Ethnic Group Development Plan

October 2016

LAO: Greater Mekong Subregion Health Security Project

Prepared by the Ministry of Health for the Asian Development Bank.

CURRENCY EQUIVALENTS

(as of 22 September 2016)

Currency unit	–	kip (KN)
KN1.00	=	$0.00012
$1.00	=	KN8,115.00

ACRONYMS

ADB	–	Asian Development Bank
AIDS	–	Acquired immunodeficiency syndrome
AHI	–	Avian Human Influenza
AOP	–	Annual Operational Plan
APSED	–	Asia-Pacific Strategy for Emerging Diseases
ARI	–	Acute Respiratory Infections
AI	–	Avian Influenza
BCC	–	Behavioral Change Communications
CDC	–	Communicable Diseases Control
CDC1	–	First GMS Regional Communicable Diseases Control Project
CDC2	–	Second GMS Regional Communicable Diseases Control Project
CHADS	–	Center for HIV/AIDS, Dermatology, and STIs
DMF	–	Design and Monitoring Framework
EGDP	–	Ethnic Group Development plan
EHF	–	Ebola Hemorrhagic Fever
EMG		Ethnic Minority Group
GMS	–	Greater Mekong Subregion
HEF	–	Health Equity Funds
HSGP	–	Health Sector Governance Program
HSRF	–	Health Sector Reform Framework
HIV	–	Human Immunodeficiency Virus
HMIS	–	Health Management Information System
IEC	–	Information, Education and Communication
IHR	–	International Health Regulations
IMR	–	Infant Mortality Rate
LECS	–	Lao Economic and Consumption Survey
LNF	–	Lao National Front
LSIS	–	Lao Social Indicator Survey
LWU	–	Lao Women's Union
MDG	–	Millennium Development Goal
MERS	–	Middle-East Respiratory Syndrome
MEV		Migrants, Ethnic and other Vulnerable Groups
M&E	–	Monitoring and Evaluation
MMR	–	Maternal Mortality Ratio
MNCH	–	Maternal, Neonatal and Child Health
MOH	–	Ministry of Health
MOL		Ministry of Labor
MOF	–	Ministry of Finance
MPI	–	Ministry of Planning and Investment
NCAW	–	National Commission for the Advancement of Women

NESDP	–	National Economic and Social Development Plan
NGO	–	Non-governmental Organization
PAM	–	Project Administration Manual
PCR	–	Project Completion Report
PHC	–	Primary Health Care
PMU	–	Project Management Unit
SARS	–	Severe Acute Respiratory Distress Syndrome
SDR	–	Special Drawings Right
SPS	–	Safeguard Policy Statement
U5MR	–	Under-five Mortality Rate
VHV	–	village health volunteer

NOTES

(i) The fiscal year (FY) of the Government of Lao PDR and its agencies ends on 31 December (from 2016 onwards). “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2017 ends on 31 December 2017.

(ii) In this report, "$" refers to US dollars.

CONTENTS

1. EXECUTIVE SUMMARY

1. This Ethnic Group Development Plan summarizes the Lao-specific analysis, strategy, and plan for addressing ethnic group concerns/issues for the GMS Health Security Project based on the Government's and ADB's policy on indigenous peoples as described in the ADB 2009 Safeguard Policy Statement (SPS). The 49 ethnic minority groups (EMGs) recognized by the government make up about 34% of the total population[1]. It is more practical to focus on EMGs[2] that may not have access to services, have higher mortality rates and CDC burden and worse health indicators overall than the general population. In the context of the Project, this ethnic group development plan (EGDP) focuses on the first group, including remote ethnic groups, and internal and external migrants. The challenges of control of infectious diseases of regional relevance in these two subgroups are quite different.

2. The proposed GMS Health Security Project (the Project) for Cambodia, the Lao PDR, Myanmar and Viet Nam aims to improve regional public health security by strengthening health security systems and CDC in border areas, in particular for migrants, youth, and ethnic minorities. Three components or outputs[3] are proposed: (i) improved GMS cooperation and CDC in border areas; (ii) strengthened national disease surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

3. The project will cover a total of 12 provinces in the Lao PDR, in addition to 12 provinces in Cambodia, 36 provinces in Viet Nam, and 5 states and one region in Myanmar. In Lao, about 1.4m people live in targeted project areas, of whom just under 1m are in EMGs. The targeted provinces in the Lao PDR are Bokeo, Luang Namtha, Oudomxay, Phongsali, Houaphanh, Xiengkhouang, Bolikhamxai, Khammouane, Saravane, Sekong, Attapeu, and Champassak. Most of the targeted provinces in the Lao PDR have a large or even predominant ethnic minority population, except Saravane province which however had a large Vietnamese population.

4. According to ADB's 2009 Safeguard Policy Statement (SPS), the Borrower is required to ensure benefits for EMGs affected by the Project. According to the Indigenous Peoples Safeguards Sourcebook[4]:

"*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook*, "IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."*

5. As per the ADB SPS, *"if [ethnic groups] are the sole or the overwhelming majority of direct project beneficiaries and when only positive impacts are identified, the elements of an [EGDP] could be included in the overall project design in lieu of preparing a separate [EGDP]."* While the project is expected to have positive impacts on IPs, they are not the sole or

[1] The Government of Lao PDR doesn't use the term "*indigenous peoples*" but instead uses "*ethnic minority*".
[2] The term "indigenous" is considered inappropriate by some governments as this implies backwardness and excludes recent migrants, so the term "ethnic minority group" (EMG) is preferred. In Lao use the "Ethnic Groups" and will not use the words "minority or Indigenous"
[3] Government uses the term 'components' and ADB uses 'outputs', therefore both terms are used in this IPP
[4] ADB. 2013. *Indigenous Peoples Safeguards: A Planning and Implementation Good Practice Sourcebook (Draft Working Document).* Manila

overwhelming majority of direct project beneficiaries. Furthermore, given the scale and complexity of this regional project, the potential for not achieving certain intended positive impact on ethnic monitories justifies a category B and warrants preparation of this EGDP to help achieve intended impact on EMGs.

6. This EGDP for the Lao PDR summarizes the findings of the assessment and consultation process. No negative impact is foreseen. The major concern is that proposed benefits for minority ethnic groups do not or not fully materialize. Potential shortcomings may related to (i) project relevance and appropriateness for certain ethnic groups, (ii) project efficiency and (iii) sustainability of interventions. In particular for Component 1, CDC in border areas, interventions such as community campaigns should be appropriate for ethnic groups. Surveillance and response systems should also be appropriate given limited community resources. Accessing laboratory services is a major challenge. Improving infection control in hospitals is affected by family care traditions of EMGs. Each of these needs to be mitigated to the extent possible. Sustainability of interaction of communities and health services depends very much on appropriateness of staff and affordability of services, as well as on integration of ethnic group needs in provincial annual plans. Much will depend on the strength of the inclusive planning and monitoring process at central level and in the provinces, and the special efforts needed to reach some groups.

7. It is recommended that MOH collaborate with government organizations outside of MOH, as well as with NGOs which are more actively addressing ethnic group issues. In the Lao PDR, legislation on ethnic minority groups is in place, but implementation remains weak. While health services for EMGs are given high priority, the Government is facing capacity constraints that affect services for EMGs. The Lao PDR also doesn't have a large number of NGOs addressing minority ethnic group issues. However, grass-root organizations like The Lao Women's Union may also be relied upon for social mobilization and village health care development.

8. It is recommended that MOH aim for mainstreaming of EGDP activities in all operations, including routine public health planning, administration, and services, as well as for Project implementation. The EGDP strategy aims to (i) enhance equal opportunity, (ii) target vulnerable groups, and (iii) promote EGDP dimensions in all Project activities. It proposes to maximize benefits for vulnerable groups in border areas who are likely to be at increased risk of infectious diseases, including migrants, HIV infected young people, pregnant women, and isolated ethnic groups. The EGDP (or IPP as it is referred to by ADB in the other GMS countries) is aligned with national contexts, and legislative and policy commitments.

9. Related ADB health projects have shown a steady improvement in EGDP implementation. Project Directors are committed to provide the necessary leadership and inputs to fully implement the EGDP. Key features of the EGP are mirrored in the project Design and Monitoring Framework (DMF), Loan Covenants, and Project Administration Manual (PAM).

10. The project will allocate funds for the implementation of the plan. Activities funded by the project include outreach activities, information education and communication campaigns under output 1. The total budget for those activities is estimated at $$1.6 million. The project will engage a national safeguard specialist 6 person-months to support and monitor the activities in the plan. The safeguard specialist will be hired at the beginning of the project and the activities will be conducted during the whole duration of the project.

2. PROJECT DESCRIPTION

1. GMS leaders are committed to enhance regional health security following outbreaks of emerging infectious diseases (EIDs), notably severe acute respiratory syndrome (SARS) in 2003, and Avian Influenza in 2004. Recent outbreaks of Ebola Hemorrhagic Fever (EHF) in West Africa and Middle-East Respiratory Syndrome (MERS) in South Korea show respectively, how EIDs can get out of control with major human impact, and how a relatively small outbreak in a hospital can have major economic impact. New zoonosis pose a constant threat in the region.

2. Misuse of antibiotics for bacterial infections is causing drug resistance, while new antibiotics are few and expensive. Nosocomial infections in hospitals are increasing due to poor infection prevention and control (IPC). Common infections like Dengue and Cholera show genetic adaptation. Climate change including global warming and frequent flooding may also increase the disease burden of infectious diseases. While the incidence of HIV/AIDS, tuberculosis and malaria have declined following major investments, drug resistant types are also considered EIDs and major threats for the control of these diseases. Childhood infections preventable through immunizations are resurging due to weak vaccination systems. Continued investment will be needed to keep communicable diseases under control.

3. The overarching drivers for GMS control of emerging and re-emerging infectious diseases (EIDs) are the International Health Regulations (IHR, 2005) and the Asia Pacific Strategy for Emerging Diseases (APSED, 2010) and related disease control and health system building strategies of the World Health Organization (WHO). The IHR and APSED strategic areas guide efforts to improve public health security, including surveillance and outbreak response, risk analysis and communication, community preparedness, laboratory services, hospital infection control, and regional cooperation. Other WHO global and regional strategies also guide control efforts, such as for the control of HIV/AIDS, malaria, tuberculosis, dengue, and neglected tropical diseases; strengthening of laboratory services, infection control in hospitals, and the control of fake drugs.

4. The term health security[5] refers to a public health goal of prevention of major epidemics or other disasters with major impact on health and the economy, and is concerned with the health of populations, in contrast to universal health coverage, which is concerned with the right of every individual to affordable, quality health care. Investment in the control of emerging diseases has strong public goods, market failure and equity rationale, in addition to potential economic and political consequences of a major epidemic or pandemic.

5. MOH and WHO have conducted evaluation of APSED implementation in 2015. Lao has not yet achieved IHR and APSED targets. Core functions owned by MOH are well in place, but other functions depending more on collaboration with other countries, sectors, partners, community, and the private sector are less advanced. There is major progress in the control of malaria, less progress in the control of HIV/AIDS, tuberculosis (TB), and dengue, and major emerging concerns of nosocomial infections and multiple drug resistance.

