



Technical Assistance Consultant's Report

Project Number: 40019 (TA 4855)
September 2007

Viet Nam: Health Care in the South Central Coast Region

Prepared by Robert Taylor

This consultant's report does not necessarily reflect the views of ADB or the Government concerned, and ADB and the Government cannot be held liable for its contents. All the views expressed herein may not be incorporated into the proposed project's design.

Asian Development Bank

Project Number: VIE 4855

Project Preparation

Final Report: September 28, 2007

Proposed Loan

Socialist Republic of Viet Nam: Health Care in the
South Central Coast Region

CURRENCY EQUIVALENTS

(as of 24 August 2007)

| | | |
|---------------|---|----------------|
| Currency Unit | – | Dong (VND) |
| VND1.00 | = | \$0.0000615687 |
| \$1.00 | = | VND16,242 |

ABBREVIATIONS

| | | |
|----------|---|--|
| ADB | – | Asian Development Bank |
| AI | – | avian influenza |
| AusAID | – | Australian Agency for International Development |
| BCC | – | behavior change communication |
| CBM | – | community-based monitoring |
| CEM | – | Committee for Ethnic Minorities |
| CHS | – | commune health station |
| CSP | – | country strategy and program |
| DALY | – | disability adjusted life years |
| DHC | – | district health center |
| DOH | – | Provincial department of health |
| DTWG | – | District Training Work Group |
| EC | – | European Commission |
| EMDP | – | Ethnic Minorities Development Plan |
| EOC | – | Essential Obstetric Care |
| GDP | – | gross domestic product |
| GTZ | – | German Agency for Technical Cooperation |
| HCFP | – | Health Care Funds for the Poor |
| HEMA | – | Health in Mountainous Areas |
| HMIS | – | hospital (or health) management information systems |
| HIV/AIDS | – | human immunodeficiency virus/acquired immunodeficiency syndrome |
| HP | – | Health Promotion |
| HPG | – | Health Partnership Group |
| HR | – | Human resources |
| HRD | – | Human resources development |
| ICP | – | Inter-commune polyclinic |
| IEC | – | Information, education and communication |
| IMCI | – | Integrated Management of Childhood Illnesses |
| IMR | – | Infant mortality rate (number of deaths of children <1 year of age per 1000 live births) |
| ITWG | – | Inter-Provincial Training Working Group |
| Jahr | – | Joint Annual Health Review |
| MCH | – | Maternal and Child Health |
| M&E | – | Monitoring and Evaluation |
| MDG | – | Millennium Development Goal |
| MIS | – | management information systems |
| MMR | – | Maternal mortality rate (number of maternal deaths per 100,000 live births) |
| MOH | – | Ministry of Health |
| MOF | – | Ministry of Finance |
| MTEP | – | Medium Term Expenditure Plan |
| NGO | – | non-governmental organization |

| | | |
|--------|---|--|
| OCR | – | ordinary capital resources |
| ODA | – | official development assistance |
| O&M | – | operations and maintenance |
| PHC | – | primary health care |
| PMU | – | project management unit |
| PPC | – | Provincial People's Committee |
| PPMU | – | provincial project management unit |
| PRA | – | Participatory Rapid Appraisal |
| PTWG | – | Provincial Training Work Group |
| RH | – | Reproductive Health |
| RHC | – | Reproductive Health Center, provincial level |
| RHP | – | Rural Health Project |
| SARS | – | severe acute respiratory syndrome |
| SBT | – | Skill-Based Training |
| SBV | – | State Bank of Viet Nam |
| SCCR | – | South Central Coast Region |
| SDP | – | sector development program |
| SEDP | – | Socio-Economic Development Plan (2006-2010) |
| SMS | – | secondary medical school |
| TA | – | technical assistance |
| TBA | – | Traditional Birth Attendant |
| TMC | – | Technical Medical College |
| TOR | – | terms of reference |
| UNFPA | – | United Nations Population Fund |
| UNICEF | – | United Nations Children's Fund |
| VDG | – | Viet Nam Development Goal |
| VHIA | – | Viet Nam Health insurance Authority |
| VHW | – | village health worker |
| VRM | – | Viet Nam Resident Mission (ADB) |
| WB | – | World Bank |
| WHO | – | World Health Organization |

NOTES

- (i) The fiscal year (FY) of the Government and its agencies ends on 31 December. FY before a calendar year denotes the year in which the fiscal year ends, e.g., FY2007 ends on 31 December 2007.
- (ii) In this report, "\$" refers to US dollars.

| | |
|-------------------------|--|
| Team leader | Robert J. Taylor, Team Leader, Project Preparation |
| Consultants | Bronwyn Hine, Human Resources; Tran Duc Lam, Deputy Team Leader; Duong Huy Luong, Community Development; Eugenia McGill, Sociologist; Ross McLeod, Economist; James Mielke, Human Resources; Reihana Mohideen, Sociologist; Tran Mai Oanh, Financial Management; Nguyen Quang Thai, Architect; and Le Minh Sang, Environment and Resettlement. |
| ADB | Vincent de Wit, Principal Health Specialist, Lisa Studdert, Health Specialist; Emi Masaki, Health Economist |
| MOH counterparts | Duong Huy Lieu, Director Department of Planning and Finance; Nguyen Hoang Long, Vice Director DOPF; Nguyen Doan Tu, Director, Rural Health Project; Nguyen Mai An, Donor Agency Liaison; Provincial authorities and health officers; Pham Thi Nga, Administrative Assistant |

