Ethnic Group Development Plan, Myanmar

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Myanmar: Greater Mekong Subregion Health Security

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

CURRENCY EQUIVALENTS

(as of 7 April 2016)

Currency unit	–	kyat (MMK)
MMK1.00	=	$0.00085
$1.00	=	MMK1,170

ACRONYMS

ADB	–	Asian Development Bank
AH	-	Affected Household
AHI	–	Avian Human Influenza
AI	–	Avian Influenza
AIDS	–	Acquired immunodeficiency syndrome
AOP	–	Annual Operational Plan
ANM	--	Auxiliary Nurse Midwife
APSED	–	Asia-Pacific Strategy for Emerging Diseases
ARI	–	Acute Respiratory Infections
BMA	–	Burma Medical Association
BWM	–	Burmese Women Association
CBO	–	Community-based Organization
CDC	–	Communicable Diseases Control
CDC1	–	First GMS Regional Communicable Diseases Control Project
CDC2	–	Second GMS Regional Communicable Diseases Control Project
CLMV	–	Cambodia, Lao PDR, Myanmar and Viet Nam
CLV	–	Cambodia, Lao PDR and Viet Nam
CTA	--	Chief Technical Adviser
DCDC	–	Department of Communicable Diseases Control
DIHC	–	Department of International Health Cooperation
DMF	–	Design and Monitoring Framework
DMS	–	Department of Medical Services
DPH	–	Department of Public Health
EA	–	Executing Agency
EHF	–	Ebola Hemorrhagic Fever
EGDP	–	Ethnic Group development plan
EHF	–	Ebola Hemorrhagic Fever
EID	–	Emerging Infectious Diseases
EMDP	–	Ethnic Minority Development Plan
EG	–	Ethnic Minority Group
GAP	–	Gender Action Plan
GMS	–	Greater Mekong Subregion
GSSS	–	Gender and Social Safeguards Specialist
HEF	–	Health Equity Funds
HIV	–	Human Immunodeficiency Virus
HMIS	–	Health Management Information System
HSP	–	Health Security Project
IA	–	Implementing Agency
IEC	–	Information, Education and Communication
IHR	–	International Health Regulations
ILO	–	International Labour Organization
IMR	–	Infant Mortality Rate
IOM	–	International Organization of Migration
MDG	–	Millennium Development Goal
MERS	–	Middle-east Respiratory Syndrome
MEV	–	Migrants, Ethnic and other Vulnerable Groups

MOHS	–	Ministry of Health and Sports
MMR	–	Maternal Mortality Ratio
MNCH	–	Maternal, Neonatal and Child Health
MOF	–	Ministry of Finance
MOLES	–	Ministry of Labour, Employment, and Social Security
M&E	–	Monitoring and Evaluation
NGO	–	Non-governmental Organization
NHL	–	National Health Laboratory
OD	-	Operational District
PAM	–	Project Administration Manual
PCR	–	Project Completion Report
PDR	–	People’s Democratic Republic (Lao-)
PHC	–	Primary Health Care
PMU	–	Project Management Unit
PRC	–	People’s Republic of China
RCU	–	Regional Cooperation Unit
RHU	–	Regional Health Office
RSC	–	Regional Steering Committee
SARS	–	Severe Acute Respiratory Distress Syndrome
SDR	–	Special Drawings Right
SPS	–	Safeguard Policy Statement
S/RHO	–	State/Region Health Office
S/RMU	–	State/Region Management Unit
U5MR	–	Under-five Mortality Rate
UNAIDS	–	United Nations Joint Program for the Control of HIV/AIDS
UNDP	–	United Nations Development Program
UNFPA	–	United Nations Fund for Population and Development
UHC	–	Universal Health Coverage
UNICEF	–	United Nations Children Fund
VHW	–	village health worker
WHO	–	World Health Organization

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.

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CONTENTS

1. EXECUTIVE SUMMARY ... 1
2. DESCRIPTION OF THE PROJECT ... 4
3. SOCIAL IMPACT ASSESSEMNT ... 8
   A. Legal and Institutional Framework ... 8
   B. Baseline Information ... 10
   C. Stakeholders and Consultations ... 12
   D. Vulnerabilities, Risks, and Project Effects ... 13
   E. People's Perceptions ... 14
   F. Proposed Measures ... 15
4. INFORMATION, DISCLOSURE, CONSULTATION AND PARTICIPATION ... 15
5. BENEFITS, IMPACT AND MITIGATING MEASURES ... 16
   A. Mitigating Measures ... 17
6. CAPACITY BUILDING ... 17
7. INSTITUTIONAL ARRANGEMENTS ... 18
8. GRIEVANCE REDRESS MECHANISM ... 18
9. MONITORING, REPORTING, AND EVALUATION ... 18
10. BUDGET AND FINANCING ... 19

ANNEX 1: INFORMATION ON MIGRANTS, ETHNIC AND OTHER VULNERABLE GROUPS ... 20

ANNEX 2: EGDP CONSULTATION ... 27

ANNEX 3: ETHNIC GROUP DEVELOPMENT PLAN ... 32

1. EXECUTIVE SUMMARY

1. This Ethnic Group Development Plan (EGDP) presents the Myanmar-specific ethnic group analysis, strategy, and plan for the GMS Health Security Project based on the Government's and ADB's policy on indigenous people.[1] Ethnic groups (EGs)[2] are the majority population in several of Myanmar's States, and elsewhere are also fully mainstreamed in Myanmar society.[3] It would be more practical to focus on EGs that may not have access to services, are being displaced, or lack citizen rights and empowerment. In the context of the Project, this EGDP focuses on the first group, including remote ethnic groups, and internal and external migrants over half of whom are EGs. The challenges of control of infectious diseases of regional relevance in these two subgroups are quite different.

2. The proposed GMS Health Security Project for Cambodia, the Lao PDR, Myanmar and Viet Nam aims to improve regional public health security by strengthening health security systems and Communicable Diseases Control (CDC) in border areas, particularly for migrants, youth, and ethnic minorities. Three components or outputs[4] 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 5 states and 1 region in Myanmar, 13 provinces in Cambodia, 12 provinces in the Lao PDR, and 36 provinces in Viet Nam. In Myanmar, approximately 2m people (two thirds of those living in target project areas) are classed as EGs, living in diverse socio-economic settings with different customs and languages. In Myanmar, the targeted states and region[5] are Shan North, Shan East, Kayah, Kayin, and Mon States, and Tanintharyi region bordering China and Thailand. Tanintharyi region has a high poverty rate of over 30%. All provinces have substantial populations of EGs, for example the Shan, Kayin, Rakhine, Chinese, Mon, Kachin, Indians and Kayah as well as others.

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[6]:

"*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*

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[1] As described in the ADB Safeguard Policy Statement (2009).

[2] In Myanmar, the term *ethnic group* is more commonly used instead of *ethnic minority group* or *indigenous people.*

[3] The Government of Myanmar doesn't use the term "*indigenous peoples*" but "*race*" or "*ethnic minority*".