6. Overall, public health security systems for APSED and other significant diseases need to become more mainstreamed, standardized, reliable, and financially sustainable. Second, in view of the increase in communication, urbanization and industrialization, the traditional dependence on a single public health system no longer holds, and MOH will need to strengthen

[5] Health security is achieved through a set of activities, both proactive and reactive, to minimize vulnerability to acute public health events that endanger the collective health of national populations.

its capacity for collaboration with other sectors. Progress in APSED is affected by health system limitations, but these are not clearly identified. Key areas are IT connectivity, basic staff capacity and administrative and management capacity. In general, the private sector is a big unknown in terms of surveillance and response.

7. While there is a high risk of the spread of diseases and drug resistance, surveillance and response systems have not been fully capable of real-time and accurate information, indicating epidemic status at local levels. Several disease reporting systems are in place, but are not linked, do not reach communities, and fail to provide necessary diagnostics and quality public health information to make meaningful decisions in a timely manner. Computerization of data management would allow linkages with clinical services and e-learning. Competent field epidemiologists at provincial level and assistants at district level are few, thereby also limiting the efforts to improve disease control and community prevention and preparedness.

8. One way to address this is through integration of public outreach services, including community health promotion, prevention and outbreak preparedness, active case finding, screening, and, if necessary outbreak response ranging from food poisoning and dengue control to simulation exercises and control of the EIDs. Such packaging of services could make services more efficient and provide tangible staff learning opportunities. Capacity building for control of EIDs and other regional health threats can be combined. Further quality and efficiency improvement can be gained by combining services, such as for combining laboratories in regional hubs; and by improving quality control and audit of public health services, in both public and private sectors.

9. Laboratory services are complex, requiring some 20 subsystems to be in place. In Lao PDR, insufficient effort has gone into strategic planning, human resource development, referral and maintenance systems, quality assurance and audit, and medical-laboratory linkages. Addressing these system gaps will enhance benefits of past investments.

10. Hospitals are the most likely recipients for any emerging disease, and also pose a major concern in terms of spreading these and other diseases. In addition, hospitals are a source of nosocomial infections and drug resistance. Current facilities and practices in health facilities regarding infection prevention and control (IPC) are substandard, in terms of IPC management, staff capacity, facilities (isolation ward, sanitary ware, laundry, medical wears), hygiene practice standards, and practices (handwashing, visitors).

11. Regional cooperation currently consists mainly in the form of ad hoc information exchange and sometimes joint outbreak response, without standard operating procedures and regularity of reporting. Cross-border cooperation is gaining momentum but needs to be integrated as part of regular CDC. In previous projects, knowledge management activities have been quite prominent and have generated technology transfer, staff capacity, leverage, competition and commitment, and monitoring progress; but their potential, e.g. developing disease control strategies, early warning of outbreaks, and joint diseases control, is yet to be fully developed. Regional workshops on health security need to focus more on agreements for action, and follow-up. The regional cooperation unit may need to be strengthened.

12. The proposed Greater Mekong Subregion Health Security Project (the Project) is designed to support regional cooperation and national capacity building for prevention and control of emerging infectious diseases (EIDs) and other diseases of regional importance including malaria, dengue, TB, HIV/AIDS, cholera and nosocomial and drug-resistant infections.

13. The Project builds on the achievements and lessons learned of the Governments of the Greater Mekong Subregion (GMS) and partners in enhancing GMS health security and reducing the burden of communicable diseases. MOH Lao PDR is currently running the CDC2 extension project with support of ADB, and is also implementing the Health Governance Program with support of ADB and the World Bank, and health system development with support of Lux Development. Other major partners in the field of CDC are WHO and other UN agencies.

14. The project will assist with implementation of the Government's drive towards Universal Health Coverage, with complementary Public Health Security. MOH Lao PDR is giving priority to strategic investment for poor border districts with multiple risks of communicable diseases and weaker public health system, especially along borders with China and Viet Nam.

15. The Project aims to expand beyond core APSED capacities to improve strategic areas that have received less attention, in particular to reach communities and hard to each groups in border areas, cooperation and linkages, and improving quality and biosafety of services. The Project will help develop disease prevention and control, especially in poor border districts.

16. The impact will be GMS public health security strengthened. The outcome will be improved GMS health system performance, with regard to health security. The proposed project locations are provinces and districts along the borders and economic corridors. Selection of project provinces is based on (i) economic status of the province; (ii) health and health services statistics; (iii) regional risks and priority clusters; and (iv) existing support from other partners. In Cambodia, the project will cover 13 provinces; in Lao PDR, 12 provinces; in Myanmar, 6 states and regions; and in Viet Nam, 36 provinces. The project outputs will be: (i) improved GMS cooperation and CDC in border areas; (ii) strengthened national diseases surveillance and outbreak response systems; and (iii) improved laboratory services and hospital infection prevention and control.

(i) **Strengthened regional, cross-border, and inter-sectoral CDC.** Output 1 will: (a) strengthen regional, cross-border and inter-sectoral cooperation for the control of epidemics including EIDs, Dengue and other important regional diseases, and (b) increase access to CDC for at risk youth, migrants and ethnic groups in border areas by providing outreach services using outbreak response teams.

(ii) **Strengthened national disease surveillance and outbreak response.** Output 2 will enhance the current surveillance and response system by: (a) expanding web-based reporting for improved surveillance and response capacities, and (b) improved community preparedness and syndromic reporting at village level.

(iii) **Improved laboratory services and hospital infection prevention and control**. Output 3 will: (a) improve quantity and biosafety of laboratory services; (b) scale up where appropriate for monitoring hospital based infection and drug resistance, and (c) improve hospital hygiene and management of highly infectious diseases.

17. **Cost Estimates and Financing.** In the Lao PDR, the Project is estimated to cost $12.6 million, to be financed by an ADB loan of $12 million and $0.6 million in Government counterpart funds. About $3 million of the project is reserved for regional and cross-border cooperation and CDC in border areas directly targeting MEV, who will also benefit from general improvement of health services provided they use these services. Targeted outreach activities will encourage ethnic groups to use services.

18. **Project Implementation.** The Ministries of Health (MOH) will be the executing agencies (EAs), responsible for in-country implementation and coordination among countries. In the Lao PDR, the EA is represented by the Department of Planning and International Cooperation (DPIC) in MOH, with the Director General of DPIC as the Project Director, who reports to the MOH Steering Committee chaired by the Minister of Health.

19. In the Lao PDR, a deputy project director in DPIC will assist the project director in day-to-day project coordination and management, including administration. The existing CDC2 project management unit (PMU) will continue with project administration and coordination. The Communicable Disease Control Department, National Center for Malariology, Parasitology and Entomology (CNLPE), the National Center for Laboratory and Epidemiology (NCLE) and 12 provincial health departments will also serve as IAs. Within each project management unit (PMU), a gender and social safeguards specialist (GSSS) will be engaged to help plan, provide capacity building for, and monitor GAP implementation. The PMU will support: (i) annual operational planning, coordination and budgeting, (ii) project implementation activities, (iii) proper procurement, financial management, (iv) adherence to safeguards, and (v) monitoring and reporting. At provincial or township level, the provincial / township health department (P/THD) will be the designated project implementation units (PIUs). There are up to 3 positions in each PIU to be financially supported by the Project in each province/township, depending on the workload. This includes a provincial project coordinator, a technical officer and an account assistant.

20. A regional steering committee will guide regional coordination and activities. The regional coordination unit of the GMS Health Security Project based on MOH Vientiane will continue supporting regional events and information exchanges. The Project supports: (i) comprehensive provincial health annual operational plans to improve targeting, quality and access; and (ii) proper procurement procedures and financial management. Three east-west corridors and one multi-limbed north-south corridor represent 4 distinct geographical clusters of MEV issues, as shown in Table 2. The north-south corridor connects major industrial areas in China with similar production areas in Viet Nam, Lao PDR, Cambodia, Thailand, and Myanmar.

21. **Scope.** To support regional health security, the Project will directly support Cambodia, Lao PDR, Myanmar, and Viet Nam and encourage participation of the Peoples Republic of China (PRC) and Thailand in regional and cross border activities. All country project proposals include in the scope regional cooperation and CDC in border areas, surveillance and response, and laboratory quality improvement, and hospital hygiene, but there are differences in emphasis among the 4 countries. Both MOH Cambodia and MOH Lao PDR give emphasis to reaching those not being reached with CDC in border areas. In Myanmar, the aim at this early stage is to develop model services in state laboratories and major border hospitals. In Viet Nam, the emphasis is to develop the district health center. In Lao, major emphasis is given to improving access and capacity development of the health system.

22. **Location:** The Project will cover 3 clusters totaling 12 provinces in the north (6), central (2) and south (4) as shown in Annex 1. Specifically, the 12 provinces are: Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu and Champasack.

3. SOCIAL IMPACT ASSESSMENT

A. Legal and Institutional Framework

23. According to ADB's 2009 *Safeguard Policy Statement*, the objectives are to design and implement projects in a way that fosters full respect for Indigenous Peoples' identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by the Indigenous Peoples themselves so that they: (i) receive culturally appropriate social and economic benefits; (ii) do not suffer adverse impacts as a result of projects; and (iii) can participate actively in projects that affect them. ADB indigenous peoples' policy as presented in the SPS includes the following principles:

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

(ii) Undertake a culturally appropriate and gender-sensitive social impact assessment or use similar methods to assess potential project impacts, both positive and adverse, on Indigenous Peoples. Give full consideration to options the affected Indigenous Peoples prefer in relation to the provision of project benefits and the design of mitigation measures. Identify social and economic benefits for affected Indigenous Peoples that are culturally appropriate and gender and inter-generationally inclusive and develop measures to avoid, minimize, and/or mitigate adverse impacts on Indigenous Peoples.

(iii) Undertake meaningful consultations with affected Indigenous Peoples communities and concerned Indigenous Peoples organizations to solicit their participation (i) in designing, implementing, and monitoring measures to avoid adverse impacts or, when avoidance is not possible, to minimize, mitigate, or compensate for such effects; and (ii) in tailoring project benefits for affected Indigenous Peoples communities in a culturally appropriate manner. To enhance Indigenous Peoples' active participation, projects affecting them will provide for culturally appropriate and gender inclusive capacity development. Establish a culturally appropriate and gender inclusive grievance mechanism to receive and facilitate resolution of the Indigenous Peoples' concerns.

(iv) Ascertain the consent of affected Indigenous Peoples communities to the following project activities: (i) commercial development of the cultural resources and knowledge of Indigenous Peoples; (ii) physical displacement from traditional or customary lands; and (iii) commercial development of natural resources within customary lands under use that would impact the livelihoods or the cultural, ceremonial, or spiritual uses that define the identity and community of Indigenous Peoples. For the purposes of policy application, the consent of affected Indigenous Peoples communities refers to a collective expression by the affected Indigenous Peoples communities, through individuals and/or their recognized representatives, of broad community support for such project activities. Broad community support may exist even if some individuals or groups object to the project activities.

