will identify needs and problems, as well as plan, implement, monitor and evaluate their own activities, so the CMB will be trained/empowered to receive the queries and address them by themselves, in consultation and agreement with their members. The proposed steps for this option are: 1) The ISHCs, led by CMB, will set up the GRM at the club level, either in the form of a comment box to be placed at the ISHC monthly meeting venue, and/or allocation of time during the monthly club meetings and annual club review meetings for the members to raise their queries/comments if any and address them; 2) Once the CMB receive a complaint, they will verify it if needed, and raise this in the club meetings, and discuss with the club members to address it. If the complainant is satisfied with the ISHC response, the complaint is closed here. The case will be recorded in the ISHC meeting note and reported in the ISHC monthly report to provincial AE/PT. In case the complainant is not satisfied with the ISHC response, he/she can raise it to the village/commune/district AE, as described in the below second option.

**Second, raise their concerns/queries to village/commune/district AE:** The complainant can raise their complaint to the local AE at various levels. In this case the local AE will verify the information, and together with the ISHC to address it (as in the 1<sup>st</sup> option). If the complainant is satisfied with the local AE response, the complaint is closed here. The case will be recorded in the ISHC meeting note and/or reported in the ISHC monthly report to provincial AE/PT. In case the complainant is not satisfied with the local AE response, he/she can raise it to the provincial AE/PPT, as described in the below third option.

**Third, raise their concerns/queries to provincial AE/PPT or national PT/HAIV:** Below is the proposed procedures:

If any one from EM group or any stakeholder affected by the project has a serious concern and query relating the project management and implementation: **Submit complaints**

### Choose who

- **HAIV:**
  - + PM: name, email, tel
  - + Other PT members (name, email, phone)
- **Provincial AE and local AE in project site**
- + provincial AE: ...
- + district AE: ....
- + commune AE
- + village AE...
- **Club Management Board Chair** (name, phone)

### Choose how

- Electronically (fill in forms in website)
  - Writing (E-mail) using the form preferably
  - Phone
  - In person (filling the form preferably)
- Provide personal information and contact details so that we can follow up with you. Provide details of the complaint as much as possible, with any evidence/all copies of documents which may support the complaint

### Receive Complaints by project GRM staff – give acknowledgement

- **For writing complaint (email or electronic):** Give the complainant a receipt or a confirmation email of acknowledgment with a reference number to track the complaint.
- **For verbal complaint:** register the complainant information and details of the complaint into the system, and give the complainant a reference number to track his/her complaint.

### File Complaints and Register Complaints

**GRM Staff: enter the complaint into the GRM Tracking Matrix.** The complaints register records the following information:

- Complaint Reference Number
- Date of receipt of complaint
- Name of complainant
- Confirmation that a complaint is acknowledged
- Brief description of Complaint
- Details of internal and external communication
- Action taken: (Including remedies / determinations / result)
- Date of finalization of complaint (Original documentation must be kept on file).
- Referral and Examination of complaints

### Project response

- Validate the complaint
- Investigate with appropriate urgency
- Come up with any the actions to be taken and any recommendations for corrective measures to avoid possible recurrence.



## Notifying Complainant and Closing the complaint

- **Notifying complainant** of the decision/solution/ action immediately (in writing, or by calling or sending the a text message) about a summary of issues raised and reason for the decision.
- **Closing Complainant:** A complaint is closed in the following cases:
  - Where the decision/solution of complaint is accepted by the complainant, the GRM staff shall close the complaint and sign outcome and date in the Complaint Register.
  - A complaint that is not related to the project or any of its components.
  - A complaint that is being heard by the judiciary.
  - A malicious complaint.

**Additional Dispute Resolution Scheme** Where the complainant is not satisfied with the outcome of his/her complaint, the following procedures shall be considered:



### Internal Dispute Resolution Scheme

Advise the complainants to readdress the issues to HAIV's Country Director (CD) or Finance & Admin Manager (FAM) request a further review or consideration.