CONTENTS

| | Page |
|--|-------------|
| LOAN AND PROJECT SUMMARY | iii |
| MAP | vii |
| I. INTRODUCTION | 1 |
| II. RATIONALE: SECTOR PERFORMANCE, PROBLEMS, AND OPPORTUNITIES | 1 |
| A. Performance Indicators and Analysis | 1 |
| B. Analysis of Key Problems and Opportunities | 6 |
| III. THE PROPOSED PROJECT | 17 |
| A. Impact and Outcome | 17 |
| B. Outputs | 18 |
| C. Special Features | 28 |
| D. Project Investment Plan | 28 |
| E. Financing Plan | 29 |
| F. Implementation Arrangements | 30 |
| IV. PROJECT BENEFITS, IMPACTS, ASSUMPTIONS, AND RISKS | 34 |
| A. Project Benefits and Impacts | 34 |
| B. Project Assumptions and Risks | 36 |
| V. ASSURANCES | 38 |
| A. Specific Assurances | 39 |
| B. Conditions for Loan Effectiveness | 39 |
| APPENDIXES | 40 |
| 1. Design and Monitoring Framework | 40 |
| 2. Performance Indicators | 44 |
| 3. Implementation Schedule | 46 |
| 4. Health Policy Framework | 47 |
| 5. External Assistance | 51 |
| 6. Summary Initial Environmental Examination | 54 |
| 7. Summary Resettlement Framework | 58 |
| 8. Summary Poverty Reduction and Social Strategy | 61 |
| 9. Ethnic Minority Development Plan | 63 |
| 10. Gender Strategy | 69 |
| 11. Consulting Services | 74 |
| 12. Technical Assistance | 79 |
| 13. Indicative List of Training Activities | 86 |
| 14. Civil Works | 93 |
| 15. Indicative List of Major Equipment | 96 |
| 16. Non-Medical Equipment and Materials | 99 |
| 17. Financial Management Assessment | 101 |
| 18. Economic and Financial Sustainability Analysis | 103 |

| | | |
|-----|--|-----|
| 19. | Provincial Health Expenditure and Medium Term Planning | 108 |
| 20. | Detailed Cost Estimates | 113 |

SUPPLEMENTARY APPENDICES

| | |
|----|--------------------------------|
| A. | Economic Analysis and MTEPs |
| B. | Health Care Funds for the Poor |
| C. | Financial Management |
| D. | Community Development |
| E. | Social Analysis |
| F. | Human Resources Planning |
| G. | Training Systems |
| H. | Management Strengthening |
| I. | Environment & Resettlement |
| J. | Civil Works and Equipment |

LOAN AND PROJECT SUMMARY

| | |
|-------------------------------|---|
| Borrower | Socialist Republic of Viet Nam |
| Classification | <p>Targeting classification: Targeted intervention</p> <p>Sector: Health, nutrition, and social protection</p> <p>Subsector: Health systems</p> <p>Themes: Inclusive social development, gender and development</p> <p>Subthemes: Human development, indigenous peoples, gender equity in opportunities.</p> |
| Environment Assessment | <p>Environmental Category: B</p> <p>In replacing or upgrading old and outdated hospital facilities, or constructing new facilities, the Project will safeguard the environment by upgrading or constructing medical waste management systems and training hospital staff in waste management theory and practice – significantly improving the handling and disposal of medical wastes in those facilities and reducing environmental threats to their surrounding communities.</p> |
| Project Description | <p>The objective of the proposed Project is to improve the health status of the poor, women, children, ethnic minorities, and other vulnerable groups, and strengthen health systems in eight provinces in Viet Nam’s South Central Coast Region.</p> <p>The Project has four components: (i) upgrading district, regional, and provincial hospitals, (ii) strengthening human resources, (iii) improving access and quality of health care for the poor, and (iv) strengthening health systems management.</p> |
| Rationale | <p>While Viet Nam has made remarkable progress in reducing poverty and improving the health status of its citizens, those who live in rural areas, especially ethnic minorities, lag behind. To continue its many advancements, and to extend these benefits more broadly, the Government of Viet Nam has set out an ambitious plan to address an array of continuing problems in the health sector, including deteriorating and poorly equipped infrastructure; shortages of skilled health workers; constraints on access to health services, especially for the poor; and limited capacity to govern and manage an increasingly complex health system. The Government’s plans are consistent with ADB’s country strategy and program and are the foundation for this project’s goals and design.</p> |
| Impact and Outcome | <p>The impact of the Project will be improved health status of the poor, women, children, ethnic minorities, and other vulnerable groups, and stronger health systems in eight provinces in the South Central Coast Region. Major Project outcomes include: (i) improved health service resources in the eight provinces, providing improved quantity and quality of health care; (ii)</p> |

increased numbers of skilled health staff providing quality health care services; (iii) improved access and quality of health care for the poor, near poor, and other vulnerable groups; and (iv) increased capacity to manage provincial health systems and hospitals in terms of equity, efficiency, and effectiveness.

The Project will improve the health status of Viet Nam's population, supporting the Government's goals to achieve its health-related Viet Nam Development Goals by 2015. The Project will support Government efforts to develop a comprehensive and well managed health system that preserves the gains in health status already achieved, extends those gains to the poor and underserved, and is better able to address emerging challenges and changing demands.

Project Investment Plan The investment cost of the project is estimated at \$80 million, including taxes and duties of \$4.2 million.

Financing Plan

**Cost Estimates
(\$ million)**

| Source | Foreign Exchange | Local Currency | Total Cost | Percent |
|---------------|-------------------------|-----------------------|-------------------|----------------|
| ADB Loan | 26.2 | 33.8 | 60.0 | 75.0 |
| Government | 00.0 | 20.0 | 20.0 | 25.0 |
| Total | 26.2 | 53.8 | 80.0 | 100.0 |

ADB = Asian Development Bank, ADF = Asian Development Fund.

Note: Numbers may not add due to rounding

Source: Asian Development Bank estimates.

Allocation and Relending Terms The Government has requested a loan of \$60,000,000 from the Asian Development Bank's Special Fund resources to help finance the Project. The loan will have a 32-year term, including a grace period of 8 years, and an interest rate of 1% during the grace period and 1.5% per annum thereafter. The Government will contribute \$20 million through central and provincial counterpart contributions.