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

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

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

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

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

24. The Borrower is required to prepare an EGDP to protect, and ensure benefits for ethnic minorities affected by the Project. According to the Indigenous People's Safeguards Sourcebook, "*The borrower/client is responsible for assessing projects and their environmental and social impacts, preparing safeguard plans, and engaging with affected communities through information disclosure, consultation, and informed participation following all policy principles and safeguard requirements."* According to the Sourcebook*, "IP safeguards are triggered when a project affects either positively or negatively and either directly or indirectly the indigenous people (para 8)."* Furthermore, "*the project is expected to have only limited impact and is accordingly categorized as B (para 67)."* In the same Sourcebook, it is noted that *"a stand-alone [EGDP] may not have to be prepared when … only positive impacts are expected from the project."* ADB clarified that given the scale and complexity of this regional project, the potential for not achieving certain intended positive impact on ethnic monitories justifies a category B and warrants preparation of the EGDP to help achieve intended impact on EMG.

25. Government strategies relating to EMGs is outlined in three major policies: Lao Constitution 2003, Decree of the National Assembly of the Lao PDR No.213/NA, dated 24 November 2008 regarding promulgation of the amended the called names and the number of the ethnics in the Lao PDR, and the Guiding Notification of the Lao Front for National Construction, dated 4 February 2009.

26. The 7th National Economic and Social Development Plan (NESDP),[6] which runs from 2011 until 2015, calls for authorities to integrate smaller villages, particularly in the more remote areas, to facilitate administration and allow better provision of services. This relocation can have significant effects on EG communities as they move to areas of lower altitude and flat land, which entail different livelihood and farming systems. The NESDP calls for the authorities to:

(i) Integrate small scattered villages to be merged and reorganized to become bigger villages and establish new communities (small town) to become a model in rural and remote areas with 1–2 towns per province.
(ii) Resettle displaced people by developing permanent new agricultural lands and living facilities, completely halt (and reverse) deforestation, and stop shifting cultivation.
(iii) Continue village grouping (kumban) as an anti-poverty and rural/human resource development approach.

27. The project will follow ADB SPS principles, and government requirements and regulations.

B. Baseline Information

28. Key demographic, economic and social indicators of the 4 targeted GMS countries are in Table 1. Several indicators regarding the specific health status of minority ethnic groups are lacking. Data gaps will be filled through a participatory assessment during the early stages of project implementation, to identify gaps in health security and plan for a package of activities including screening, diagnostics, disease control, and referral to established programs. This is discussed further in section VI. Proposed Measures.

Table 1: Key Demographic, Economic and Social Indicators in the GMS

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Economic growth rate %	7.0	6.5	8	6.0
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Population below 15 years	31.1	34.7	24.5	23.2
Median age in years	24.5	19.3	28.5	29.6
Sex ratio (% m/f)	95	99	94	112
Population growth rate (%)	1.8	1.9	0.8	1.0
Population density per square kilometer	85	29	79	279
Urban population (%)	20.5	37.6	33.6	33.0
Urban growth rate (%)	2.7	4.9	2.5	3
Per capita income in US$	1008	1589	1184	1868
People earning below $1.25 per day (%)	19	23	26	13
Unemployed as % of labour force	0.3	1.4	3.4	2.0
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	NA	1.184	11

[6] Ministry of Planning and Investment. 2011. *National Economic and Social Development Plan, 2011–2015: Targets for 2015.* Vientiane.

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Tourist arrivals (1,000)	4.200	2.500	2.000	7.500
Mobile phones subscribers/100 persons	134	66	12.8	131
Internet users estimate (% population)	6	13	1	44
Primary/Secondary GER f/m	81/89	76/82	79/78	89/87
Child mortality general population	42.5	41.9	62.4	21.7
Child mortality in ethnic minorities	NA	NA	NA	39
Child malnutrition in main population %	28.3	33.9	NA	16.9
Child malnutrition ethnic minorities %	NA	NA	NA	34.2
HIV prevalence in main population %	0.6	0.3	0.7	0.5
HIV prevalence among sex workers %	4.6	1.3	18.4*/**	3
TB incidence main population /100,000	390	189	369	140
Malaria cases confirmed total	21,309	46,202	333,871	17,128
Malaria deaths confirmed / 100,000	1.7	4.4	5.4	0.1
Full Immunization main population %	NA	49	NA	>95%
Full Immunization EMGs %	NA	NA	NA	<85%
Contraceptive prevalence rate (%)	51	50	46	78

Sources: UN basic statistics and other UN agencies

*Viet Nam Economic and Development Strategy Handbook, 2004

** anecdotal reports, e.g., one study reports under age Hmong sex workers for tourists in Sapa

*** e.g., one study for Lao migrants returning from Thailand

**** BWHO National Survey of Tuberculosis Prevalence 2010

/ SEAJTM Prevalence of Tuberculosis in Migrants 1996

*/** HIV data from UNAIDS 2008 report

HIV data from UNAIDS 2014 report

WHO and World Bank indicators

SEAJTM Prevalence of Tuberculosis in Migrants 1996

CHAS Country Report 2014-15 and Lao PDR MCH annual report

29. While the GMS has been politically stable, all countries experienced rapid economic growth and major poverty reduction due to rapid expansion of the industrial and services sectors including tourism, even though some two third of people continue to depend on agriculture as a livelihood. This development was brought about with increased connectivity and foreign investment partly concentrated in economic zones. It has also contributed to rapid urbanization and major internal and external migration. The population in the GMS is relatively young, with 23%-35% of the population below the age of 15, the so-called demographic dividend. However, 13% to 26% of people in these 4 countries are very poor, living on less than $1.25 per person per day. While child mortality has declined substantially, child malnutrition is still high, and so are the prevalence of major communicable diseases, while health sector coverage of the population is not yet universal.

30. In Lao PDR, there are 49 EMGs that are officially recognized by the government and make up about 34% of the total population of Laos.[7] They are categorized according to four ethno-linguistic families.[8] The Tai-Kadai family includes Lao, Lue, Phoutay, and other lowland groups, and account for 67% of the national population. The Mon-Khmer family includes groups such as the Khmu, Khuan, and Samtao that account for 23% of the population. The Hmong, Yao, and other Hmong-Tien groups account for

[7] 2014 estimates from the Department of Planning and International Cooperation, Ministry of Health.

[8] The actual number of ethnic groups may be as high as 236 depending on the level of classification used in regards to groups and subgroups within the main ethno-linguistic families (Chamberlain et. al.1996)

3% of the national population. The categorization of the four main ethno-linguistic families in three predominant habitat is now being discouraged.[9]

31. The Lao Tai and other Tai Kadai traditionally live in the lowland, valley floor regions of the country that historically have cultivated paddy, practiced Buddhism, and are integrated into the national economy. These correspond to the Lao-Tai group and represent approximately 65% of the population. The Mon-Khmer traditionally dominate the middle hills and for the most part practice swidden agriculture (rain fed upland hill rice, maize), many raise cattle, most are reliant on forest products, and to some extent are isolated from the dominant lowland culture. Many groups exhibit varying degrees of assimilation and adaptation to Tai-Lao culture. These groups are the original inhabitants of Southeast Asia. The Sino-Tibetan Burma and Hmong-Lewmien) groups live in the highland areas practicing swidden agriculture growing mainly hill rice, maize, and traditionally, many have grown opium. Many of these groups are recent arrivals from Southern China and Vietnam. The distribution of EMGs is shown in Table 2.

Table 2: Distribution of Ethnic Groups by Province in the Lao PDR

Province	Total Pop	% EMG	2014 EMG Popn	% and No. of Lao-Tai		% and No. of Mon-Khmer		% and No. of Sino Tibeto-Burma		% and No.of Hmong-Lewmien		% and No. Other	
Oudomxai	329,110	78.5%	253,177	20.6%	54,281	60.5%	150,584	5.7%	10,466	12.3%	35,340	0.0%	156
Phongsali	180,996	80.4%	145,203	18.9%	25,198	20.7%	31,240	53.6%	78,921	6.1%	8,811	0.0%	0
Luang Namtha	181,000	72.2%	123,975	26.9%	34,632	34.3%	35,892	31.2%	43,209	6.8%	9,175	0.0%	0
Bokeo	182,198	62.4%	111,294	37.1%	39,137	28.4%	43,266	18.2%	11,202	15.1%	16,074	0.1%	268
Xiengkhouang	263,465	51.3%	129,540	48.0%	55,326	10.0%	15,037	0.1%	120	41.2%	58,115	0.0%	0
Luangpabang	472,618	70.7%	302,364	30.0%	79,866	51.4%	151,169	0.2%	419	17.6%	52,343	0.1%	313
Houaphan	340,828	44.4%	150,345	55.7%	66,283	20.3%	28,812	0.0%	38	23.1%	34,628	0.0%	13
Sayabouly	403,504	27.2%	106,955	73.6%	58,727	15.8%	27,685	0.1%	206	9.9%	13,397	0.0%	115
Saisomboun	81,801	67.1%	54,824	32.0%	13,876	19.3%	8,198	0.1%	67	47.7%	32,202	0.3%	158
Vientiane Prov	446,270	30.8%	143,469	70.7%	69,680	16.6%	31,956	0.1%	91	11.5%	19,657	0.0%	22
Bolikhamxai	294,707	29.7%	76,420	74.6%	42,182	8.8%	9,067	0.1%	68	14.5%	16,252	0.7%	1,007
Khammouane	434,199	19.5%	64,896	76.4%	41,230	21.5%	21,600	0.1%	176	0.0%	12	0.7%	870
Savannakhet	1,004,646	29.2%	222,757	69.9%	114,959	29.2%	105,742	0.0%	0	0.0%	0	0.2%	348
Champassak	727,821	13.4%	100,654	85.1%	57,208	13.4%	41,925	0.0%	0	0.0%	0	0.2%	401
Saravan	403,575	48.9%	151,431	49.8%	47,751	48.9%	101,195	0.0%	0	0.0%	0	0.6%	1,529
Sekong	115,165	89.3%	98,765	10.0%	11,958	89.3%	86,082	0.0%	0	0.0%	0	0.1%	80
Attapeu	143,934	69.3%	87,857	29.2%	25,180	69.6%	61,550	0.0%	0	0.0%	0	0.1%	77
Vte Capital	903,747	3.7%	40,090	95.0%	36,731	1.4%	601	0.2%	72	2.3%	2,320	0.1%	38
Total	**6,909,583**	**34.2%**	**2,364,017**	**59.3%**	**874,208**	**26.8%**	**951,603**	**4.6%**	**145,055**	**8.2%**	**298,326**	**0.2%**	**5,395**

Sources of data: Population and EMG estimated for 2014 by DPIC, MOH,

32. Several studies of the World Bank, UN, and other agencies have documented that ethnic minorities have on average less income, are move often poor and very poor, have less access to health services, and have worse health indicators. The gaps in poverty and health indicators

[9] The VI Ordinary Session of the National Assembly, via Decision No. 213/NA, dated 24 November 2008, noted that the Lao PDR has 49 ethnic groups, with sub-groups and classified into 4 linguistic family such as: Lao-Tai linguistic family contents 8 ethnic groups, Mon-Khmer linguistic family content 32 ethnic groups, Hmong-Iu-Mien linguistic family contents 2 ethnic groups and Chine-Tibet linguistic family contents 7 ethnic groups. The national assembly also agreed to delete the 3 major ethnic terms "Lao Loum", "Lao Theung" and "Lao Soung" .

are actually widening. The poverty rate is highest in the northern mountains, and the mountains along the border with Vietnam; and among the Mon-Khmer (42.3%) and Hmong-Lewmien (39.8%) groups. The large Lao-Tai group have substantially lower poverty incidence than the other ethnic groups (15.4%). The Mon-Khmer have poverty incidence more than two and a half times the rate of the Lao-Tai and have seen a relatively slow decline in poverty incidence compared to the Lao-Tai (lowland dwellers) (date?).[10]

33. EMGs have higher mortality rates, and burden of communicable disease than the majority population. Increasing mobility and affluence will further increase the risk of communicable diseases, and some ethnic groups are ill informed about these risks, or may have customs which obstruct prevention of diseases. In certain traditional communities, for example, there are fears that vaccination of children will lead to infertility. Tracking recent outbreaks of polio, it was found that some Hmong communities have extremely low vaccination coverage. Similarly, it was found that EMG migrants have higher levels of HIV and TB infections. EMG use of health services is mostly lower including for vaccination. Political conflict, geographical and social isolation, language barriers, traditional customs, and poverty have contributed to the disparities between EMGs and majority ethnic groups and need to be taken into consideration when preparing project interventions.