[4] Government uses the term 'components' and ADB uses 'outputs', therefore both terms are used in this EGDP

[5] Administratively, Shan North and Shan East are parts of the Shan State, one of 15 States, Regions and Territory the makes up the Union. The capital city of the 'Shan State' is Taunggyi, where the Chief Minister and the Shan State Government have their offices. Kengtung (Eastern Shan) and Lashio (Northern Shan), the targeted project areas are within the Shan State.

[6] ADB. 2013. *Indigenous Peoples Safeguards: A Planning and Implementation Good Practice Sourcebook (Draft Working Document)*. Manila

[EGDP]." While the project is expected to have positive impacts on IPs, they are not the sole or 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 Myanmar 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 for the Ministry of Health and Sports (MOHS) to continue collaborating with religious, military, and grassroots organizations and NGOs, which are more capable of addressing ethnic group issues at community level and in difficult locations. In Myanmar, EGs comprise about 35% of the population. Basic ethnic group legislation is in place, such as constitutional rights and obligations, but the focus is on poverty reduction is by location rather than by EG. There may be need for further legislation to deal with hard to reach EGs. The Government continues to face political and capacity constraints that limit services for EGs. The Myanmar MOHS is experienced working with various state organizations and NGOs, but is less experienced contracting with NGOs or establishing public private partnerships to provide such services. Due to staff constraints in remote rural areas, the option of the government directly providing services in place of contracted NGOs is still to be determined. However, village health groups and grass-root organizations may also be relied upon for social mobilization and village health care development.

8. It is recommended that MOHS 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 (indigenous peoples plan) implementation. Project Directors are committed to provide the necessary leadership and inputs to fully implement the EGDP. Key features of the EGDP 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 $0.9 million. The project will engage a national safeguard specialist 9 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. DESCRIPTION OF THE PROJECT

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 also have major economic impact. New zoonosis diseases also pose a constant threat in the region.

2. The 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. While climate change including global warming and frequent flooding may also further increase the disease burden of infectious diseases. While the incidence of HIV/AIDS, tuberculosis and malaria have declined following major investments, drug resistant strains, such as those for malaria and TB, are also considered EIDs and major threats for the control of these diseases. Preventable childhood infections are resurging due to weak vaccination systems, further requiring 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[7] 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. This is in line with the concept of 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 a strong public good and equity rationale, also considering the potential economic and political consequences of a major epidemic or pandemic.

5. MOHS and WHO conducted an evaluation of APSED implementation in 2015. Myanmar has not yet achieved IHR and APSED targets. Core functions owned by MOHS 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 MOHS will

[7] According to WHO, 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.

need to strengthen 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 information technology (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, further 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 Myanmar, 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.

1 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 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. ADB is currently supporting the CDC2 extension in Cambodia, Lao PDR and Viet Nam. Other major partners in the field of CDC are WHO, other UN agencies, and USA.

14. The project will assist with implementation of the Government's drive towards Universal Health Coverage and also support government goals to advance Public Health Security. The countries give priority to disease prevention and control in poor border districts with multiple risks of communicable diseases and weaker public health system.

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.** This component will (i) strengthen regional, cross-border and inter-sectoral cooperation for the control of epidemics including EIDs, Dengue and other important regional diseases; and, (ii) 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**. This component will extent the current surveillance and response system by expanding web-based reporting, improve surveillance and response capacities, and improving community preparedness and syndromic reporting at village level.

(iii) **Improved laboratory services and hospital infection prevention and control**. This component will improve quantity and biosafety of laboratory services, scale up where appropriate for monitoring hospital based infection and drug resistance, and improve hospital hygiene and management of highly infectious diseases.

17. **Cost estimates and financing.** In Myanmar, 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 $4.0 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. Provincial administrations will encourage ethnic groups to use services.

18. **Project implementation.** The Ministries of Health (MOH) in each country will be the executing agencies (EAs), responsible for in-country implementation and coordination among countries. In Myanmar, the EA is represented by the Department of Public Health and the Department of Medical Services (for consideration of the Minister of Health). The MOHS steering committee chaired by the Minister of Health will direct and monitor the project implementation. MOHS will appoint a senior government officer as project director.

19. The project management unit (PMU) will be established in the MOHS to 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. A deputy project director will assist the project director in day-to-day project coordination and management, including administration. The National Health Laboratory (NHL) and the 12 townships health departments will be 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. 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. 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.

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 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 currently being reached for CDC in border areas. In Myanmar, the aim at this early stage is to develop model services in state laboratories and major border hospitals.

22. **Location**. The Project is to cover 3 east-west corridors and one multi-limbed north-south corridor representing 4 distinct geographical clusters of MEV issues, as shown in Annex 1. In Myanmar, it includes Shan North, Shan East, Kayah, Kayin, and Mon States, and Tanintharyi region bordering China, the Lao PDR, and Thailand. In Cambodia, 13 provinces are included in 3 clusters in the north-west, north-east, and south-east. In the Lao PDR, 12 provinces are included in 3 clusters in the north, center and south of the country. In Viet Nam, 36 provinces are included along the northern border with China and the western border with the Lao PDR and Cambodia. The north-south corridor connects major industrial areas in China with industrial areas in Viet Nam, Lao PDR, Cambodia, Thailand, and Myanmar and is the important one in terms of traffic flow, while migration flows are mainly to Thailand. The central corridor comprises most EGs, and the north-south corridor passes through few locations with high concentration of EGs, which could be hotspots for targeting.

23. In Myanmar, all 5 states have substantial populations of EGs. The GoM has identified 135 ethnic groups, with some states named after the larger ethnic groups. Tanintharyi region has a high poverty rate of over 30%. Within all border districts along economic corridors, hotspots and communities with high burden of communicable diseases and low CDC coverage will be selected, using reported and estimates cases. Selection criteria will also consider local commitment, presence of partners, and feasibility of having impact on these communities. The project districts will conduct a participatory assessment and

planning process, and ensure that plans are included in the provincial annual operational plan, and sustained from local sources after project completion.

3. SOCIAL IMPACT ASSESSEMNT

A. Legal and Institutional Framework

24. According to ADB's 2009 *Safeguard Policy Statement (SPS)*, the objectives of [EGs'] safeguards are to design and implement projects in a way that fosters full respect for [EGs'] identity, dignity, human rights, livelihood systems, and cultural uniqueness as defined by the [EGs] 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 policy for EGs as presented in the SPS includes the following principles:

(i) Screen early on to determine (i) whether [EGs] are present in, or have collective attachment to, the project area; and (ii) whether project impacts on [EGs] 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 [EGs]. Give full consideration to options the affected [EGs] prefer in relation to the provision of project benefits and the design of mitigation measures. Identify social and economic benefits for affected [EGs] that are culturally appropriate and gender and inter-generationally inclusive and develop measures to avoid, minimize, and/or mitigate adverse impacts on [EGs].

(iii) Undertake meaningful consultations with affected [EGs] and concerned [EGs] 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 [EGs] in a culturally appropriate manner. To enhance [EGs'] 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 [EGs'] concerns.