Period of Utilization Until 31 December 2013

Estimated Project Completion Date 30 June 2013

Implementation Arrangements

The Project will be implemented by a central project management unit established within MOH and by provincial project management units established within the provincial departments of health in the eight targeted provinces. Overall guidance will be provided by a project steering committee, chaired by the Vice Minister of the Ministry of Health, with representation from concerned departments of the MOH, Ministry of Finance, Ministry of Planning and Investment, and the State Bank of Viet Nam.

Executing Agency

Ministry of Health

Procurement

All ADB-financed procurement for the Project will follow ADB's Guidelines for Procurement. Civil works under the Project are scattered throughout the South Central Coast Region and are not likely to attract the interest of international contractors. Therefore, it is proposed that civil work contracts be awarded on the basis of National Competitive Bidding (NCB) procedures acceptable to ADB. Contracts for the supply of materials, equipment, and medical supplies in packages valued at \$500,000 or more will be procured through International Competitive Bidding (ICB). Some medical equipment (e.g., hospital beds, delivery beds, and tables) that is locally produced and is unlikely to attract foreign suppliers will be procured through NCB. Minor items or packages costing \$10,000 or less will be procured under direct purchase procedures in accordance with Government rules acceptable to ADB.

Consulting Services

The Project will require 8 international consultants for a total of 84 person-months, 8 national consultants for a total of 434 person months, a nongovernment organization for 30 person-months, and short term consultants for a total of 30 person-months. MOH has requested ADB to help recruit the international consultants, while MOH will recruit the national consultants. All consultants will be hired in accordance with ADB's *Guidelines on the Use of Consultants (2007)*, as amended from time to time. All consultants will be contracted through a firm in accordance with ADB's *Guidelines on the Use of Consultants*, using the simplified technical proposal and the fixed budget selection method. In case no suitable consultants can be hired through a firm, consultants may be recruited as individuals in accordance with ADB's procedures.

Project Benefits and Beneficiaries

The Project will upgrade or construct 30 hospitals, and provide medical equipment for 44 hospitals. It will improve access to quality health services for nearly 9 million people (about 4.6 million women and 4.4 million men) living in the eight target provinces of the South Central Coast Region, thereby directly or indirectly improving their health status. The Project will especially benefit 2.1 million women in the reproductive age group, 537,000 ethnic minorities, 1.3 million poor people, 1 million children under five, and 870,000 elderly.

Due to self-selection and specific project design, the majority of the project beneficiaries will be the poor and women. In addition, the project interventions will directly benefit 1,700,000 poor people through improvements in the administration of the Health Care Funds for the Poor.

The Project will train over 11,000 health care workers, the majority of whom will be women, over 2000 management personnel, and 846 community members.

The Project will assist in establishing plans and procedures for the recruitment and training of health workers. It will improve management and supervision of health services and assist the government in making health financing more equitable and efficient. At the provincial and districts level, the Project will strengthen management capacity.