C. Stakeholders and Consultations

34. In MOH, EG issues are referred to in general plans. As the government aims to mainstream EMGs, there is no specific policy, strategy, plan or designated unit for EMGs. The Department of Planning and International Cooperation (DPIC), and Health Information Management Systems (HIMS) is tasked with ensuring adequate services for EMGs in view of achieving Universal Health Coverage (UHC), which will among others require improving the monitoring system and planning special investments. Each village or group of village has a village health group responsible for assisting with the implementation of health activities, reporting diseases, and planning village health improvements.

35. There are several organizations that are involved in the wellbeing of EMGs, including the military, religious and grass-roots organizations, NGOs, and Government services. The lead government agency in regard to EMGs is the Department of Ethnic Affairs (DEA), under the Lao Front for National Construction (LFNC). This organization is the mass organization which establish from central to village level. It is mandated to the Lao Women's Union (LWU) and the Lao Youth Union (LYU) are also set up from central to village level. The military operated an extensive network of health services for their personnel and dependents in border areas, including in remote rural areas with security problems. The military medical personnel sometimes provide health services for local EMGs. For example, the Ministry of National Defense has their own hospital named 103 Hospital, and the Ministry of Public Security also has their hospital named 109 Hospital. Both facilities provide services for their own forces and general patients as well in respective communities.

36. In Lao PDR, the proportion of migrants that belong to EMGs is not known, but probably small. EMG migrants may be less able to benefit from the comprehensive labor code which aims to ensure a wide range of rights, benefits and protections, because they are more likely to lack permanent addresses and formal documentation. Further, the presence of national or

[10] Most increase in wealth is in urban areas and along economic corridors, while more rural parts of Lao benefit less. With increasing connectivity, education and economic participation, poverty among EMGs will reduce, inequality among ethnic groups will reduce, but inequality between income groups will increase further.

international associations or interest groups for specific EMGs may not extend to the most disadvantaged groups. One problem is that of educated EMGs migrating to Vientiane Capital and other secondary towns. The impact of this process on the EMG transition is not known.

37. The consultation process has covered some stakeholders including Ministry of Health; Provincial Health Departments; Health Center Staff; Village heads; patients; community members; DPs (please see Annex 2), but also relies on information gained from the CDC2 project, the ongoing project with model healthy village development in the 12 provinces. In addition, consultants visited stakeholders in Bokeo province (other team visit Luangnamtha province), the Bokeo borders with major tourism industry, casinos, and large migrant populations. EMGs in these locations are mainly from abroad (Thailand, China, Burma). The consultation and participation process undertaken during preparation of this EGDP is discussed further in Section C. Information, Disclosure, Consultation And Participation.

D. Vulnerabilities, Risks, and Project Effects

38. EMGs in GMS border areas can no longer be thought of simply in terms of disadvantage due to isolation; they are becoming increasingly less isolated, more disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. EMGs are beginning this process of integration from a very disadvantaged position. Migrants, EMGs and other vulnerable groups (MEVs) such a youth and pregnant women need special attention in any health administration, but this is often not happening, in part because health plans are disease-focused. See Annex 1 for more background of MEVs in the GMS.

39. EMG populations living near regional economic corridors bear a disproportion burden of the health costs of the rapid social and economic changes created by these developments. Relocation and/or resettlement of EMGs have been supported by governments and donors in CLMV for various reasons. In some provinces, movements of highland EMGs to lower altitudes as a result of voluntary and involuntary resettlement has had a chain migration effect, resulting in the depopulation of whole highland areas.[11]

40. When highland-dwelling EMGs move to lower altitudes, they are exposed to malaria, to which they have little acquired resistance, so in the early phase of relocation to lower altitudes, there have been high mortality rates from malaria, as well as morbidity resulting from exposure to other water-born and environmentally-related infectious diseases.

41. EMG populations who suffer from food deficit and malnutrition are more vulnerable to contracting new and emerging infectious diseases, and those who live close to rapidly

[11] Gebert, R. 1995. *Socio-economic baseline survey*. Muang Sing: GTZ Integrated Food Security Programme. Cohen, P.T. 2000a. "Lue across borders: pilgrimage and the Muang Sing reliquary in Northern Lao PDR. In G.Evans, C. Hutton and Kuah-Khun Eng (eds.) *Where China Meets Southeast Asia: Social and Cultural Change in the Border Region*. Singapore: Institute of Southeast Asian Studies. Cohen, P.T., 2000. "Resettlement, opium and labour dependence: Akha-Tai relations in Northern Laos", *Development and Change*, 31:179-200. Romagny, L. and Daviau, S. 2003. *Synthesis of Reports on Resettlement inLong District, Luang Namtha province, Lao PDR*. Action Contre La Lyttleton, C. 2005. "Market-bound: relocation and disjunction in northwest Lao PDR**".** In Toyota, M., Jatrana, S., and Yeoh, B., 2003 (eds.) *Migration and Health in Asia.* Routledge. Alton, C. and Houmphanh Rattanavong, 2004. *Service Delivery and Resettlement: Options for Development Planning*, unpublished report, UNDP: Lao PDR, Vientiane. McCaskill D. and K. Kampe (eds.) 1997. *Development or Domestication: Indigenous Peoples of Southeast Asia* Chiang Mai: Silkworm Press.

developing hubs on transport corridor areas are particularly vulnerable to recruitment into sexual services industry, to cross border human trafficking. Under these circumstances they become vulnerable to infection with HIV and other sexually transmitted diseases.

42. Some EMGs may use health services, when they are available, only as a last resort. This may be because of lack of experience but also reflects anxiety about modern health services and expense of accessing them. Shifting cultivation practices also limit the opportunities to access the health service for some EMGs, especially women. EMGs have had limited exposure to modern scientific knowledge about the cause of diseases, and less opportunity to learn about the value of vaccination, vector control and other measures. Language and educational constraints, coupled with rude behaviors by some health care professionals, cause some to feel ashamed and reluctant to access services, and numerous reports of belittling treatment of EMGs by government health workers were shared informally during the field research. Programs aiming to promote behavior change (e.g. building and using latrines, drinking boiled water, removing disease vector breeding sites, hygienic management of animals, hand-washing, using bed nets, and acceptance of vaccination) are mainly designed for the general population and do not take account of cultural differences in behavior and need to use culturally relevant modes of communication in EMG villages.

43. Provision of free health insurance through the health equity fund has enabled poor EMGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered by the health cards.

44. Although EMGs are more likely to have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EMGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The disparities are highlighted in country specific data showing that provinces with high infant and child mortality rates also have high concentrations of EMGs. Surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by health centers and hospitals. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive.

45. The Project does not impose any vulnerabilities or risks or negative project effect on the EMGs in the project area. The only risk there may be is that EMGs are excluded from the benefits of the Project. Hence the EGDP aims to ensure that the project design, implementation, and monitoring maximizes benefits for EMGs.

E. People's Perceptions

46. Based on 10 years of ADB-supported project experience, the proposed project interventions are much appreciated. The problem is on the supply side rather than the demand side, in that MOH lacks the means to reach remote EMGs and migrants, and may be unable to assign staff to these places.

47. EMG village health groups indicated that common health problems are respiratory and diarrheal infections, dengue, infections, fever, cough, and problems of pregnancy and accidents that require referral. They are willing to collaborate but for time constraints if the interventions are not controversial and accepted in the community. They don't want one time promises, but continuity of engagement. Village health groups already participate in CDC in terms of planning model healthy village development, disease reporting and community preparedness, facilitating

immunization and case finding, and referring people. The proposed project interventions didn't raise any objections. However, community-based interventions require thorough preparation to achieve the desired results.

F. Proposed Measures

48. Each project implementation unit established at provincial level will support project border districts, through a consultation process with village health groups, community based organizations and other representative groups, to (i) identify migrants and ethnic groups along borders and economic corridors, (ii) identify gaps in communicable disease control; and (iii) plan activities including screening, diagnostics, disease control, and referral to established health facilities. Village or facility CDC plans will be included in provincial annual plans and budgets. This should help achieve benefits for migrants and ethnic groups in this project. Progress should be routinely reported to MOH. Further details of EGDP specific activities are available in annex 3.

4. INFORMATION, DISCLOSURE, CONSULTATION AND PARTICIPATION

49. The EA will ensure that the EGDP is endorsed and translated into Laos and disclosed on their, and ADB's, website. The EGDP is also to be summarized in local languages and made available to EG communities in an appropriate form and manner. The disclosure will provide sufficient information to ensure that all community members (women and men of all EGs) are made to understand the roles, responsibilities, and processes of the VAC in regards to dispute resolution, the involvement of the LNF, and also of the additional avenues available should local mediation fail. ADB will disclose the endorsed EGDP on their web site upon receipt. Information disclosure and consultation activities will be monitored and included in regular monitoring reports.

50. Within the first year of project implementation, and then on an annual basis, focus group meetings should be convened with separate groups of EG men and women to assess project performance and to assess the flow of benefits and impacts on EG members. These participatory evaluations have been specified in the EGDP to be used in ongoing monitoring of EGDP implementation, adjusting as necessary to ensure ongoing community support. These assessments should request EG members to identify perceived issues or constraints as well as recommendations to improve implementation.

51. The Indigenous Peoples safeguards are triggered if a project directly or indirectly affects the dignity, human rights, livelihood systems, or culture of Indigenous Peoples or affects the territories or natural or cultural resources that Indigenous Peoples own, use, occupy, or claim as an ancestral domain or asset. The term Indigenous Peoples is used in a generic sense to refer to a distinct, vulnerable, social and cultural group possessing the following characteristics in varying degrees: (i) self-identification as members of a distinct indigenous cultural group and recognition of this identity by others; (ii) collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories; (iii) customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and (iv) a distinct language, often different from the official language of the country or region. In considering these characteristics, national legislation, customary law, and any international conventions to which the country is a party will be taken into account. A group that has lost collective attachment to geographically distinct

habitats or ancestral territories in the project area because of forced severance remains eligible for coverage under this policy.