+ CD: [thuytb@helpagevn.org](mailto:thuytb@helpagevn.org); 0904006040

+ FAM: [dathq@helpagevn.org](mailto:dathq@helpagevn.org); 0989996750

- Advise the complainants to readdress the issue either to the HelpAge Regional level or HelpAge Headquarter, if the above is not satisfactory to him/her

### External Dispute Resolution Scheme

In case the complainants are not satisfied with the internal procedures for handling complaints, the outcomes of the complaints or for any unhandled complaints, the GRM staff shall provide information on a complainant's right to refer their complaint to the relevant government bodies at provincial, district or commune levels for grievances.

## **VIII. MONITORING AND EVALUATION**

The responsibility for overall monitoring and implementing the EMDPs rests with the PT. In case of necessity, the PT may seek support from HAIV and or Regional HelpAge office for external monitoring of the implementation of EMDP. During monitoring of EMDP implementation, the key indicators, including those of gender actions, will be monitored and reflected in monitoring reports.

## **IX. BUDGET**

The budget for the implementation of EMDP is mainstreamed into the project budget for project activities, such as project regular technical support trips, project orientation meetings, project training, ISHC monthly meeting, project annual meetings... , as well as incorporated in the costs for project HR. When needed, some activities, such as site specific social assessment, can also be conducted by the provincial AE, in collaboration with, or by district and/or commune AE, as appropriate, after being guided/trained by the PT, using the provincial AE own budget, without charging to the project.

## **X. ANNEX ONE: Elements for an EMDP**

### **Executive Summary**

This section describes briefly the *critical facts, significant findings* from the social assessment, and *recommended actions to manage adverse impact (if any) and proposed development intervention activities* on the basis on the social assessment results.

#### **I. Description of the Project**

This section provides a general description of the *project goal, project components, potential adverse impact (if any) at the community and project levels*. Make clear the identified adverse impact, especially at the community level.

#### **II. Legal and institutional framework applicable to EM peoples**

#### **III. Description of the project population, with a focus on information relating to the elderly's life and livelihoods**

- Baseline information on the demographic, social, cultural, and political characteristics of the potentially affected EM population, or EM's communities.
- Types of income generation activities, including income sources
- Annual natural hazards that may affect their livelihood and income earning capacity;
- Community relationship (social capital, kinship, social network...)

#### **IV. Social Impact Assessment**

This section describes:

- **Methods of consultation.**
- **Summary of results.**
  - Potential impact of projects (positive and adverse) on their social and economic life of EM in the project area (both directly and indirectly);
  - Preferences of EM for support (from the project) in development activities intended for them (explored through needs assessment exercise conducted during the social assessment);
  - An action plan of measures to ensure EM in the project area receive social and economic benefits culturally appropriate to them, including, where necessary, measures to enhance the capacity of the local project implementing agencies;
  - Gender issues: to ensure the engagement of both men and women in project activities.

#### **V. Information Disclosure:**

This section will:

- a) describe information disclosure process with the affected EM peoples that was carried out during project preparation;
- b) summarizes their comments on the results of the social impact assessment and identifies concerns raised during consultation and how these have been addressed in project design;

- c) describe consultation and participation mechanisms to be used during implementation to ensure EM peoples' participation during implementation; and
- d) confirm disclosure of the draft and final EMDP to the affected EM communities.

**VI. Capacity Building:** This section provides measures to strengthen the social, legal, and technical capabilities of (a) local AE in addressing EM peoples' issues in the project area; and (b) ISHC Management Boards in the project area to enable them to represent affected EM peoples more effectively.

**VII. GRM:** This section describes the procedures to redress grievances by affected EM peoples. It also explains how the procedures are accessible on a participatory manner to EM peoples and culturally appropriate and gender sensitive.

**VIII. Institutional Arrangement:** This section describes institutional arrangement responsibilities and mechanisms for carrying out the various measures of the EMDP.

**IX. M&E:** This section describes the mechanisms and benchmarks appropriate to the project for monitoring and evaluating the implementation of the EMDP.

**X. Budget and Financing:** This section provides an itemized budget for all activities described in the EMDP