(iv) Ascertain the consent of affected [EGs] to the following project activities: (i) commercial development of the cultural resources and knowledge of [EGs]; (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 [EGs]. For the purposes of policy application, the consent of affected [EGs] refers to a collective expression by the affected [EGs] , 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 [EGs] 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 [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 [EGs]. The [EGDP] includes a framework for continued consultation with the affected [EGs] during project implementation; specifies measures to ensure that [EGs] 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 [EGs]and other stakeholders. The final [EGDP] and its updates will also be disclosed to the affected [EGs]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 [EGs] have traditionally owned or customarily used or occupied, or (ii) involuntary acquisition of such lands.

(ix) Monitor implementation of the [EGDP] 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.

25. 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 may not have to be prepared when … only positive impacts are expected from the project."* While they are not the sole or overwhelming majority of expected project beneficiaries, and given the scale and complexity of this regional project, this EGDP has been prepared to help ensure that intended positive impacts on ethnic monitories are achieved.

26. Government policy relating to EGs identifies three essential features for EG development:[8] (i) the 2008 Constitution prescribes rights of EGs; (ii) The 1982 Citizenship Law enables EGs to be registered as citizens; and (iii) there are also initiatives to promote and support EGs e.g.; ethnic national days and committees have been designated and Ethnic Affairs Ministry has been established recently to work for ethnic groups in Myanmar. But policy and planning processes have not yet been amended by the new Government.

27. The Framework for Economic and Social Reforms (FESR) 2014[9] identifies policy priorities for the period 2012 to 2015. It acts as a bridge between the 5th Five-Year Plan (2011-12 to 2015-16) on one hand and, on the other, the reform-oriented National Comprehensive Development Plan (2011-31) and future five-year plans that will support it.

[8] The 2008 Constitution and the 1982 Citizenship Law.
[9] The 2014 National Framework for Economic and Social Reforms (FESR)

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

B. Baseline Information

29. Key demographic, economic and social indicators of the 4 targeted GMS countries are in Table 1. Several indicators regarding the specific health status of EMG are lacking[10]. 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
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
Indicator (latest available, 2013-2015)	Cambodia	Lao PDR	Myanmar	Viet Nam
Economic growth rate %	7.0	6.5	8	6.0

[10] This lack of information om ethnic groups was also observed by a UNFPA report

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
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Full Immunization main population %	NA	49	NA	>95%
Full Immunization EMGs %	NA	NA	NA	<85%
Contraceptive prevalence rate (%)	51	50	46	78

Sources: UN Statistics Division, 2013-2015
*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
*/***WHO and UNICEF estimates of immunization coverage: 2014 revision
HIV data from UNAIDS 2014 report
WHO and World Bank indicators
SEAJTM Prevalence of Tuberculosis in Migrants 1996

30. 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 is the prevalence of major communicable diseases, while health sector coverage of the population is not yet universal.

31. About one third of the population in the Lao PDR and Myanmar are EGs. This is much less in Viet Nam at 14%, and only about 5% in Cambodia.[11] These EGs are a very mixed group, but typically live in the highlands and mountains. In Myanmar EGs mainly live in respective States which are bounded central low land area of the country, with some small groups living elsewhere mixed by geographically and scattered throughout the country. It may be noted that some EGs were decimated during the war. People today are also hesitant to identify themselves as belonging to an EG, which is considered a lower social status in the hierarchical and status-conscious Myanmar society.

C. Stakeholders and Consultations

32. In MOHS, EG issues are referred to in general plans. As the government aims to mainstream EGs, there is no specific policy, strategy, plan or designated unit for EGs. The Department of Planning and Health Information Systems (DPHIS) is tasked with ensuring adequate services for EGs in view of achieving Universal Health Coverage (UHC), which will among others require improving the monitoring system and planning special investments. Each village or village tract has a village health group responsible for assisting with the implementation of health activities, reporting diseases, and planning village health improvements. There are many community based ethnic groups in Mon and Kayin State. These community-based ethnic groups work for basic health care and small health care centres in their states dominantly in southern border areas of Myanmar.

33. In Myanmar, several organizations are involved in the wellbeing of EGs, including religious and grass-root organizations, NGOs, EG associations and Government services. The lead government agency on EGs is the Ministry of Ethnic Affairs which was recently established by the new Government, and mandated on 30 March 2016 by Formation of Union Government. Most EG associations are formally or informally established in their respective states and also in other areas. The military operates 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 EGs. The Buddhist organizations, faith-based organizations and some social welfare organizations such as NGOs operate basic health services throughout the country. Muslim and Christian facilities provide services for their respective communities.

34. The proportion of migrants and mobile populations who belong to EGs, especially in proposed project areas, is not known. The presence of national or international associations or interest groups for specific EGs may not extend to the most disadvantaged groups, thus EG migrants may be less likely to benefit from the wide range of rights, benefits and protections. The impact of this process on the EG transition is not known as well. However, this new leadership could play an important role in policy making and planning in near future.

35. The consultation process has covered some stakeholders including Mon Women's Organization and some EG health staff in Mon State, Kayin State and Shan (east) State but also relies on information gained from the CDC2 project, the ongoing project with model healthy village development in the north-eastern provinces. Mon, Kayin and Eastern Shan States are both major borders with major industrial development, trade zone, casinos, and large migrant populations. The consultation and participation process undertaken during

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[11] Cambodia has between 1%-10% of EMGs, depending on the definition of EMG. If all minorities are included including Chinese, Cham and Vietnamese, it reaches 10%. If only traditional EMGs are included, it may be 1%.

preparation of this EGDP is discussed further in Section C. Information, Disclosure, Consultation and Participation.

D. Vulnerabilities, Risks, and Project Effects

36. EGs 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. EGs are beginning this process of integration from a very disadvantaged position. Migrants, EGs 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.

37. EG 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 EGs have been supported by governments and donors in CLMV for various reasons. In some provinces, movements of highland EGs 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.[12]

38. When highland-dwelling EGs 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.

39. EG 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 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.

40. Some EGs 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. Traditional beliefs and practices are common especially in remote areas. Shifting cultivation practices also limit the opportunities to access the health service for some EGs, especially women and children. EGs 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

[12] 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 Faim mission in Lao PDR. 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.

belittling treatment of EGs 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 EG villages. However, community-based interventions, such as those focused on malaria-prevention, are being currently implemented by organizations such as Save the Children and Population Services International (PSI). In addition, the United Nations Refugee Agency (UNHCR) currently implements behavior change and communication programs to prevent the transmission of HIV among migrant populations on the Thai-Myanmar border.

41. Provision of free health insurances has enabled poor EGs to have improved access to health services. However, costs for transportation, meals, some medicines and high-tech treatments are not covered under the Government scheme.

42. Although EGs 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 EGs 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 EGs. For example, surveillance data does not include ethnicity when it is collated at national and often also at provincial levels, though this data is collected by border check points, health centers and hospitals particularly Thai-Myanmar border. Therefore, most epidemiological data, unless based on special surveys, is not ethnically sensitive.