52. Key questions concerning EMGs in project design, apart from general health status, include (i) their understanding of communicable diseases, causes, treatment, and prevention; (ii) EMG's use of services and their perceptions of acceptability, availability, quality and affordability of government and other health services; and (iii) community organization for health services and participation in the project cycle. The project has no negative impact on EMGs, so the focus is on how to improve positive impacts for EMGs.

53. The national and international social safeguard specialists conducted an assessment of social impact, including review of documents, field visits, stakeholder meetings, workshops, and assessment and disclosure of social impacts and mitigating measures from 3-16 October 2015. They met with MOH departments, other ministries, and other partners and stakeholders. Discussions were held with local community people, and separately with EMGs. Social safeguard specialists participated in a national workshop in Hanoi on 9 October 2015, where specific points on involuntary resettlement and Project impact on EMG and corresponding mitigation measures were discussed, in accordance with ADB's SPS 2009. The provincial and district health authorities will disclose the EGDP contents to community representatives benefitting from the project. The project will finance outreach activities during which relevant portions of the EGDP will be disclosed and local safeguards experts hired by the project will support disclosure of the EGDP to beneficiaries.

54. As summarized in Annex 3, patients and other locals were generally satisfied with the health services. They particularly praised the attitude of health staff, trying to assist in sometime difficult conditions. Emergency Services was singled out as a priority for improvement. The main change noted by the patients and other locals was the improvement in medicines. Local health staff noted the need for more in-service training and outreach services. Government officials emphasized that everyone has access to free health services including all ethnic groups and migrants. However, they also noted a lack of qualified staff in local health facilities, and that certain EMGs were hard to reach and didn't make much use of public health services. Out of pocket payment was not considered an issue for the poor as the health facility provided services for free, or could provide waiver for poor people.

55. Among the risks noted were: (i) lack of interest of targeted EMGs; (ii) weak provincial effort in participatory planning, implementation, and monitoring; (iii) lack of effort reaching isolated EMGs, migrant camps, and hotspots; and (iii) insufficient technical and financial backstopping of MOH. For migrants an additional issue is that it may be difficult for migrants to access health services due to unregistered migration and employment conditions; and for health staff to access and inspect labor camps, factories and casinos, which require collaboration with Ministry of Labor (MOL) and business owners. The Project design will support the development and harmonization of strategies where appropriate. The project will support implementation through CDC activities in border areas, as per output 1.

5. BENEFICIAL MEASURES

56. Direct beneficiaries in Component 1 will include prioritized EMGs[12], migrants, laborers in camps, youth, national and provincial preventive medicine officers, district health center staff, commune health station staff and village health workers. It is expected that in Lao in the 36 targeted districts, the project will reach about 1m EMGs. Migrants, youth, pregnant women, and remote EMGs will receive additional screening and referral for treatment as needed. Project implementation units in provinces will conduct results-based, participatory planning to ensure strong commitment from all stakeholders, and prepare annual plans with activities and targets to be financed from project funds. It is expected that the provision of a vehicle and motorcycle (under Component 2) will increase mobility of provincial teams to reach out to these communities. Component 1 will also support regional, cross-border, and inter-sectoral cooperation for joint planning to extend services to the target groups, and joint activities. Monitoring and supporting this component will be critical and the main assignment of the CTA, gender and social safeguard experts.

57. Component 2 will help improve community preparedness, timely detection, investigation, risk analysis, risk communication, and containment of emerging and other diseases of regional significance, such as Malaria, Dengue, Cholera, TB and HIV/AIDS. Direct beneficiaries in Component 2 include health staff, and community health workers, who will improve outbreak reporting and response and community preparedness that is appropriate for EMG communities.

58. Component 3 will improve diagnostic capacity by improving laboratory quality, and also reduce the risk of spread of dangerous infections through better laboratory biosafety, hospital infection control, and better case management of infectious diseases. Direct beneficiaries in Component 3 include laboratory and hospital staff, many of whom belong to EMGs, and will work in EMG areas.

59. The purpose of this Ethnic Groups Development Plan (EGDP) is to (i) outline the potential positive and negative impacts of the project on ethnic groups; (ii) specify actions to address these impacts; and (iii) help mitigate negative impacts and enhance benefits to EMG communities. To increase support for EMGs in the project, the project management unit (PMU) at central level and provincial level PMU will ensure full implementation of the EGDP. To facilitate this process, key features of this EGDP are mirrored in the project DMF, loan assurances, and PAM and aligned with the existing national policy commitments to ethnic group development in the four project countries. These include participatory assessment and planning with EMGs, outreach to migrants, and disease control campaigns, as well as improved disease reporting and outbreak response, and better access to diagnostic services and hospital treatment of infections.

60. The actions in the EGDP (Annex 6) support integration of EMG needs and interests into Project outputs, and ensure effective participation and access to Project benefits. The assessment and participatory planning will help enhance benefits for EMGs. No negative project impacts were identified that would require mitigation measures, however lack of participation

[12] Component 1 targets people in border districts, including migrants and mobile populations, vulnerable women and infants, ethnic groups, and in general, poor and people living in remote areas. These populations suffer from a high burden of illnesses and common infections such as malaria, tuberculosis, dysentery, diarrhoea, typhoid fever, acute respiratory infections, measles, and parasitic infections. Poverty and economic integration also pushes and pulls these people into professions and habits with high risk of HIV/AIDS and drug resistance. Without appropriate care these diseases result in high mortality, disability, and malnutrition, impact on learning and productivity. In addition, these marginalized high risk people that are not in touch with the public health system also pose a risk for the unnoticed spread of these diseases that may result in outbreaks.

and weak implementation threatens the desired positive impact.

6. CAPACITY BUILDING

61. The EGDP activities are mainstreamed into project implementation activities which will be implemented by the district and provincial health management and service teams. In order to ensure the EGDP is disseminated and that each level understands the actions and activities proposed under the EGDP and the grievance procedures; and that all understand their corresponding role and responsibilities, pre-start up training for provincial and district managers is recommended. The Project will assist with training and capacity building of MOH/PMU and PIUs, including for implementation of the EGDP, through training and field visits. This will be supported by the CTA and the gender and social safeguards specialist. It will be critical for MOH to attract competent mid-career consultants to provide effective capacity building. Training will also be provided for infection prevention and control nurses and field epidemiologists, with some orientation towards ethnic minority and migrant concerns. Key features of the EGDP, such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and PAM.

7. INSTITUTIONAL ARRANGEMENTS

62. As the lead agency, the Department of Planning and International Cooperation will be responsible to the Minister of Health for quality, effectiveness, efficiency of Project implementation within funds allocated. Provincial Health Departments (PHDs) will be the project implementing agencies (PIA) and implement the project in their provinces. Each PHD, as PIA, will nominate focal points for project coordination and administration, project planning and monitoring. PHDs and lower levels will be provided with training to implement project activities.

63. The MoH, provincial managers have responsibility to ensure that EG staffing targets are pursued and also that field teams are adopting recommendations and the special measures contained in the EGDP in respect to working with EGs. Provincial and district level teams should assign one person at each level to act as the focal point for social safeguards work. Safeguard oversight will be provided through the Project Management Unit (PMU) with guidance from the Chief Technical Advisor (CTA) who will provide 32 months of intermittent input to the project and support from the Domestic Safeguard Specialist who will provide 6 months of intermittent input. The CTA and Safeguards Specialist will cover all three safeguard areas of resettlement, EGs, and environment. Technical assistance is required to ensure safeguard plans are implemented and monitored correctly and also to raise local capacity in regards to understanding the rationale and triggers for safeguard measures.

64. The Regional Steering Committee (RSC) established under CDC1 will give guidance in Project implementation, policy dialogue, and building of regional capacity and cooperation for CDC, facilitating country decisions on the use of pooled funds for regional activities. It will be chaired by the minister or vice-minister of the host country and will consist of leading representatives from the national SCs, project directors, and ADB and WHO representatives. The Regional Coordination Unit (RCU) will act as the secretariat for regional coordination activities and the management of regional funds. Regional project meetings will be held 6 months before the RSC meeting to follow up regional activities and organize regional events, and report these to the RSC.

65. Related ADB health projects have shown a steady improvement in EGDP implementation. Project Directors are committed to provide the necessary leadership and inputs to fully implement the EGDP. Key features of the EGPD such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and PAM.

8. GRIEVANCE REDRESS MECHANISM

66. Regular meetings and consultation will seek to minimize dissatisfaction among project-affected people. Local stakeholders' opinions and concerns will be part of the project planning and implementation. The participatory approach will encourage people to raise any concerns before conflicts may appear in the design and implementation of Project activities. The beneficiaries can address their concerns through their representative. The complaint will be assessed and negotiated into a solution between the project representative (focal point or IA) and local authorities, and then fed back to the communities as part of the participatory planning process. If the conflict is not solved amicably, it will be taken to the PMU or MOH Steering Committee under the MOH. The project representatives at various levels will be responsible for reporting any grievances up to the appropriate level. The particular activities will be carried out after such conflict is resolved satisfactorily.

67. Although no grievances are envisaged under the proposed GMSHSP, the ADB Safeguard Policy Statement (2009) does require a grievance redress mechanism. In the Lao PDR, the judicial system starts at the local level with the Village Committee (VAC), which is normally used for grievances against local government agencies, civil actions, and minor criminal matters. In the case of most EG communities there is a more informal but very influential Village Elders group that includes individuals with social capital and influential social position in the community. The Village Elders should also participate in the grievance hearing and resolution at the village level.

68. The EG members may make verbal complaints at the village level. If the issue is to be referred to the district authorities, formal complaints must be put in writing and bear the village stamp to indicate that the complaint has been referred correctly through the local grassroots authorities. If the village has difficulty in submitting a formal written complaint, the Lao National Front (LNF) office at district level will provide the necessary assistance to do so. Complaints received must be documented and acted upon immediately. The VACs will be advised of the need to keep records of grievance hearings and the information needed.

69. Should issues not be resolved at the village level, an appeals process at district and provincial levels will be made available through the respective health office who will act on behalf of the project owner. The respective district or provincial health office will be required to request the participation of the provincial or district LNF representatives at any grievance hearing. Any grievance not resolved at the local level can be referred to the Department of Planning and International Cooperation, MoH, and again, with the participation of LNF representatives. If the matter is still not resolved, the issue can be referred to the Provincial Peoples' Court.

70. Grievance resolution will be aligned with the other safeguard processes where possible. The procedural steps for filing and resolution of grievance and complaints are described in Table 4 below.

71. Grievance resolution will be aligned with the other safeguard processes where possible. The procedural steps for filing and resolution of grievance and complaints are described in Table 4 below.