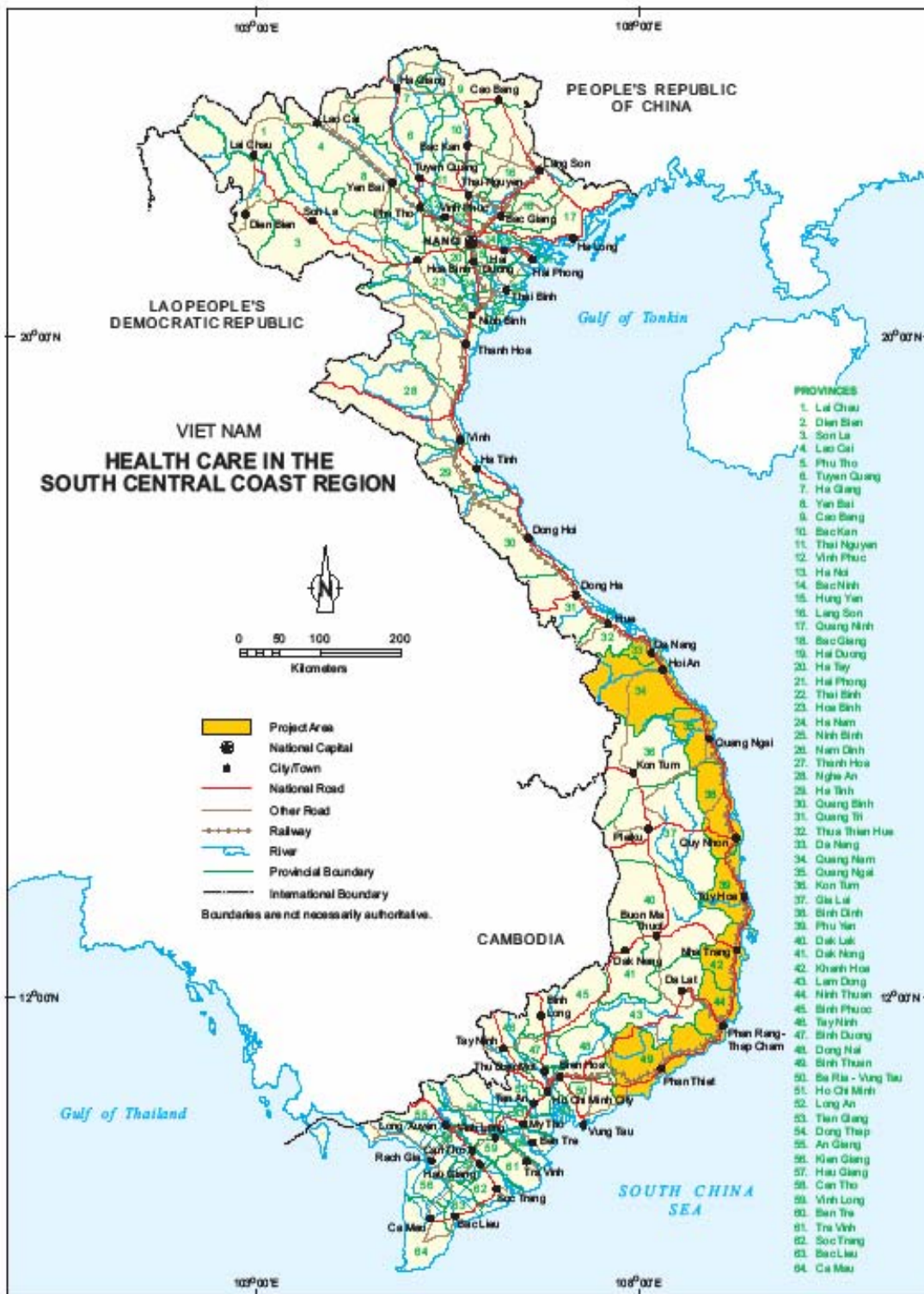
Risks and Assumptions

Investments in infrastructure and medical equipment are based on the assumption that Government will provide the necessary funding to cover recurrent costs, but there is a risk that funding will be inadequate and that some essential services and activities may be neglected.

Investments to strengthen human resource planning and to strengthen local training capacities, assume that Government will increase its efforts to retain qualified health personnel. The risk is that the disparity between Government and private wages will continue to widen, drawing workers away from public service.

Investments to improve access to health care for the poor, assume that Government officials and community health workers are open to changing their approach to interacting with ethnic minorities, and that ethnic minorities are open to changing their attitudes and behavior toward seeking health care. It also assumes that improving the administration of HCFP can increase the proportion of enrollees that seek curative care services.

Investments in strengthening local managerial capacities assume that further efforts toward decentralization continue. But there is risk that the momentum toward decentralization will be slowed by a lack of clearly defined authorities and responsibilities at each level of Government.



I. INTRODUCTION

1. The Government of Viet Nam has requested ADB to support the project titled Health Care in the South Central Coast Region Project (the Project) as per Five Year Plan (2006-2010).¹ The ADB Country Strategy and Program 2007–2009 includes ADF \$60 million for an \$80 million project in 2008, standby in 2007, with a Government contribution of \$20 million.
2. The project preparatory TA was approved on 24 October, 2006. Project preparation was started on 28 February, 2007. The TA used a participatory planning approach with the MOH and eight provinces, including three workshops. Each province prepared a medium term expenditure plan and framework for its provincial health program. The plans were to be results-based and pro-poor, setting provincial priorities for health improvement, and thereby directing investments by the Government and other agencies, including ADB. A total of twelve consultants assisted Government counterparts in the planning process.
3. The TA team prepared a Draft Final Report (DFR) which was circulated, along with reports of experts, eight draft provincial five-year plans, and a TA implementation report. A tripartite meeting between the Government, ADB and consultants was held on 4 August 2007. This report is the Final Report on Project Preparation and incorporates comments and modifications emerging from the tripartite meeting and the fact finding mission that followed. The draft provincial five-year plans, the analysis of the various sub-sectors by the consultants, and the TA implementation report are available as supplementary appendices.

II. RATIONALE: SECTOR PERFORMANCE, PROBLEMS, AND OPPORTUNITIES

4. While Viet Nam has made remarkable progress in reducing poverty and improving the health status of its citizens, those who live in rural areas, especially ethnic minorities, lag behind. To continue its many advancements, and to extend their benefits more broadly, the Government of Viet Nam has set out an ambitious plan to address an array of continuing problems in the health sector, including deteriorating and poorly equipped infrastructure; shortages of skilled health workers; constraints on access to health services, especially for the poor; and limited capacity to govern and manage an increasingly complex health system.² The Government's plans are consistent with ADB's country strategy and program and are the foundation for this project's goals and design.³

A. Performance Indicators and Analysis

5. **Poverty Reduction.** As a reflection of Viet Nam's booming economy, poverty levels have dropped from over 58 percent in 1993 to less than 20 percent today. In that same period, on average, real income has grown at an annual rate of 7.3 percent, while average per capita income grew from \$288 to \$622 per year. These remarkable gains are due to a combination of

¹ The World Bank is similarly preparing the Health Care in the North Central Coast Region Project. The title may change as discussed by the Vice-Minister.

² Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006.

³ This project proposal was prepared in February-August, 2007, in accordance with the Technical Assistance Report, Project Number: 40019, "Socialist Republic of Viet Nam: Preparing the Health Care in the South Central Coast Region Project," October 2006.

sustained business-led growth in economic output and employment, and well balanced Government economic policies.⁴

6. Economic progress has not been uniform, however. As might be expected, urban areas have benefited more than rural. In 2004, the incidence of poverty was 26.4 percent in rural areas compared to 13.7 percent in urban areas. And, while food poverty has been largely eliminated in urban households (3.3 percent), 8.1 percent of rural households remain food-poor. Early in the last decade, sustained growth in the agricultural sector was pivotal in reducing poverty in rural areas, but more recently the rapid development of industry and service have resulted in a decline in the share of GDP attributable to agriculture and fisheries. At present, agriculture generates only 21 percent of GDP, with a 57 percent share of total employment. The likely result will be an accelerated rural-urban shift as increased numbers of agricultural workers seek higher paying opportunities in urban areas and along key transport corridors in coastal provinces.⁵ This shift will have important repercussions for the coastal region targeted in this project, the eight provinces of the South Central Coast Region.