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

E. People's Perceptions

44. The proposed project interventions are much appreciated. The problem is on the supply side rather than the demand side, in that MOHS lacks the means to reach remote EMGs and migrants, and may be unable to assigned staff to these places.[13] NGOs are heavily engaged with EG work, but increasingly this function is being handed over to Operational Districts (ODs). One drawback of results-based budgeting is that it often focuses on the low hanging fruits to get the results, and consequently inadequately plan for EGs.

45. EG 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. EGs reside in isolated, hilly regions far from community facilities and systems, and it will be important to promote a sense of ownership of project interventions.

[13] In Myanmar, this has always been a problem despite incentive programs that are in place.

F. Proposed Measures

46. In preparation of project implementation, each PHD will request border Bag Packed Health Worker Team (BPHWT) to identify MEVs along economic corridors, and engage the village health group, CBO or other representative group to engage in a participatory assessment to identify gaps in health security and plan for a package of activities including screening, diagnostics, disease control, and referral to the established programs. Village or facility CDC plans will be included in Bag Packed Health Worker Team (BPHWT) annual plans and budgets, and if possible scaled up to OD or township level. This should help achieve benefits for MEVs in this project. Progress in rolling out the EGDP should be reported to MOHS. Further, MOHS can collaborate with EG Associations and CBOs that are working for EGs especially in health sector. Further details of EGDP specific activities are available in annex 3.

4. INFORMATION, DISCLOSURE, CONSULTATION AND PARTICIPATION

47. 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.

48. Key questions concerning EGs in project design, apart from general health status, include (i) their understanding of communicable diseases, causes, treatment, and prevention; (ii) EGs' 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 gender sensitive mechanisms for meaningful consultation with EGs in the project cycle. The project has no negative impact on EGs, so the focus is on how to improve positive impacts for EGs.

49. 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 20 September 2015 to 2 October 2015 and 15-26 February 2016. They met with MOHS Departments, WHO, IOM, World Bank, UNOPS, UNAIDS, the NGO Gender Group and Mon Women Organization. In one of the workshops, social safeguard requirements were presented to the Government.

50. The team visited Mon, Kayin and Shan States, and conducted interviews with state officials, health staff, and community members. Tools adopted by consultants for gathering information during field visits included open interviews and observations. Respondents were asked about their circumstances, views on health services, and health priorities. As there are no negative effects expected from the Project, the focus was on understanding the conditions and how the EGs could be assisted better through the project design. This is

provided in the EGDP assessment in Annex 3. The 7 implementing agencies (IAs) (5 states, 1 region, and 1 national health laboratory) will further engage affected EGs in local assessment and planning and disclose project plans, including this EGDP, to affected groups following completion of these documents. Both draft and final EGDP will be disclosed and posted in State and Regional Public Health Offices as well as respective General Administration Offices and on ADB's website.

51. 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 EGs 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 waver for poor people.

52. Among the risks noted were: (i) lack of interest of targeted EGs; (ii) weak provincial effort in participatory planning, implementation, and monitoring; (iii) lack of effort reaching isolated EGs, migrant camps, and hotspots; and (iii) insufficient technical and financial backstopping of MOHS. For migrants an additional issue is that 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 requires collaboration with 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. BENEFITS, IMPACT AND MITIGATING MEASURES

53. Direct beneficiaries in Component 1 will include prioritized EGs[15], migrants, laborers in camps, youth, local health staff, and community health workers. It is expected that in the 300 targeted districts (12 in Myanmar), the project will reach about 1 million MEVs, mostly through outreach. Migrants, youth, pregnant women, and remote EGs 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 motorcycles (under Component 1) and vehicles (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 CTAs, and the gender and social safeguard experts.

54. Component 2 will help improve community preparedness, timely detection, investigation, risk analysis, risk communication, and containment of emerging and other

[15] 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.

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 EG communities.

55. 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 staff and hospital staff, many of whom belong to EGs, and will work in EG areas.

A. Mitigating Measures

56. The purpose of this 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 EG communities. During project preparation EG communities and their representatives were consulted using key informant and focus group discussions (consultation will be continued during project implementation). To increase support for EGs and achieve positive outcomes for EGs in the project, project management units at central level (EEA/PMU) and state/region level (IA/PPMU) 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 EGs, 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.

57. The actions in the EGDP (Annex 6) support integration of EG 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 EGs. No negative project impacts were identified that would require mitigation measures, however lack of participation and weak implementation threatens the desired positive impact.

6. CAPACITY BUILDING

58. MOHS departments have demonstrated support for donor funded projects, but have less experience in working directly with partners. The WB has initiated a project to strengthen the health services, including capacity building of MOHS in administration and financial management. Related ADB health projects have shown a steady improvement in EGDP implementation, although there is no experience with health projects in Myanmar. However, Project Directors are committed to provide the necessary leadership and inputs to fully implement the EGDP.[16]

59. The Project will assist with training and capacity building of MOHS/PMU and PIUs, including for implementation of the EGDP, through training and field visits. This will be supported by the CTA and GSSS, who will particularly focus on component one with most EG issues. It will be critical for MOHS to attract competent mid-career consultants to provide effective capacity building. Training will also be provided for IPC nurses and field epidemiologists, with some orientation towards ethnic minority and migrant concerns. Key features of the EFDP, such as support for outreach, participatory assessment and planning, education, screening, and referral are mirrored in the project DMF, loan covenants, and

[16] Capacity assessment and capacity building in terms of facilities, human resources, technical capabilities and systems is of paramount importance and this should be on-going for a sustainable outcome of the project.

PAM.

7. INSTITUTIONAL ARRANGEMENTS

60. DPH and DMS will jointly represent MOHS as the EA and will be responsible for overall direction to ensure implementation of the EGDP. The PMU will be responsible for coordinating implementation of the EGDP through the IAs and S/RMUs. The PMU will have focal points for gender and social safeguards. The Chief Technical Advisor (CTA) and Gender and Social Safeguards Specialist (GSSS) will be engaged with special responsibility for Component 1. Linkages will be established with community-based organizations and partners as needed.

61. The S/RHD and National Health Laboratory will be the IAs responsible for EGDP implementation within their location/field. Each S/RHD will nominate focal points for EMGs and migrant safeguards. These focal points will be provided with sufficient means to ensure that EGDP related priorities are being mainstreamed and prioritized where possible.[17]

8. GRIEVANCE REDRESS MECHANISM

62. 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 MOHS Steering Committee under the MOHS. 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.[18] In cases where AHs do not have the writing skills or are unable to express their grievances verbally, AHs are allowed to seek assistance from any recognized local group, NGO, family member, village heads or community chiefs to have their complaints or grievances written for them. Throughout the grievance redress process, the responsible committee will ensure that the concerned AHs are provided with copies of complaints and decisions or resolutions reached.