Table 1: Grievance Procedure

Stages	Activities/Procedures
Stage 1	At the village level, AP files a complaint/grievance verbally or in writing to VAC/VE at village level. If unwritten the VAC/VE will assist to put it in writing and provide a copy to the project at district level. The head of the district project unit and the VC will hear the complaint in public for transparency, and based on their traditional method of conciliation and mediation. Resolution is required within 5 days after the complaint/grievance was received.
Stage 2	If no solution or understanding is reached within 5 days, the AP can bring the complaint at the district level. The GRC at the district level will meet the AP, and aim to resolve within 10 days after receiving the complaint.
Stage 3	If the AP is still unsatisfied or has not received any decision from the GRC at the district level, he/she can seek redress at provincial GRC that should decide the issue within 10 days.
Stage 4	The AP may elevate the complaint for hearing at the PMO if still unsatisfied with the decision of GRC at the provincial level. The PMO will ensure to resolve each complaint within 10 days after receiving the appeal.
Stage 5	As a last resort, the AP may file the case to the local Court of Law, with assistance from PMO. The decision of the Court of Law is final and executory.

AP = affected person, GRC = Grievance Redress Committee, PMO = Project Management Office, VAC = Village Committee, VE = Village Elder

9. MONITORING, REPORTING, AND EVALUATION

72. The executing agency (EA) will take action to ensure that a monitoring and evaluation system is formulated and implemented. As mentioned earlier, the EGDP contains suggested activities with indicators and targets which must be included in the M&E system. The CTA and Safeguards Specialist will assist the PMO M&E officer to ensure that all EGDP indicators are properly identified and defined and included in the project M&E system. The PMO M&E officer will receive updated reports from the provincial coordination unit and safeguard focal point, and prepare quarterly reports for the EA at central level using the design monitoring framework which is prepared and submitted to ADB on a quarterly basis.

73. Project evaluation will be carried out in three phases: (i) Project inception: capacity building, participatory assessment and planning, identification of sites, planning implementation

details; (ii) Mid-term evaluation: assessment of progress of EGP implementation and adjustments, after 1.5 years; and (iii) End-of-Project evaluation and impact assessment after 5 years. The inception report, mid-term evaluation and project evaluation will be made available on internet. Each S/RMU will carry out assessment of all training activities, and baseline and end-of-project data collection for assessing trends in the use of CDC services by EMG in border areas under Component 1. No survey will be done: community and health facility records will be used to assess trends. Project evaluation will include an assessment of the effectiveness of EGDP, in terms of enhancing positive impacts. The evaluation will also assess the participation of stakeholders in project implementation. Beneficiaries will be informed verbally about the availability of reports online. Social Monitoring reports discussing progress in implementing the EGDP will be disclosed on ADB's website

10. BUDGET AND FINANCING

74. Estimated costs of CDC for vulnerable groups are budgeted for under component 1, and estimated at $1.6 million. The activities in the EGDP are integrated into the overall arrangements and total budget of the project, including for consulting services. EGDP-related training and communication activities will be incorporated into other project training and communication activities.

75. The activities will be implemented over the entire period of the project. During the first year, the townships will undertake a situation analysis, together with a participatory planning process with all stakeholders. This will be facilitated by the national safeguards specialist.

ANNEX 1: Information on Migrants, Ethnic and other Vulnerable Groups

1. Various migrants, mobile populations, ethnic minorities and other vulnerable groups (MEVs) in border areas and economic corridors work in plantations, factories and entertainment services. Depending on the type of occupation and living conditions, these women and men are exposed to various risks such as poor working conditions, higher risk of infectious diseases, and less access to services. Unskilled labor is provided by internal and external migrants but also by local people living near factories. Skilled labor is also often provided by internal or external migrants. While most migrants periodically return home, some are deported after confinement of 1-2 months as illegal laborers. Many migrants are exposed to various forms of exploitation more likely to result in illness and infections. However, there is little information on the actual health status of ethnic groups and migrants.

A. General

2. Table 1 summarizes the demographic, economic and social environment in 4 GMS countries, which provides the setting for ethnic groups, migrants, and minors.

Table 1: Key Demographic, Economic and Social Indicators in the GMS

Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Population below 15 years	31.1	34.7	24.5	23.2
Median age in years	24.5	19.3	28.5	29.6
Sex ratio (% m/f)	95	99	94	112
Population growth rate (%)	1.8	1.9	0.8	1.0
Population density per square kilometer	85	29	79	279
Urban population (%)	20.5	37.6	33.6	33.0
Urban growth rate (%)	2.7	4.9	2.5	3
Per capita income in US$	1008	1589	1184	1868
People earning below $1.25 per day (%)	19	23	26	13
Unemployed as % of labour force	0.3	1.4	3.4	2.0
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	Na	1.184	11
Tourist arrivals (1,000)	4.200	2.500	2.000	7.500
Mobile phones subscribers/100 persons	134	66	12.8	131
Internet users estimate (% population)	6	13	1	44
Primary/Secondary GER f/m	81/89	76/82	79/78	89/87
Contraceptive prevalence rate (%)	51	50	46	78

Source: UN Statistics Division, 2013-2015

3. As table 1 illustrates, there are multiple developments in the GMS including rapid urbanization and connectivity, migrant labor opportunities, increasing income and cost of living, and ourism. These changes facilitate the rapid spread of infections in the region and require new mechanism for their control, for which governments are less prepared. Among these is reaching those not being reached with appropriate interventions and delivery channels, as discussed below.

B. Ethnic minorities

4. The GMS is an increasingly interlinked geographical and economic region that shows remarkable ethnic and social diversity. Historically, it has seen successive dynasties, migrations, conflicts, and occupations, but despite this intermingling has retained distinct populations and ethnic groups. While some of the ethnic groups are original inhabitants, others migrated later from neighboring countries, either by conquest, or to lands traditionally less populated, in particular the highlands and mountains, and habitats rive with endemic diseases. These ethnic groups maintained practices and customs from their homeland, and adjusted in various ways to their new surroundings. Many of these ethnic groups in the GMS are trans-border people, and form a major part of the population in some provinces in Cambodia, Lao PDR and Viet Nam, and states in Myanmar. Remarkably, many of these ethnic groups have remained isolated and homogenous, even when adopting to new economic opportunities in agriculture, tourism, trade and migrant labor.

5. While there are still some traditional and less informed ethnic groups living in isolated locations, the majority of them is in one way or another exposed to developments at home and abroad, bringing both opportunities in terms of trade and labor, and risks in terms of social instability, diseases and drugs. While some ethnic groups and families have been able to make use of new economic opportunities, many have had difficulty adjusting, with sometimes serious consequences such as new poverty, malnutrition, and diseases. Insufficient effort is made to ensure that no harm is done to ethnic groups, and that they are provided with appropriate opportunities. Mobility and migration of ethnic groups should therefore be of major concern in the context of regional health security.

6. A remarkable feature is the low median age of populations, in particular in the Lao PDR. In addition, as shown in several UN studies, a large proportion of external migrants are below 18 years of age, but reportedly less so than in other GMS countries. These minors are especially vulnerable to all kinds of exploitation. Those returning home may have less access to health services. Child migration and its consequences is a serious child rights issue which is not receiving much attention in the health sector.

C. Migrants

7. Road construction in the GMS is rapidly improving regional and local connectivity, opening up new areas and creating economic corridors and employment. Settlements along these roads attract entrepreneurs and migrants. Immigration and trade agreements stimulate the flow of people and goods between countries. Tourism promotion and increased wealth add regional travel and demand for services. More recently, due to the rapid expansion of plantations and industrial zones with labor opportunities, with internal migration in areas traditionally settled by ethnic minorities, integration of various ethnic groups is continuing at a much faster pace, causing rapid transition in terms of changing social structures, labor, consumption, and exploitation.

Lao attracts migrants from China, Thailand and Viet Nam including farmers, laborers for services, industries and plantations; and workers for the construction boom. Only a small proportion of these migrants are from poor EMGs, but most migrants have language problems, are not familiar with health services, and may not have access to subsidized care. At the same time, about 1 million Laotians are working abroad, mainly in Thailand and the USA, including 30% of Lao's university graduates. It is hoped that, as economic opportunities in Lao are improving, this diaspora will slow down.

8. While migration overall has been a major force for poverty reduction in the region, studies show that EMGs are more often left behind due to lack of economic opportunity, such as lack of quality agricultural land, social exclusion, lack of credit, and geographical isolation with lack of access to markets. EMGs are also more often illegal migrants, for example because they lack education, and victims of mis-information about salary and labor conditions, and sometime confinement, coercion and trafficking. Studies show that illegal migrants often live in very poor living condition.

9. Economic developments accelerate social and economic changes are likely to have both positive and negative impacts on health. Migrant labor may increase exposure to communicable diseases related to new behavior, such as tuberculosis, HIV/AIDS, hepatitis; habitat, such as malaria and, dengue, and lack of access to services, such as for food and water-borne diseases. Lack of knowledge of diseases and access to services make them prone to spreading diseases, including EIDs. Migrant laborers are also more prone to accidents, alcoholism, drug addiction and malnutrition.

10. The risks will vary by age, education, gender, occupation and location. EMGs and migrants in border areas will generally have less access to services. MEVs may be less willing to access services due to lack of awareness, financial hardship, illegal labor, addiction, and lack of rights. Cross-border migrant workers with HIV or TB may not be able to continue treatment. There are two major child rights issues: youth and pregnant women are particularly at risk of exploitation and abuse and may have less access to services.

11. Providing effective CDC for MEVs will not only help improve health and health security, but will contribute towards child protection, better learning in school, economic productivity, and poverty reduction, all high on the Government's list of priorities.

12. In the GMS, public and private health services are reaching a large part of the population. the Government focuses on providing services to the general public. However, those not being reached by any formal health service, migrants and mobile people, ethnic minorities, and other vulnerable groups (MEVs) will continue to be at risk of, and spread infections, including possibly more drug resistant infections. As the health status improves, the impact of those not reached by the health system, marginal groups such as migrants and ethnic groups, becomes relatively larger, and it will become more cost-effective for the government to develop ways to reach these groups, at a higher unit cost.

13. Among the reasons why both formal public and private health services have made less effort in reaching these marginal groups are living conditions and services in these areas, language problems, market failure, government regulations limiting adequate compensation, and in general lack of trained people, many of whom migrate after education. Hence, special arrangements are needed to reach these people, often requiring a more multi-sectoral and partnership approach.

14. Access to the public health system is less than satisfactory in mountainous border districts. The population in these districts includes ethnic groups and migrants from other districts, and mobile people working cross-border. While these people have a higher disease burden and may sustain the spread of infections, their access to health services is less.

15. A WHO SEARO report divides mobile and migrant populations (MMPs) broadly in three groups: (i) those affiliated to an employer, including semi-mobile employees and seasonal farm

workers; (ii) those affiliated with the government, including military, security personnel, and border guards; and (iii) non-affiliated, including ad hoc laborers, new settlers, highly mobile labourers and short-term migrants.[13] While all these groups would need to be targeted in terms of relevant information on prevention of diseases such as malaria, HIV/AID, tuberculosis, and other conditions, the first 2 groups are organized and therefore, in principle, easier to access. However, experience shows that it is also difficult to access organized groups of migrants working in plantations, casinos, and factories. While the Governments has laws and policies in place to reach these people usually through the Ministry of Labor, this is not sufficient in terms of quality and quantity of inspection and migrant access to services. Hence, special arrangements are needed, with special agreements between those in charge. For non-affiliated, often illegal migrants including ethnic minorities and minors, it is even more difficult to encourage them to use public services. Grassroot organizations and NGOs should play a major role in this field. Viet Nam has so far shown less recognition of the potential roles of NGOs in this regard.