7. Ethnic minorities, in particular, have not kept pace with the economic progress experienced by others. In 2002, 69.3 percent of ethnic minorities were still in poverty compared to only 23.1 percent of citizens of Kinh or Chinese origin. While ethnic minorities are only 14 percent of Viet Nam's population, they account for 39 percent of those living below the poverty line. Based on a 2004 study, of the 500,000 ethnic minorities living in the eight targeted provinces of the South Central Coast Region, more than 90 percent were estimated to live in poverty, compared to only 15 percent of Kinh and Chinese. Some 72 percent of minorities in the SSC Region were considered food poor.⁶

8. Ethnic minorities suffer from the same constraints to access as other rural poor, only more so. Disproportionately, ethnic minorities live in the most remote areas of the country. Thirty three percent of ethnic minorities live more than two kilometers from an all-weather road, compared to only 16 percent of Viet Nam's Kinh/Chinese population.

9. **Improved Health Status.** For most of Viet Nam's 83 million people, health status has also shown remarkable improvements. The Infant Mortality Rate (IMR) declined from 54.8 in 1979-1983, to 36.7 in 2000, followed by a dramatic drop to 17.8 in 2005. The percentage of low-weight newborns (under 2500 grams) has dropped progressively from 7.3 percent in 1998, to 6.5 percent in 2002, to 5.1 percent in 2005.⁷ In 2005, 97.8 percent of children under one year of age had been fully immunized. Malnutrition among children under five has steadily declined from 43.9 percent in 1996, to 33.1 percent in 2000, to 25.2 percent in 2005. Polio and newborn tetanus have been eradicated.

10. The Maternal Mortality Rate (MMR) has declined significantly, from 130 (per 100,000 live births) in 1992, to 95 in 2000, to an estimated 80 in 2005.⁸ Importantly, in 2005, 96.1 percent of deliveries were attended by a trained health worker. The Crude Death Rate (CDR) has declined from 7.3 in 1988-1989 to 5.3 in 2005. Life expectancy in Viet Nam is now 71.3 years, well above most other Asian Countries except Singapore (79), Brunei (74), and Malaysia (73).⁹

⁴ Asian Development Bank, "Country Strategy and Program: Viet Nam 2007-2010," ADB, October 2006.

⁵ Asian Development Bank, "Country Strategy and Program: Viet Nam 2007-2010," ADB, October 2006.

⁶ Swinkles, Rob, and Carrie Turk, *Explaining Ethnic Minority Poverty in Vietnam: a summary of recent trends and current challenges*, World Bank, Vietnam, 2006.

⁷ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 1.

⁸ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 13.

⁹ Ministry of Health, "Health Statistics Yearbook 2005, HSID, Planning – Financial Department, S. R. Vietnam.

While increased life expectancy is largely a result of decreased child mortality, there are increasing numbers of Vietnamese of advanced age. According to the projections of the National Geriatrics Institute, by 2014 ten percent of the population will be 60 years of age, or older – with a corresponding increase in the disease patterns of the elderly.¹⁰

11. As health status has improved, patterns of disease have been changing. In 1976, for example, infectious diseases accounted for 55.51 percent of morbidity, compared to only 26.13 percent in 2004. During the same period, non-infectious diseases – such as heart disease and cancer - became more predominate, growing from 42.65 percent to 60.80 percent. And with economic prosperity and the proliferation of motorbikes, injury and accidents grew dramatically, from only 1.84 percent in 1976 to a peak of 13 percent of total morbidity in 2004.¹¹ Some health problems remain while others threats are emerging. Malaria remains prevalent, although deaths attributable to malaria have declined sharply. Dengue fever remains endemic; tuberculosis shows no sign of declining, with 50-60,000 new cases each year; and threats of HIV/AIDS, avian influenza, and SARS loom ominously. HIV infections, for example, have increased from 33,747 cases reported through 2000, to 90,380 cases through December 2004.

12. But the health status of those who live in rural areas, especially ethnic minorities, has not progressed as rapidly as for urban dwellers. Life expectancy in the more rural and mountainous Northwest, for example, was only 66.6 years (based on 2002 data), compared to a high of 73.9 years in the Southeast (Ho Chi Minh City and its environs).¹² And in a 2004 study, the Infant Mortality Rate was 33.9 in the Northwest compared to 10.6 in the Southeast provinces. Overall, the IMR in rural areas was 20.4, twice the 9.7 rate in urban areas.¹³ Among ethnic minorities the differences are more pronounced. At the time of a 1999 study, the IMR for the whole country was 36.7, but for ethnic Gia Rai it was 69, and 56 for ethnic H'mong. The IMR for the Kinh was only 21.¹⁴

13. In 2004, according to a household survey, 4 percent of Kinh and Chinese children under five were experiencing very severe malnutrition, compared to more than 33 percent of ethnic minority children residing in the same districts. In the districts studied in the South Central Coast Region, 72 percent of ethnic minority children were food poor, compared to only 5 percent of Kinh children.¹⁵

14. Rural women, especially ethnic minority women, are particularly disadvantaged. Maternal mortality, for example, varies widely by urban/rural, region, and ethnicity. An MOH study conducted in 2000-2001, found maternal mortality rates of 79 per 100,000 live births in urban areas, compared to 145 in rural areas; 81 in the delta region compared to 269 in the mountainous and midland areas; and 81 among Kinh compared to 316 among ethnic minorities.¹⁶ There is also evidence that pregnancies and maternal deaths are under-reported among ethnic women.

¹⁰ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 4.

¹¹ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006, p.7.

¹² Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 2.

¹³ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 5.

¹⁴ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 5.

¹⁵ Swinkler, Rob, and Carrie Turk, "Explaining Ethnic Minority Poverty in Vietnam: a summary of recent trends and current challenges," draft background paper for CEM/MPI meeting on Ethnic Minority Poverty, Hanoi, 28 September, 2006.

¹⁶ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 14.