9. MONITORING, REPORTING, AND EVALUATION

63. Monitoring, reporting and evaluation of the project for EGDP will follow the overall project monitoring, reporting and evaluation arrangements. PMU and S/RMUs, in consultation with beneficiaries, will ensure that appropriate EGDP sensitive indicators are collected at community and health facility levels with reference to the targets and indicators I Annex 6. PMU will prepare comprehensive quarterly reports based on agreed indicators as shown in the DMF. The reports will be submitted to ADB within the next quarter. 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. The beneficiaries will also be informed via Township Health Officers and community Heads by FGD on the project progress. Social Monitoring reports discussing progress in implementing the EGDP will be disclosed on ADB's website.

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

[17] Facilities and personnel need to have the capacity to deliver effective outputs/outcomes. Therefore Capacity Building is an essential component for all EAs, IAs and PMU at all levels. Roles of CTA and GSSS are critical.

[18] Grievances procedures should be put in place but may be culturally difficult to implement in some cases.

implementation details; (ii) Mid-term evaluation: assessment of progress of EGDP 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 EG 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 about about the availability of reports online.

10. BUDGET AND FINANCING

65. Estimated costs of CDC for vulnerable groups are budgeted for under Component 1, at a cost of about $0.9 million, most of which will benefit EG as targeted states are mainly populated by EGs. 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. 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.

66. 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. The GMS has distinct populations and hundreds of ethnic groups (EGs) and languages. While some EGs have lived in the GMS for a long time, other EGs migrated only recently from within the country or from neighboring countries. Perhaps due to their relative isolation, those in the highlands and mountains typically retained their culture and customs until recently. In recent years, large numbers of migrants have been moving in and out of the highlands and mountains, and new towns have developed in border areas.

2. Based on the 2014 Myanmar Population and Housing Census, Myanmar had a population of 51.4 million. The country is divided in 7 regions, 7 states and the capital region Nay Pyi Taw. The populations in Yangon, Ayeyawady, Mandalay, and Sagaing regions comprise about half the population. Females outnumber males by 7%, and 25% of the population is below 15 years. The country is in a political, economic and social transition with rapid economic growth. Project target area population is as follow:

Target Population	Total	Male	Female
Laisho	323405	158512	164893
Muse	117507	60946	56561
Keng Ton	171620	87779	83841
Tachileik	148021	74827	73194
Loikaw	128401	63109	65292
Mese	6319	3402	2917
Hpa An	421575	203910	217665
Myawaddy	195624	99771	95853
Mawlamyaing	289388	139026	150362
Ye	152485	76089	76396
Dawei	125605	60044	65561
Kawthaung	116980	59507	57473
	2,196,930	1,086,922	1,110,008

Source: Myanmar Population and Housing Census, 2014

3. Based on Health in Myanmar, 2014, the country has 135 national races[19] speaking over 100 languages and dialects. The major ethnic groups are Bamar (Burmese), Shan, Kachin, Kayah, Kayin, Mon, Chin, Rakhine. About 90% of the population is Buddhist. There are some less developed ethnic subgroups, in particular in the mountains in Kachin, Shan and Rakhin states. The Burmese mostly live in the central lowland of Myanmar, with Yangon as the economic hub. The second largest EG, the Shan, live on a ridged plateau in the east of the country. The other ethnic groups also live in mountainous areas along the borders of Myanmar, such as the Rakkhine and Chin in the west, the Kachin in the north, the Kayah and the Karen in the east, and the Mon in the south. The income poverty rate is slightly higher in rural areas at 29.2% compared to urban areas at 25.6%. By region, income poverty

[19] The GoM claims that there are 135 'ethnic races' in Myanmar. In March of 2016 another 'non-Burmese language speaking' group in the northern Shan State was designated an ethnic group called Mone Wan(Bamar)

is the highest in Chin (73%), followed by Rakhine (44%), Tanintharyi (33%), Shan (33%), and Ayeyarwardy (32%). Transitionary poverty is substantial in Myanmar, affecting about one third of the population, as households lack support of services to cope with financial shocks like for medical services.

4. Studies have documented that ethnic minorities are often left behind due to lack of economic opportunity, such as lack of quality agricultural land, social exclusion, lack of credit, and lack of access to markets. On average they have less income, and are move often poor and very poor. Gaps in poverty and health indicators are actually widening. EGs have less access to health services, and have worse health indicators. Women in Myanmar have relative equality in terms of major decisions, however in property ownership and financial aspects, the roles that girls and women assume throughout their lives are still based on culturally accepted notions of male dominance. Women also have additional workload of child caring and risks of childbearing.

5. Integration of various EGs, sometimes through resettlement but increasingly through migration, is continuing at a fast pace, while they start from a very disadvantaged position. Integration of EGs has been troubled by conflict, and illegal practices, causing major migration to Thailand. It is estimated that there are 1.2 million refugees living in Thailand and elsewhere. Due to civil conflicts there are internally displaced populations in some areas of the country for example in Kachin, Rakhine, Shan states. They are among the poorest and most vulnerable population groups and have limited access to quality health services, and combined with language and cultural barriers for many of them, they are highly vulnerable in terms of health services. They may not be identified in local population statistics and therefore local health plans may not be able to deliver in time the quality services that accommodate the particular circumstances and needs of internally displaced groups

6. Construction of highways and rural access roads in the GMS is rapidly improving regional and local connectivity, opening up new areas and creating economic corridors with industrial zones, plantations, and services that attract entrepreneurs, tourists, and migrants in search of employment. This development has been a major force for poverty reduction in the GMS, with both positive and negative impacts on health. Increasing mobility and income may increase food availability and access to health services, but also risks the spread of communicable diseases.

7. An increasing number of migrants, ethnic minorities and other vulnerable groups (MEVs) work in plantations, factories and entertainment and services in border areas and along economic corridors. Due to changing lifestyle, poor living and working conditions, unsafe transport, and less access to health services, these women and men have increased exposure to such conditions as malaria, dengue, tuberculosis, HIV/AIDS, water and food-born infections, malnutrition and road accidents. A major problem is that these returning migrants do not get pre-screening nor do they have access to treatment at home, so they have to try to return to Thailand to continue treatment. Default rate is high, leading to drug resistance. Such data for Myanmar are not available. However, there is a lack of disaggregated information.

8. The 2014 census listed the total number of internal migrants as 9.4 million. The number of unregistered migrants is not known. About 1 million registered external migrants and an unknown number of illegal migrants live abroad. More than half of these are likely to be EGs, who migrate primarily because of economic opportunity.

9. The rapid economic transition and weak enforcement of labor laws create an environment of exploitation of migrants.[20] An International Labor Organization (ILO) survey of internal migrants found that 24% of migrants were in a situation of forced labour, which, among others, often involved long working hours and poor living and working conditions.[21] Youth and young women are especially at risk of abuse. From 6% to 10% of migrants are under-age. There is also evidence of exploitation within Myanmar, including sexual exploitation, such as in Kachin and northern Shan states, were some women are forced into prostitution or marriage inside China.[22] Prostitution and drug addiction are widespread throughout Myanmar, despite strict government laws.