Table 2: Geographical Clusters Along Economic Corridors

Cluster and Corridor	Main Ethnic Groups	Ethnic minority characteristics	Implications
Cluster 1: Northern corridor: Vietnam North, Lao North, Myanmar-east, Myanmar-east, Thailand-north-east	Large ethnic minority populations, in particular originating from China, mainly Sino-Tibetan and Hmong but also Mon-Khmer	Relatively isolated, self-sustaining highland groups with high burden of HIV, respiratory infections and other common infections, at risk of epidemics through trade, less accessing health services	Some border districts are hard to reach based on government conditions, but these highly remote people may also be less at risk of epidemics. Focus on accessible hotspots for outreach services, community workers.
Cluster 2: Central corridor: Vietnam Central, Lao-south-central, Cambodia north-east, Thailand north-east, Myanmar-central	Large ethnic minority populations, including large indigenous Mon-Khmer and related groups and migrants from northern areas	Relatively isolated, traditional, poor and less educated highland groups and migrant workers, with high burden of common diseases, at risk of epidemics of malaria and dengue and less accessing health services	Border districts may be more accessible but face political problems. Focus on providing ethnic minority friendly services[14] at health facilities, free services, and community workers
Cluster 3: Southern corridor: Viet Nam-	Largely inhabited by non-ethnic	Largely integrated populations, better	No need for special services for ethnic

[13] WHO SEARO. Vector control and personal protection of migrant and mobile populations in the GMS: A matrix guidance on the best options and methodologies. New Delhi. 2015

[14] From the "Second Health Care in the Central Highlands Project" - Project No.44265, IPP document, para 51 shows that: i) Some ethnic people disagree with using the examination room for both men and women, because they think the examination is private. A mutual usage may cause them to feel ashamed, shy or even humiliated, ii) In clinical practices, the patients have to expose a part of or the whole of their bodies to be examined or to experience medical techniques, then the design of windows, door, construction materials should be appropriate with the facility but should ensure the privacy, iii) Some ethnic groups even think the direction of the facility and the door should be appropriate with indigenous culture, thus, before the construction of the new facility, there should be a survey of cultural feature and a meeting with the representatives and indigenous people to seek for an appropriate solution.

south, Cambodia south-east to north-west, Thailand east to West, Myanmar-south	minorities including Kinh, Khmer, Thai and Burmese. Has large migrant and Muslim populations	educated, mainly living in lowlands, industrial zones, high burden of dengue, diarrheal diseases, more timely reporting of diseases and accessing services	minorities. Needs special care for illegal migrants by providing them information and access to free health services.
North-South Corridor: China-south to major cities in the GMS	Mainly passes through non-ethnic minority populations except when passing through cluster 1 corridor	Mostly migrant ethnic groups providing unskilled labor and other services along the economic corridors	No need for special services for ethnic minorities. Needs BCC and services for migrant workers in hotspots, factories, casinos and labor camps.

Note: Primary targeted provinces/states/region in CLMV countries and neighboring states and provinces in China and Thailand are in Table 2.

Table 3: Targeted Provinces/States

Cambodia	12	Pailin, Battambang, Banthey Meanchay, Preah Vihar, Stung Treng Rattanakiri, Mondulkiri, Kratie, Tbong Khmum, Prey Veng, Svey Rieng, Kampot,
Lao PDR	12	Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu, Champasack
Myanmar	6	Shan North, Shan East, Kaya, Kayin, Mon, Tanintharyi
Viet Nam	36	Quang Ninh, Lang Son, Cao Bang, Ha Giang, Lao Cai, Lai Chau, Dien Bien, Son La, Thanh Hoa, Nghe An, Ha Tinh, Quan Binh, Quan Tri, Thua Thien, Quan Nam, Kon Tum, Gia Lai, Dak Lak, Lam Dong, Dak Nong, Binh Phuoc, Tay Ninh, Long An, Donh Thap, An Giang, Kien Giang, Bac Lieu, Sok Trang, Tra Vinh, Ben Tre, Ba Ria, Thai Binh, Hai Phong, Yen Bai, Tuyen Quang and Bac Kan Provinces
China	1	Yunnan
Thailand	12	Mae Hong Son, Chiang Mai, Chang Rai, Phayao, Buen Khan, Nhakon Phanom, Udon-Ratchatani, Sa Kaew, Tak, Kanchanaburi, Ratchaburi, Phetshaburi

16. Within these provinces/states, border districts/townships will be selected with hotspots in border areas along economic corridors with high burden of communicable diseases and low CDC coverage in MEVs. Selection criteria will also consider local commitment, presence of partners, and cost-effectiveness of reaching and having impact on these MEVs. The provincial preventive medicine centers will need to conduct the selection process after initial orientation. Plans will need to be included in provincial annual operational plans, approved at higher level, and investment sustained from local sources in subsequent years.

17. In summary, most EMGs in GMS border areas can no longer be thought of simply in terms of disadvantage due to isolation; they are becoming increasingly less isolated, more

disease-prone, more marginalized while being rapidly integrated into national and regional economic processes and the associated processes of social change. This transformation is largely a result of new roads opening up previously isolated areas, attracting not only investment in mines, plantations, dams, logging and other enterprises growing numbers of national and international cross-border migrants. In most cases, EMGs are beginning this process of integration from a very disadvantaged position. Although EMGs are more likely have a higher burden of infectious diseases than mainstream populations due to factors outlined above, there are no comprehensive national or regional data comparing CDC incidence and prevalence among EMGs compared with majority populations in CLMV, although some information can be inferred from provincial data. The disparities are highlighted in country specific data showing that provinces with high infant and child mortality rates also have high concentrations of EMGs. Surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by health centers and hospitals. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive. Table 4 presents some proxy indicators comparing health status of EMGs and their use of health services with the general population:

Table 4: Health status of Ethnic Minorities and Migrants and Use of Health Services compared to General Population

Indicator (latest available)	Cambodia	Lao PDR	Myanmar	Viet Nam
Population (millions)	15.9	6.8	54.2	92.5
Ethnic minority population (%)	5	40	32	14
Internal migrants per year (1,000)	5.500	70	940	1.400
Estimated external migrants (1,000)	76	22	103	68
Refugees (1,000)	92	Na	1.184	11
Child mortality general population	42.5	41.9	62.4	21.7
Child mortality ethnic minorities	NA	NA	NA	39
Child malnutrition in main population %	28.3	33.9	NA	16.9
Child malnutrition ethnic minorities %				34.2
HIV prevalence in main population %	0.6	0.3	0.7	0.5
HIV prevalence among sex workers %	4.6	NA	18.4*/**	3
TB incidence main population /100k	390	189	369	140
Malaria cases confirmed fy 2013	21,309	46,202	333,871	17,128
Malaria deaths confirmed / 100k fy 2013	1.7	4.4	5.4	0.1
Full Immunization main population %	NA	NA	NA	>95%
Full Immunization EMGs %	NA	NA	NA	<85%

*Viet Nam Economic and Development Strategy Handbook, 2004
** anecdotal reports, e.g., one study reports under age Hmong sex workers for tourists in Sapa
*** e.g., one study for Lao migrants returning from Thailand
**** BWHO National Survey of Tuberculosis Prevalence 2010
/ SEAJTM Prevalence of Tuberculosis in Migrants 1996
*/** HIV data from UNAIDS 2008 report
HIV data from UNAIDS 2014 report
WHO and World Bank indicators
SEAJTM Prevalence of Tuberculosis in Migrants 1996

ANNEX 2: EGDP Consultation (conducted in Q4 2015)

Topic	Questions	Responses	Proposed action
Ministry of Health			
Health Plans	Are policies for ethnic groups and migrants adequate?	In 12 provinces has equity fund for poor ethnic group not cover of migrants in border area in 2017 HOH equity fund will cover all provinces	Cooperate with MOH and MoLS to improve health service for ethnic & migrant
	Are national plans addressing needs of ethnic groups and migrants?	Yes, national plans almost mentioned on ethnic groups and less for migrants; the government prioritized to develop villages of high proportion of EMGs.	
	Are there legal barriers?	There are no legal barriers of EMGs and migrants follow government rules and procedures.	
	What are planning issues for ethnic groups and migrants in regional CDC?	The planning is covering of ethnic groups and migrants in remote area.	MOH in cooperated with NGOs that working in these areas
	Is investment in CDC addressing the needs of ethnic groups?	Few para in this current CDC, MOH will improve services to remote areas cover of ethnic minority	MOH in cooperated with NGOs that working in these areas
	What could be negative impact of a regional CDC project on ethnic groups and migrants?	Alignment national program into regional CDC and make sure of sustainable after project complete.	MOH to develop a regional CDC program
	Are Government and partners active in regional CDC?	Yes, government and partners in region is working together at policy and planning level. At provincial level has cross-border CDC cooperation not at national level. These plans do not specifically address regional concerns related to EMGs and migrants, but do make some recommendations.	
	What would be major constraints for CDC in border areas?	The main constraint in each border areas is security problems between country. In some border did not have a local health officer neither office for working	Some local border have no health office
Health Status	Is the specific health status of ethnic groups and migrants known?	MoLS and NA responsible for EMGs and migrants workers it is not including of health indicators. Some migrants HIV/AIDS indicators collected by CHAS based on survey not surveillance.	MOH does not have a regularly system for collection of migrants health, however MoLS have some report of migrant worker
	What explains the poor health status of ethnic groups and migrants	No clear system for evidence of poor health status of EMGs as in each health facilities in remote areas. Also no survey or surveillance of their health problem and how they search for treatment as the difficulty of access to health service. Migrants labors have the same problem	MoLS developed the labor law in 2009 and it will review and adopted to ASEAN labor law

Topic	Questions	Responses	Proposed action
		as MoLS have limited regulation and supervision of migrant labor	in 2020
	Are ethnic groups and migrants more prone to epidemics?	It depends on their exposure determined by occupation and living conditions, health status, knowledge, and timely reporting but specific risk profiles are lacking	CDC should make a survey of extract from their regularly surveillance
Health Services	What are the problems of providing health services for ethnic groups and migrants?	In additional problem of communication and trust of health service. In timber area or remote area construction may have their own health service	
	Are health services affordable for ethnic groups and migrants?	Health services have equity fund for poor ethnic existing in remote health facilities in whole country.	This needs to be further investigated through interviews of patients
Department of Planning & Cooperation			
Health Plans	Are EMGs and migrants specifically referred to?	Sure that EMGs is primarily target gaps in health plan same as gender, however the general direction of health service should be available to the general public, irrespective of ethnic status.	Health plan should include of migrant
Health Status	Occurrence of epidemics	There have not been a major cases of emerging infectious diseases	
	What are the specific health problems of EMGs and migrants?	EMGs often have hygiene and poverty related diseases like diarrheal diseases, pneumonia, tuberculosis and malnutrition. Prevalence of sexually transmitted diseases may be higher in migrants but they usually go to a private clinic.	The project should assist with health promotion and safe sex in communities, and link people to health facilities
Health Services	What are the major hurdles for ethnic groups and migrants to access services?	Some ethnic groups prefer traditional medicine. If they live far away, travel time and transport costs are problems. Migrants may be reluctant to access public health services, or may not get permission	
	For those who can't pay out of pocket, are there arrangements?	Yes, in all public hospital have user fee for health care service for people who can afford to pay.	To be investigated if this works adequately
Health Monito-ring	Are health and health services data split by ethnic groups and migrants?	Yes, in the registration book at each health facility have one column for ethnic group, unfortunately that not in the national health statistic. Migrant not existing in the registration book	The project may assist national health statistic to keep the record
Health Staff			
Health Plans	Are you aware of any special arrangements for EMGs and migrants?	Not known	To be investigated
Health Status	What do you see as the major health problems of ethnic groups and migrants?	EMGs who living in remote area are poor and limited knowledge of hygienic and practice of traditional believing many of them are suffered from common infections. Migrants almost using of their	Health problems to be identified by the IA outreach team using a participatory approach with target