15. **South Central Coast Region.** The South Central Coast Region (SCCR) stretches over 800 kilometers along Viet Nam's scenic coast, the principal transportation route from Da Nang Province at the north to the southern tip of Binh Thuan Province. For its entire length, the SCCR borders the provinces of the Central Highlands, sharing some of that region's characteristics – remote villages, poverty, and clusters of ethnic minorities – and consequently, poorer health status.

16. The southern extreme of the SCCR terminates within 100 kilometers of Ho Chi Minh City. In fact, until 2006, Binh Thuan and Ninh Thuan provinces were considered, along with HCM City and other provinces, to be part of the North East South Region. The South Central Coast Region now encompasses eight provinces, including: Da Nang, Quang Nam, Quang Ngai, Binh Dinh, Phu Yen, Khanh Hoa, Ninh Thuan, and Binh Thuan.

17. The SCCR is largely rural and agricultural. Its coast provides several excellent harbors, a growing ship-building industry, several scenic beaches for tourists, and excellent fishing; the fertile lowlands are carpeted with rice paddies; the low mountains to the west are dotted with cinnamon trees and fruit orchards; and still further west, higher mountains hide patches of old growth forest and remote valleys.

18. The population of the region is nearly 9 million, over 10 percent of Viet Nam's total population of 83 million. With an incidence of poverty of 19.0 percent, and a rural population of 68.8 percent, SCCR ranks just below the national average, as shown in the following table.

**Viet Nam & South Central Coast Region
Key Indicators
2005**

| | Population | Percent Rural | Incidence of Poverty | Births Attended by HW | IMR | Percent <5 Wasting | <1 Full Immunity Coverage |
|------------|------------|---------------|----------------------|-----------------------|------|--------------------|---------------------------|
| Viet Nam | 83,119,900 | 73.0% | 19.5% | 93.38% | 17.8 | 6.9% | 97.8% |
| SCC Region | 8,762,700 | 68.8% | 19.0% | 97.85% | 18.2 | 6.1% | 98.4% |
| De Nang | 777,100 | 13.8% | 4.33% | 100% | 9.0 | 4.5% | 99.6% |
| Quang Nam | 1,463,300 | 82.9% | 36.28% | 95.34% | 22.0 | 5.3% | 97.9% |
| Quang Ngai | 1,269,100 | 85.6% | 36.14% | - | 20.8 | 5.3% | 99.6% |
| Binh Dinh | 1,556,700 | 74.8% | 28.31% | 95.67% | 20.3 | 8.5% | 99.2% |
| Phu Yen | 861,100 | 79.1% | 21.04% | 99.79% | 30.8 | 4.9% | 96.5% |
| Khanh Hoa | 1,122,500 | 60.1% | 9.72% | 98.47% | 14.7 | 6.5% | 97.5% |
| Ninh Thuan | 562,300 | 67.4% | 45.03% | 96.38% | 22.6 | 7.2% | 97.3% |
| Binh Thuan | 1,150,600 | 62.4% | 15.70% | 98.21% | 18.7 | 7.7% | 98.4% |

Source: *Health Statistics Yearbook 2005*, HSID, Planning – Financial Department, Ministry of Health, S. R. Vietnam. Incidence of Poverty: National & Regional: *Health Statistics Yearbook 2005*. Provincial: Vietnam Household Living Standards Survey 2002, as cited in *Achieving The Millennium Development Goals*, S. R. of Viet Nam, August 2005.

19. **Health System.** Viet Nam's progress in health care has been due in large part to its commitment to establishing a four-tiered system of well distributed health care resources operating at the local, district, provincial, and national levels. The foundation, the grass roots of the system, is a network of Commune Health Stations (CHS) serving 98 percent of all

communities, 95 percent of which are staffed by at least one trained health worker. District Hospitals, usually 50 to 100 bed institutions with sizable volumes of outpatient visits, play an important role in supporting Commune Health Stations, especially with communication and transportation in emergencies. More severe illnesses are referred on to large Provincial General Hospitals, usually 500 to 700 bed institutions with an extensive array of outpatient services. Some provincial hospitals also serve as regional referral centers. In addition to the health facilities operated at the provincial level, a system of national specialty referral hospitals is operated by the Ministry of Health, with facilities located mostly in Hanoi and HCM City, but with some located in provincial capital cities such as Da Nang.

20. There are a growing number of private hospitals, mostly in major cities, and numerous and widely dispersed private clinics, often owned or staffed by doctors moon-lighting from their public hospital practice. Although their numbers are declining, there are still a number of sector hospitals serving the military and those employed in certain industries such as agriculture, mining, and transportation.

21. In February, 2005, there were 1,043 hospitals in Viet Nam - excluding those serving the military and war invalids - with a total of 136,590 patient beds, a per capita ratio of 24 beds per 10,000 population.¹⁷ Compared to its neighbors, Viet Nam's bed ratio is favorable, even though it is low compared to developed countries.¹⁸ In 2005, there were 1,000 public hospitals, accounting for 95.9 percent of all hospitals, and 97.6 percent of all hospital beds. Of these, the Ministry of Health managed 10 general and 21 specialty hospitals (3.1 percent of all hospitals), while local authorities managed 911 facilities (207 specialized hospitals, 117 provincial hospitals, and 597 district hospitals). There were 43 private hospitals, accounting for 4.1 percent of all hospitals and 2.4 percent of patient beds.¹⁹ Also, there are about 30,000 private clinics operating nation-wide.²⁰