10. A presentation at the Myanmar Health Forum: Investing in Health: the Key to Achieving a People Centered Development, on 28 July 2015, illustrated the high burden of communicable diseases in Myanmar compared to other countries in the region. Health statistics from 2012 indicate that infectious diseases are still prominent, particularly in states predominantly inhabited by EGs. Possible causes for such a high level of infectious diseases are poor preventive practices, and lack of coverage of villages. Domestic health spending in Myanmar has been extremely low until recently. This long period of low spending has caused a wasted health system, which will need many years of rebuilding.

11. In remote EG areas, the public health services are sometimes inadequate due to geographic, social and economic constraints. Health facilities may lack staff from these EMGs, as they are often less educated and can't access vocational training. Rural access roads are often lacking or not accessible in the rainy season. Many hard-to-reach villages are located in border areas with security problems, sometimes 3 days away from the township center by boat or walking. Language and cultural barriers and poor understanding of health care benefits are key factors preventing EGs from accessing facilities. Some EGs 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. In some provinces, movements of highland EGs 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.[23]

12. EG 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 and are more likely to have a higher burden of infectious diseases than mainstream populations due to factors outlined above. Some studies suggest, for example, higher level

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[20] ILO. The Mekong challenge – Underpaid, overworked and overlooked: The realities of young migrant workers in Thailand. 2006. Bangkok. www.ilo.org/asia/whatwedo/publications/WCMS_BK_PB_67_EN/lang--en/index.htm Human Rights Watch.From the tiger to the crocodile: Abuse of migrant workers in Thailand. 2010. Bangkok. www.hrw.org/sites/default/files/reports/thailand0210webwcover_0.pdf

[21] Source: Internal Labour Migration Survey, ILO-Yangon, 2015.

[22] Kachin Women's Association Thailand: Pushed to the brink: Conflict and human trafficking on the Kachin-China border. 2013.
www.kachinwomen.com/kachinwomen/images/stories/publication/pushed_to_the_brink.pdf
Burmese Women's Union. Caught between two hells: Situation of women migrants in Thailand and China. 2007. www.womenofburma.org/Report/Caught between two hells.pdf

[23] 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 Faim mission in Lao PDR. 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.

of malaria in illegal forest workers, and tuberculosis and HIV among returning migrants. However, there are no comprehensive data that include ethnicity and hospitals. Overall, the government is lacking information, policy and plan to address the needs of both remote EGs and migrants. A migrant health policy is under preparation. A strategy and plan to improve health services access of remote people, both EGs and others, may need to be developed as will.

13. Myanmar has many religious, political, and grass-root organizations that play a major role in health services delivery. Myanmar also has many national and international NGOs, with some playing a more active role in health services delivery. PSI has also set up an extensive network for social marketing and affordable quality private health services. International agencies and INGOs have either worked separately or through government health services. However, projects were typically managed separately, based on an agreement with MOHS. The new Government is yet to decide whether to encourage and allow NGOs to provide services or let state health offices take over.

14. Ethnic minority organizations that provide social services such as health care are key stakeholders for project implementation in the seven States. Most of these have arisen after cease-fire agreements between the military government and ethnic armed opposition groups. The armed groups and their affiliated organizations administer the territories under their control, and have departments responsible for areas such as education, health, finance and agriculture. In many instances, they work with local and international NGOs to set up health services in their areas. Organizations include the Kachin Independence Organization and the New Mon State Party. During the consultation process some raised concerns about the sustainability of their own health services (which they feel provide good services and have the trust of community members) in the context of the project's support to the Government's UHC program. For instance, ethnic minority community members and organizations in Mon State stated that they would like to see that the services provided by their organization are enabled to continue with the official recognition and support from the Government.

15. In May 2012, ethnic and community-based health organizations working in eastern Myanmar formed the Health Convergence Core Group (HCCG). Its membership in 2014 includes Chin, Karen, Karenni (Kayah) Mon and Shan ethnic health organizations, as well as community-based health organizations such as the Back Pack Health Worker Team (BPHWT), Mae Tao Clinic (MTC), the National Health and Education Committee (NHEC), and the Myanmar Medical Association (MMA).

16. The linkages between burden of disease and poverty and development are well known. EMGs have higher mortality rates and burden of communicable disease than the majority population. Providing effective CDC for migrants and mobile people, ethnic minorities, and other vulnerable groups (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. In the GMS, public and private health services are reaching the general population, which is the easier part to do. However, those not being reached by any formal health service, MEVs will continue to be at risk of acquiring, and spreading infections, including possibly more drug resistant infections. As the health status improves, the impact of those not reached by the health system becomes relatively larger, and it will become critical for the government to reach MEVs to achieve universal health coverage and public health security.

17. 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 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.

18. A WHO SEARO report divides mobile and migrant populations 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.[24] 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 Government 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.

19. For non-affiliated, often illegal migrants including ethnic minorities and minors, it is even more difficult to encourage them to use public services. Grass-root organizations including ethnic associations and NGOs should play a major role in this field. In view of limited capacity, the Government started contracting NGOs to manage and deliver health services, including in remote areas. However, within the last plan period, the Government decided to use health management contracts between the central level and the provincial and district governments. The Government may want to continue piloting alternative options to reach MEVs based on solid economic and social impact studies.

20. Overall, the government is lacking information, policy and plan to address the needs of both remote EGs and migrants. A migrant health policy is needed. A strategy and plan to improve health services access of remote people, both EGs and others, may need to be developed.

21. The proposed clusters and project states/region in Myanmar and provinces elsewhere are in Table 1 and Table 2. EG population distribution in Myanmar by State/region is in Table 3.

Table 1: Geographical Clusters Along Economic Corridors[25]

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.

[24] 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

[25] This information is based on the cross-border cooperation work of the ADB-financed RCU and is necessarily a crude summary of the situation, but nonetheless informative.

Cluster and Corridor	Main Ethnic Groups	Ethnic minority characteristics	Implications
Cluster 2: Central corridor: Vietnam Central, Lao-south-central, Cambodia north-east, Thailand north-east, Myanmar-central	Large ethnic minority populations, including large ethnic 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. Provide appropriate health services for EG including access to suitable community workers and free health services.
Cluster 3: Southern corridor: Viet Nam-south, Cambodia south-east to north-west, Thailand east to West, Myanmar-south	Largely inhabited by non-ethnic minorities including Kinh, Khmer, Thai and Burmese. Has large migrant and Muslim populations	Largely integrated populations, better educated, mainly living in lowlands, industrial zones, high burden of dengue, diarrheal diseases, more timely reporting of diseases and accessing services	No need for special services for ethnic 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: This table doesn't follow ADB's GMS terminology of economic corridors.