Topic	Questions	Responses	Proposed action
		camp care service few of them are using of health facilities service.	groups
	Do you think HIV and TB are higher or lower among ethnic groups and migrants?	TB is higher in among of ethnic groups, HIV higher in migrant worker. As TB common found in poor, malnutrition and elderly.	This requires a more formal study, beyond the scope of this Project
Health Services	Are ethnic groups and migrants using these health services as others?	In each province have different ethnic groups either in the big city, they are using health services except some remote area in border district was hard to access to the health facilities service. Very rare for migrant to use health service at facility as it has their own camp service.	
	Are there specific access problems in the provision of health services to ethnic groups and migrants?	Sure that it has, but no record of identify of hard accessible problem; almost with the road and transportation for ethnic groups. Migrants has camp service for each timber except for illegal timber that hard to find service	
	Are there language problems?	Yes, some ethnic could not communication with national language.	
	Are there affordability problems?	Many of them could not pay of user fee that hospital collect for treatment service; almost for surgery and some expensive care cost.	WHO report in 2009 on out of pocket
	Any other problems?	Some ethnic group has a barrier of culture to use of health care service at health facility	Almost for birth delivery
Ethnic Community Representatives			
Health Plans	Are you involved in discussions to improve health services?	Some provinces such as LNT, PSL, ODX, XK, SK and ATP that we visited were involved in the community meeting for improving of their health service	Lacking of follow up from province to central on their plan
	Do you think plans are appropriate for the local community/	In the root level the plan was appropriate unfortunately that very few selected to include in the national health plans. It means that some activities was drop out and no money. Data collection during our field trip.	
Health Status	What do you see are the major health problems in your community?	All disease that they found the major health problems but none of them mentioned of hygienic	Just for ethnic community near by the health facility
	Did you have any major epidemics?	Seasonal cough and diarrhea	As above
	Are TB and HIV major health problems?	TB and HIV has free treatment at all health facility	
	Are there specific groups more at risk?	Ethnic group in remote area that hard to access, and migrants that work at illegal timber	
Health Services	What are the good parts of the health services?	The health staff at remote health facilities that courage to work over there ever that not enough means	

Topic	Questions	Responses	Proposed action
	What parts of the health services would you like to see improved?	Staff quality and supplies equipment for running health services both in health facility and outreach	
	Are health services affordable for the poor?	No, to expensive for the villagers that qualify as not poor, as it has equity for poor	To be investigated
Ethnic Patients			
Health Status	What is the reason for your admission?	High fever, diarrhea, cough chronic, vomit ….	They could not tell with diagnosis
Health Services	Do you find the hospital clean, can you get clean water and toilet?	Province and district hospital are clean not at health center because some time no water and toilet cannot use without water	
	From how far did you travel?	From some ethnic group took almost a day to access HC, some nearby informed	
	Are you happy with the quality of care?	Yes some staff is our ethnic group so we can communicated with them	
	Are health services affordable?	Some time we paid for the fee and some time we bought additional medicine that hospital no have	
Female and Male Ethnic Members			
Health Status	What are main health problems in your community?	Cough, diarrhea, high fever with vomit and malnutrition	
Health Services	Are health services adequate	For small sick is OK but not for serious sick must go to higher hospital	They need some transport
	What is availability and attitude of staff?	The staff living near to their health service and they are helpful	
	Are medicines available?	Basic treatment mostly available	
	Other issues?	Improve of emergency services	
Partners			
Health Plans	What are planning issues for ethnic groups and migrants in regional CDC?	Lacking of data information on EMGs and migrant in health statistic and very rare to use at MOH level. Some partner such as Lux. Dev, have some few case study at the project sites only. Migrants information may existing in some INGOs that worked in their project area only and not a systematic regularly collection	The Government to conduct a survey for the migration health policy. The project can help to collect some data in target area
	Is investment in CDC addressing the needs of ethnic groups and migrants?	EMG is including ethnic in city, provinces, districts and remote area are serviced through general health system all population could access to the health facilities. Migrant based on the Labor law for health access, except illegal migrant labor need to registered	Clear information need from survey or surveillance
	Are there legal issues for ethnic groups and migrants?	Yes for ethnic group not special for migrants	To be investigated by MOH in preparation of the Migration Health

Topic	Questions	Responses	Proposed action
			Policy
	What are major gaps?	- Lack of data information to analysis - no specific issue for migrants in health plans - Developing a comprehensive multi-sectoral program endorsed by all stakeholders including the private sector for regulation and implementation	As above
Health Status	What is the HIV and TB status among ethnic groups and migrants?	Based on data information from the Global Fund project there are no conclusion data on the status of EMGs and migrants. CHAS and NTB made some survey on TB/HIV infection in migrants worker, it seems that the prevalence is high but could not compare data of reach percentage	This requires a special survey, which is beyond the scope of the project
	Is the surveillance system reaching ethnic groups and migrants?	Yes, the surveillance system reaching ethnic groups for some diseases and outbreaks are reaching all community. Migrants hard to get a clear data information	The project will strengthen the surveillance system
Health Services	How is access to health services for ethnic groups and migrants?	All population including ethnic and migrant are fully accessible to health services except some ethnic in remote that hard to access almost during the rainy season. Some illegal migrants may not access to health service	
	What is the government capacity in providing services to ethnic groups and migrants?	The government capacity is limited to provide service to ethnic group in remote area, however government try to put some GOL for improving service with distributed some qualify staff to remote province and districts. Migrants still need to improve policy and it strategy plan	
	What works better in reaching ethnic groups and migrants?	Government health service in cooperation with INGOs to improve working condition. The government should supported the INGOs to reach the remote ethnic groups and migrants as many iNGOs are working with ethnic group and migrants than the public	

1. Social Safeguards Specialists made a 3-day visit (October 21-24 2015) to Bokeo province, one of the 12 project provinces, located in North–West of Lao PDR. This province shares a boder with Thailand through the Friendship Bridge No.4 In Huoyxai, the capital city of Bokeo province.

Social Sagfeguards Specialists met with representatives from the Provincial Lao Front for National Construction (PLFNC), including heads of Ethic and Religion, Cabiniet, and Ethnic Section. PLFNC reported that in Bokeo is existing 4 Ethno-Linguistic Family Groups, 13 ethncis, 27 sub-groups, and that the major health problem faced by ethnic people is maralia, diahhrea.

The SSG Specialists visited Bolek village, located about 20 km from Huoyxai, where two major ethnic groups reside, namely Leu (Lao-Tai Ethnic) and Khmou (Mone-Khme Ethnic). They share one primary school to learn the language, and use Lao language to communicate with each other, except at own home they may use own language. The inter cultural issue is that the Lao different ethnic people can marry across ethnic groups in the same area or different area. When ill, they go to the provincial hospital and use Lao language to communicate with the medical staff, or a relative will help to translate. For serious cases, and if the household has enough money, they cross the border into Thailand to seek treatment in a Thai hospital. According to the DOH, proposals have been submitted to the District Administration Authority regarding the construction of a new health facility. The DAA will consider the new (land for land) land[15] with the agreement of the affected people[16], especially ethnic group people. A visit to the border check point at the 4th Friendship Bridge and found two women posted to work at the quarantine, but did not see any equipment to check to find out the ill visitors.

[15] Lao population density is still low, so the land for land is not big problem for the resettlement.

[16] The Lao Constitution is stated that in the Article 1: … *It is a unified country belonging to all multi-ethnic people and is indivisible*…In the Article 17:… *Land is a national heritage, and the State ensures the rights to use, transfer and inherit it in accordance with the laws.*

ANNEX 3: Ethnic Group Development Plan

Project Outputs	Sub-outputs	Ethnic Groups' Design Features/Activities	Performance Targets/Indicators
Output 1: improved GMS cooperation and CDC in border areas	1.1. Improved regional, cross-border and inter-sector cooperation 1.2 Enhanced knowledge management and community of practice (COP) 1.3 Increased access to CDC in border areas, in particular for vulnerable groups such as migrants, HIV positive youth, pregnant women, and isolated ethnic minorities.	Enhance participation, capacity building and decision making opportunities for representatives of IP in regional, cross-border, and inter-sectoral events. Use workshops for EG advocacy and increasing EG awareness among workshop participants and stakeholders/governments. Ensure full participation of EG staff for outreach activities using IP-sensitive education and care procedures. Proactively target EG at increased risk of infectious diseases with CDC activities in border areas.	Workshop materials clearly demonstrate mainstreaming of EG issues and promotion of EG-sensitive strategies. Participation of IP staff in outreach activities.
Output 2: strengthened national disease surveillance and outbreak response systems	2.1 Strengthened surveillance 2.2. Strengthened response	Collect, analyze and report EG-disaggregated data. Ensure participation of EG staff in any outbreak response teams. Increase participation of IPs in field epidemiology training.	EG disaggregated reporting for CDC project activities in each country. In districts with over 20% EGs, each outbreak response team has at least one EG staff. Of participants in field epidemiology training, at least 5% are EGs in Cambodia, 10% in Lao PDR, 20% in Myanmar, and 10% in Viet Nam.
Output 3: improved laboratory services and hospital infection prevention and control	3.1 Improved laboratory quality and biosafety 3.2 Improved infection prevention and control in hospitals	Ensure representative EG participation in laboratory training programs for districts with large EG population. Ensure representative participation of EGs in scholarships for hospital infection prevention and control. Ensure EG sensitive facilities in isolation wards	Representative participation of IPs laboratory management and quality assurance training programs Representative participation of EGs in hospital infection and control training. All repaired isolation wards provide arrangements for EGs

Project Outputs	Sub-outputs	Ethnic Groups' Design Features/Activities	Performance Targets/Indicators
Project Management	3.1 Ensure Integration of project activities in regular services 3.2 Improve efficiency and governance.	All implementation plans for specific project activities and annual operational plans (AOPs) supported provinces address gender and EG dimensions of project activities All implementing agencies have an EG focal point All quarterly reports report on progress in EG issues	Proportion of project implementation plans and AOPs that address IP dimensions adequately. Proportion of active focal points in implementing agencies (based on participation in events. Proportion of quarterly reports that report on EG issues.