Health System Infrastructure

| | MOH General Hospitals | MOH Specialty Hospitals | Provincial General Hospitals | Provincial Specialty Hospitals | District Hospitals | Hospitals in Other Sector | Private Hospitals | Regional Poli- Clinics | Commune Health Stations |
|---------------------|-----------------------------|-------------------------------|------------------------------------|--------------------------------------|-----------------------|---------------------------------|----------------------|------------------------------|-------------------------------|
| Viet Nam | 10 | 21 | 117 | 207 | 597 | 48 | 43 | 838 | 10,679 |
| Patient beds | 7,240 | 6,970 | 39,184 | 26,179 | 49,175 | 5,200 | 3,245 | 10,534 | 45,176 |
| SCC Region | 1 | 1 | 25 | 15 | 64 | | | 91 | 1,020 |
| Patient beds | | | 6,275 | 518 | 5,453 | | | 2,212 | 3,214 |
| De nang | 1 | 1 | 5 | 2 | 6 | | | - | 54 |
| Quang nam | | | 3 | - | 13 | | | 20 | 219 |
| Quang ngai | | | 1 | 2 | 12 | | | 13 | 176 |
| Binh dinh | | | 6 | 1 | 10 | | | 8 | 155 |
| Phu yen | | | 2 | 3 | 8 | | | 17 | 102 |
| Khanh hoa | | | 4 | 2 | 6 | | | 16 | 137 |
| Ninh thuan | | | 2 | 4 | 2 | | | 4 | 59 |
| Binh thuan | | | 2 | - | 7 | | | 13 | 118 |

Source: Health Statistics Yearbook 2005, HSID, Planning – Financial Department, Ministry of Health, S. R. Vietnam, and Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft).

¹⁷ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 185.

¹⁸ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 186.

¹⁹ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 185.

²⁰ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006, p. 9.

22. Seventy percent (570) of hospitals are small, with fewer than 100 beds. Twenty seven percent have less than 30 beds. At the other extreme, 30 hospitals have more than 500 beds, with 10 hospitals exceeding 700 beds.

23. **Preventive Medicine.** Historically, preventive medicine activities have centered at the commune level. But in the last few years, stimulated by the increasing prevalence of HIV/AIDS and the threats of SARS and avian influenza, efforts were introduced to establish a national system of province-based preventive medicine centers. In addition, district preventive medicine centers are to be split off from district hospitals to allow greater specialization of preventive health functions at the local level. Conceptually, these decentralized facilities are to receive programmatic and financial support from the MOH to assure their continuing attention to current and potential threats to health, and to maintain readiness in case of an epidemic or natural disaster.²¹

24. Unfortunately, national and local health authorities do not always agree on how the preventive medicine system is to be organized and managed. At least at this stage of its development, the preventive medicine system is centrally directed, in contrast to the thrust toward decentralization underway throughout the rest of the health system. From a local perspective, the preventive medicine centers appear to duplicate some services, such as diagnostic laboratory services, which already exist in the curative sector, and the centers draw personnel from already short-staffed local hospitals. By policy, however, at the district level, every effort is to be made to avoid creating new laboratories for preventive medicine where suitable laboratory facilities already exist.²²

B. Analysis of Key Problems and Opportunities

25. With Viet Nam's remarkable progress so far, gaining further improvements in health status will be challenging. With most of its Millennium Development Goals (MDG) already achieved, the Government has set out a number of its own Viet Nam Development Goals (VDG). Viet Nam's overarching goal is to further reduce the incidence of poverty to 10-11 percent by 2010.²³ Targeted outcomes include accelerating economic growth to 7.5-8.0 percent per year; increasing per capita income to \$1,050-\$1,100; and exiting low-income country status. The Government views job growth as essential, but also recognizes the need for targeted interventions to reach isolated communities with high rates of entrenched poverty.

26. In its Socio-Economic Development Plan (SEDP), the Government gives health and education a central role.²⁴ In health care, Viet Nam has targeted further reductions in maternal mortality, infant mortality, and malnutrition; reversing the prevalence of malaria and tuberculosis, and halting the growth of HIV/AIDS. A major goal is to increase life expectancy to 72 years by 2010. At the same time, the Government has identified a number of problems that need to be addressed in order to achieve these objectives, including: deteriorating and poorly equipped infrastructure; shortages of skilled health workers; limited access, especially for the poor; and

²¹ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), pp. 159-175.

²² Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006, p. 26.

²³ Asian Development Bank, "Country Strategy and Program: Viet Nam 2007-2010," ADB, October 2006. (Citing the SEDP)

²⁴ Asian Development Bank, "Country Strategy and Program: Viet Nam 2007-2010," ADB, October 2006.

the challenges of managing an increasingly complex health system.²⁵ Another problem, limited financing, will continue to constrain the Government's ability to achieve all its objectives in the desired timeframe. The Government's plans to address these problems are consistent with ADB's Country Strategy and Program, and form the foundation and rationale for this Project, Health Care in the South Central Coast Region.

1. Deteriorated Facilities and Equipment

27. As extensive as it is, Viet Nam's health system is burdened by an infrastructure that is old, badly deteriorated, and poorly equipped, with inadequate systems for water and waste management and infection control. The challenge is two-fold. First, there is a danger that the country's significant gains in health status will begin to erode if the health infrastructure continues to deteriorate. Second, given emerging threats (such as HIV/AIDS, SARS, and Avian Influeza), and shifting disease patterns (with a greater proportion of non-communicable illnesses and injuries), it is appropriate for policy makers to invest more in modernizing health facilities and equipment (and training health workers) to more adequately address changing demands.²⁶

28. District Hospitals, for example, play a central role in the health care referral system in the province. Importantly, District Hospitals maintain a direct communication link, usually a telephone, with each of the CHS units in their district. In the case of an emergency, a CHS unit can call the District Hospital to request a transport vehicle (and accompanying staff). The District Hospital will pick up the patient and transport them back to the hospital, or onward to the Provincial Hospital if necessary. Unfortunately, the facilities and equipment at most district hospitals are old and degraded.

29. In many cases, for even simple illnesses, patients will by-pass both their local CHS and the District Hospital and go directly to the Provincial Hospital. For more serious injury or illness, the Provincial Hospital may be the only place short of a national specialty hospital that has the equipment and qualified staff needed for adequate treatment. Consequently, Provincial Hospitals are typically overwhelmed with patients, with chronically over-crowded wards and large volumes of outpatients. As a result, except for those few facilities that have been recently renovated, most provincial hospital, like district hospitals, have buildings that are physically degraded and equipment that is largely outdated or in a state of ill repair.