Table 2: Targeted Provinces/States and Neighboring Provinces in China and Thailand

Cambodia	12	Pailin, Battambang, Banthey Meanchay, Preah Vihar, Stung Treng Rattanakiri, Mondulkiri, Kratie, Kandal, Tbong Khmum, Prey Veng, Svey Rieng, and Kampot Provinces
Lao PDR	12	Bokeo, Luang Namtha, Udomxay, Phonsaly, Huaphan, Xienkhuang, Bolikhamsay, Khammouane, Saravan, Sekong, Attapeu and Champasack Provinces
Myanmar	6	Shan North, Shan East, Kayah, Kayin, and Mon States, and Tanintharyi Region
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 Province
Thailand	12	Mae Hong Son, Chiang Mai, Chang Rai, Phayao, Buen Khan, Nhakon Phanom, Udon-Ratchatani, Sa Kaew, Tak, Kanchanaburi, Ratchaburi,

		and Phetshaburi Provinces

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1. Social Assessment MOH 2014
2. The Long road to Recovery, A Report by Health Information System Working Group February 2015
3. The Republic of Myanmar, Health Review, Vol:4, No.3,2014.
4. Public Health Statistics, 2012

Table 3: EG Myanmar Population by State/Region, 2014

State/Region	Male	Female	Total	Proportion of Total Population
Union	24,821,176	26,598,244	51,419,420	100.0
Kachin	877,664	811,990	1,689,654	3.28
Kayah	143,461	143,277	286,738	0.56
Kayin	775,375	797,282	1,572,657	3.06
Chin	230,005	248,685	478,690	0.93
Sagaing	2,518,155	2,802,144	5,320,299	10.34
Tanintharyi	700,403	706,031	1,406,434	2.74
Bago	2,324,214	2,539,241	4,863,455	9.46
Magway	1,814,993	2,097,718	3,912,711	7.61
Mandalay	2,919,725	3,225,863	6,145,588	11.95
Mon	986,454	1,063,828	2,050,282	3.99
Rakhine	1,529,606	1,659,357	3,188,963	6.20
Yangon	3,517,486	3,837,589	7,355,075	14.30
Shan	2,908,259	2,907,125	5,815,384	11.31
Ayeyawaddy	3,010,195	3,164,928	6,175,123	12.01
Nay Pyi Taw	565,181	593,186	1,158,367	2.25

Source: Myanmar Population and Housing Census 2014, Provisional Results, Department of Population, Ministry of Immigration and Population

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?	As per constitution, all citizens have access to almost free public health services, but policies are basic and need to be strengthened further.	Support for MOHS and ILO to develop migrant health policy
	Are national plans addressing needs of ethnic groups and migrants?	The Government is prioritizing least developed districts with high proportion of EGs. Plans for migrants relate more to labor conditions. However, migrants, many of them EGs, need to be registered to have access to health care	
	Are there legal barriers?	There are no legal barriers of EGs and migrants follow government rules and procedures.	
	What are planning issues for ethnic groups and migrants in regional CDC?	The main problem is how to provide services in remote location, for all people, not only EGs and migrants.	MOHS is considering contracting out to NGOs
	Is investment in CDC addressing the needs of ethnic groups?	The current funding can cover a majority of people but services in remote areas need to be improved further.	Contracting out to NGOs may be considered
	What could be negative impact of a regional CDC project on ethnic groups and migrants?	Two major concerns are alignment with the national program, and sustainability of services after project completion.	MOHS to develop a regional CDC program and mainstream this
	Are Government and partners active in regional CDC?	Regional cooperation is mainly at policy and planning level. There are cross-border programs with China and Thailand for HIV, malaria, and TB. There is no specific policy or plan for regional or cross-border CDC except for implementation of IHR/APSED. These plans do not specifically address regional concerns related to EGs and migrants, but do make some recommendations.	Migrant health policy should be linked to regional CDC program
	What would be major constraints for CDC in border areas?	There are still security problems in some areas, so the scope needs to be realistic. Management capacity to reach border areas depends on the local health office. There are staff constraints in facilities in border areas. Migrant workers and their families in cross border areas are not listed with official Government administration offices	Some areas are off bounds for now, for others contracting may be considered.
Health Status	Is the specific health status of ethnic groups and migrants known?	There are no national representative statistics on EGs and migrants health indicators, but there are small studies and it is generally agreed that the health status of both groups is worse than the average population, in particular because of poverty and poor living conditions. EGs are probably still having a higher prevalence of TB but less than in high risk groups. Migrants are probably more at risk of HIV but solid	MOLES, MOHS and ILO to establish a system to data on labor conditions and health status of migrants. The project can facilitate collection of disaggregated data in health facilities

Topic	Questions	Responses	Proposed action
		evidence is lacking. However, sexual exploitation is reported in migrants. Mobile sex workers have high HIV prevalence.	
	What explains the poor health status of ethnic groups and migrants	Poverty in both cases. Remote EMGs may have poor living conditions conducive to the spread of infections, and may lack access to health services. Migrants are often high school drop outs looking for work. Working and living conditions are often poor. There is insufficient regulation and supervision of migrant labor	MOLES is developing a new comprehensive labor law
	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	A new data collection system should demonstrate this
Health Services	What are the problems of providing health services for ethnic groups and migrants?	For EGs, in addition to the issues mentioned above, there may be language problems and lack of trust in the services. Unregistered migrants may avoid using health services.	Not a major issue in the targeted locations. Labor camps may be visit to find out of migrants use services
	Are health services affordable for ethnic groups and migrants?	Health services are free of charge based on certain conditions. Anyone coming to a facility is taken care of, no one is turned away. If there are expenses like medicines, the hospital can use a waver or donations to pay for services.	This needs to be further investigated through interviews of patients
		State Health Office	
Health Plans	Are EGs and migrants specifically referred to?	Plans are primarily targeting gaps in health services in certain locations, but may refer to specific issues and needs of EGs and migrants as necessary. However, the general direction is to make services available to the general public, irrespective of ethnic status.	EG issues should be mainstreamed in state plans
Health Status	Occurrence of epidemics	The main problem dengue outbreaks when hospital attendance can triple during these dengue outbreaks. There have not been major cases of emerging infectious diseases	The project should assist with dengue outbreak control
	What are the specific health problems of EGs and migrants?	EGs 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. But we don’t know.	The project should assist with health promotion and safe sex in communities, and link people to health facilities
Health Service s	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	Apart from forthcoming labor regulation, mobile clinics may be used to reach remote EGs and labor camps
	For those who can’t pay out of pocket, are there	Yes the hospital has arrangements to wave any fees but this is not used so	To be investigated if this works

Topic	Questions	Responses	Proposed action
	arrangements?	much, people who come can usually afford a small contribution.	adequately
Health Monito-ring	Are health and health services data split by ethnic groups and migrants?	No we don't have records by EG and migrant status. Some NGO services may keep this record.	The project may assist in the project locations
	Health Staff		
Health Plans	Are you aware of any special arrangements for EGs and migrants?	No, not aware	To be investigated
Health Status	What do you see as the major health problems of ethnic groups and migrants?	Most people belong to EGs, many are well do to. Any poor people may not practice hygiene so they suffer from common infections. For migrants, they have less access to services because of working conditions.	Health problems to be identified by the IA outreach team using a participatory approach with target groups
	Do you think HIV and TB are higher or lower among ethnic groups and migrants?	Don/t know, but HIV is high among sex workers, most of whom come from other locations. TB appears more common among poor and often malnourishd elderly people.	This requires a more formal study, beyond the scope of this Project
Health Service s	Are ethnic groups and migrants using these health services as others?	Most people here belong to one EG, they all use the health services, they don't consider them as EG in their own home. Migrants appear to use health services less, we know little of them, sometimes the company has its own clinic and they only come for major problems.	IA outreach teams will identify this in location
	Are there specific access problems in the provision of health services to ethnic groups and migrants?	There are some parts less accessible due to security problems but not here. We didn't visit labor camps.	As above
	Are there language problems?	Yes	
	Are there affordability problems?	Sometimes, when expensive treatment is needed which the hospital can't province	As above
	Any other problems?	Salary is sometimes delayed, and we contribute for poor patients. We should have change to get more training	To be investigated by the IA
	Ethnic Community Representatives		
Health Plans	Are you involved in discussions to improve health services?	Government staff visit us some time to discuss community health problems, not hospital problems	Outreach teams will follow participatory approach
	Do you think plans are appropriate for the local community/	Don't know the plans	As above
Health Status	What do you see are the major health problems in your community?	All kind of health problems for men, women, children, old people, hard to say	To be identified by the outreach team
	Did you have any major epidemics?	Dengue is the big problem with many hospital admissions. Malaria is much less a problem now. Seasonal cough and diarrhea.	The project will support this
	Are TB and HIV major health problems?	HIV is also a big problem. For TB, people go to the hospital	The project will target high risk groups

Topic	Questions	Responses	Proposed action
	Are there specific groups more at risk?	Maybe small children and old people. Also sex workers and drug addicts	As above
Health Services	What are the good parts of the health services?	Good behavior of staff, they are there and really try, but sometimes don't have the means.	
	What parts of the health services would you like to see improved?	Better qualified staff and more resources to run the services	The project will support dengue and infection case management training
	Are health services affordable for the poor?	We usually manage but difficult for expensive treatment.	To be investigated
Ethnic Patients			
Health Status	What is the reason for your admission?	Dengue, diarrhea, delivery, fever, malaria, gastrointestinal	
Health Services	Do you find the hospital clean, can you get clean water and toilet?	Yes	The project will support infection prevention and control
	From how far did you travel?	Mostly distant areas	The project will examine catchment population
	Are you happy with the quality of care?	Staff is trying hard	The project focuses on IPC
	Are health services affordable?	Sometimes we need to buy extra because the hospital doesn't have	The IA will examine this
Female and Male Ethnic Members			
Health Status	What are main health problems in your community?	Malnutrition, diarrhea, cough, dengue, gastrointestinal	The Project will outbreak response, education, screening, and facilitate referral
Health Services	Are health services adequate	Basic ok, not for emergencies, need to go to State/Regional Hospitals	Support for vehicles/ambulances in border towns
	What is availability and attitude of staff?	They are helpful	
	Are medicines available?	Mostly available	
	Other issues?	Improve emergency services	Support for vehicles/ambulances in border towns
Partners*			
Health Plans	What are planning issues for ethnic groups and migrants in regional CDC?	There is lack of information on the specific health statistics of EGs and migrants. However, one third of the population is EG. This is probably more important for migrants, whether EG or not. But there probably are specific issues for some small EGs in remote border areas. Some information may be available from local NGOs such as Mae Tao Clinic and Kayin Department of Health and Welfare (KDHW) in Kayin State, Kayinni Mobile Healh Committee (KnMHC) in Kayah State, Shan State	The Government to conduct a survey for the migration health policy. The project can help collect disaggregated data in target areas.

Topic	Questions	Responses	Proposed action
		Development Foundation (SSDF) in Shan State.	
	Is investment in CDC addressing the needs of ethnic groups and migrants?	EGs are serviced through the general health system. Although there are exceptions, most have access. For migrants, needs and issues are much less recognized and organized, although the Government has endorsed a 2014 ILO report on labor conditions. This needs to be followed with policies and plans, including for health services.	This needs to be examined at project level through outreach and at national level through survey
	Are there legal issues for ethnic groups and migrants?	Officially not, but there are some hurdled in accessing health services.	To be investigated by MOHS in preparation of the Migration Health Policy
	What are major gaps?	First of all lack of information to be used as a dialogue with government. Removing of any legal barriers. Developing a comprehensive multi-sectoral program endorsed by all stakeholders including the private sector for regulation and implementation	To be assessed in preparation of the Migration Health Policy
Health Status	What is the HIV and TB status among ethnic groups and migrants?	There are no conclusive data on the status of EGs and migrants. There are small studies, not representative, suggesting higher prevalence of both. HIV in sex workers, often mobile, reached 33% in 2007 before it started dropping, in part as infected people had no access to treatment	This requires a special survey, which is beyond the scope of the project
	Is the surveillance system reaching ethnic groups and migrants?	The surveillance systems for specific diseases and outbreaks are reaching almost all communities. There may be exceptions if there are security problems	The project will strengthen the surveillance system
Health Services	How is access to health services for ethnic groups and migrants?	Public health services are fully accessible for all citizens irrespective of ethnic status, but may not reach some remote groups. Migrants should be able to access public health services but may avoid this or not be allowed to do so.	The project will explore this through outreach, but not survey this
	What is the government capacity in providing services to ethnic groups and migrants?	The government has limited capacity to provide services in remote rural areas, in part due to lack of staff and government conditions. Even though recent graduates are required to rotate in these locations, and hardship allowances are available, this is not enough.	MOHS is considering contracting out in this project
	What works better in reaching ethnic groups and migrants?	Partners often support government health services to improve working conditions. NGOs may also do the same.	Contracting NGOs is less sustainable, other modalities may be explored

*IHD, DCDC, PHD, DMS
** IOM, WHO, UNAIDS, Gender Coordinating NGO
***ILO 2015, International Labor Organization. Building and Evidence-base on patterns in migration, human trafficking, and forced labour

ANNEX 3: ETHNIC GROUP DEVELOPMENT PLAN

	Sub-outputs	EG 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 EGs.	Enhance participation, capacity building and decision making opportunities for representatives of EG 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 EGs at increased risk of infectious diseases with CDC activities in border areas.	Workshop materials clearly demonstrate mainstreaming of IP issues and promotion of EG-sensitive strategies. Participation of EG 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 IP-disaggregated data. Ensure participation of EG staff in any outbreak response teams. Increase participation of EGs in field epidemiology training.	IP 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 IPs in scholarships for hospital infection prevention and control. Ensure EG sensitive facilities in isolation wards	Representative participation of EGs 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 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 IP dimensions of project activities All implementing agencies have an EG focal point	Proportion of project implementation plans and AOPs that address EG dimensions adequately. Proportion of active focal points in implementing agencies (based on participation in events.

	Sub-outputs	EG Design Features/Activities	Performance Targets/Indicators
		All quarterly reports report on progress in EG issues	Proportion of quarterly reports that report on EG issues. Proportion of consultants with EG experience.