30. The Government has stated its intent to upgrade and equip, over the next five years, a total of 497 hospitals, encompassing 3.14 million square meters of building construction and renovation.²⁷ Over the last several years, many specialized central hospitals in Hanoi and HCM City have been modernized using a combination of state and ODA funding. Of provincial hospitals, however, most were constructed years ago. According to MOH estimates, only 50 percent of provincial hospitals meet 80 percent of prescribed equipment standards, and only 5 percent have modern radiology equipment. Among district hospitals, about 30 percent have received ODA investments. Only about 50 percent of district hospitals are equipped up to 70-80 percent of standard. Accordingly, the Government has set out a number of criteria to guide the modernization of each level of its curative care system – with an emphasis on decentralization, the definition of essential services, and the introduction of modern technology. Also mentioned

²⁵ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30,2006.

²⁶ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 17.

²⁷ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30,2006, p.11.

is the need to assure that, in any hospital upgrade project, waste management systems and practices be brought up to current standards.²⁸

31. **Safe Water and Waste Management.** Hospitals in Viet Nam, as they are everywhere in the world, are significant producers of dangerous medical waste. Improperly managed, medical wastes pose an immediate risk to hospital workers and patients as well as broader risks to the surrounding community and the environment. Assuring a ready supply of safe water, and modernizing hospital waste management systems, should be a part of any effort to upgrade or replace Viet Nam's inventory of aging hospital facilities and equipment. Fundamentally, safe water and the rigorous attention to proper waste management procedures are the foundation for effective infection control in hospital. Personal hygiene – for hospital staff and patients - is dependent on an adequate water supply and well positioned and designed wash basins and lavatories.

32. In support of national policy, the Government of Viet Nam has promulgated a comprehensive array of regulations and standards addressing safe water, waste management, and other environmental concerns. Some of the most prominent decisions include assigning responsibility for the management of medical waste (Decision No. 189955/1997); regulating the segregation, collection, off-site transportation, treatment, and disposal of hospital waste (Decision No. 2575/1999); and prescribing the technical requirements for the incineration of health care waste (Decision No. 62/2001). The use of radioactive materials in health care is detailed in Inter-ministerial Circulation No. 2237/1999. Standards for water quality in hospitals, and the handling of waste water, were prescribed in 2004 (TCVN 7382).

33. While the Government has introduced regulations and standards in recent years, there are still too few modern medical waste incinerators, and many that do exist are improperly operated and maintained. Based on a MOH survey, in 2002 there were 43 modern medical waste incinerators in the entire country, with a capacity to handle about 50 percent of all medical wastes produced – if they were strategically located and in good working order.²⁹ In reality, most provinces do not yet have modern medical waste incinerators and, those that do, often do not have established procedures to coordinate their use among surrounding hospitals. Shortages of the funds needed for fuel, electricity, and maintenance further compromise their efficient utilization.

34. In addition to incinerators, there are other smaller pieces of equipment and supplies (such as color-coded waste containers and disposable plastic liners, protective gloves, etc.) that are vital to proper waste handling techniques. Safe practices require separate, color-coded containers for medical sharps (needles, blades, and the like), contaminated wastes (wound dressings, etc.), and organic wastes (tissues, etc.). There are also hazardous chemicals and radioactive wastes that need to be properly handled. Safe handling of waste starts in the hospital's clinical departments and patient wards and continues through its collection, sorting, and proper disposal. At each stage, employees must be adequately trained and diligently supervised. And, importantly, recurrent budgetary allocations must be provided to assure the ongoing financial support for training employees, purchasing supplies and fuel, and maintaining equipment in good working order.

²⁸ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006, p. 42.

²⁹ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), pp. 89-91

2. Shortage of Skilled Health Workers

35. While health workers are widely distributed throughout every level of the health care system, mal-distributions and chronic shortages exist, and the staff that are available are often not adequately trained to provide the quality of health care needed. The Government of Viet Nam has set goals to train increased numbers of health personnel – especially doctors, nurses, technicians, and pharmacists – and to improve the quality of their training.³⁰ Also emphasized is the need to improve training curricula and training materials, and to strengthen the capacity of trainers, with the aim of bridging the gap between the quantity of students and the quality of their education.

36. In 2005 there were 259,583 workers employed as civil servants in the health sector, with an estimated 12 percent employed at the central level, 31 percent at the province level, 25 percent at the district level, and 19 percent at the commune level. Over the past five years, the MOH workforce has grown 11.44 percent, an average of 2.28 percent per year – almost double the rate of population growth for the same period, which averaged 1.37 percent per annum.³¹ It should be noted, however, that the workforce in the South Central Coast Region grew much more slowly than the national average. The number of health workers per 1,000 population grew by only 0.2 in the Region between 2001 and 2005, compared to a national average of 1.7 health workers per 1,000 population. In 2005 there were 0.6 doctors per 1,000 population, up from 0.4 in 1993, and 0.63 nurses per 1,000 population, little changed from 0.62 in 1993.³² The ratio of nurses to doctors was 1.3, compared to the WHO standard of 4-5:1.³³ Commendably, 94.8 percent of Viet Nam's 10,679 commune health stations have a trained health worker, often a midwife, with 70 percent staffed by doctors.³⁴ While 93.38 percent of all deliveries are attended by a trained health worker, the gaps are primarily in remote areas where most maternity deaths occur, usually attributable to hemorrhage or eclampsia where time and the skill of the health worker are critical.

37. As expected, hospital staffing levels vary by type of facility. In 2005, the number of health workers per patient bed nationwide was 1.15, ranging from a high of 1.38 per bed in MOH-managed hospitals to a low of 1.09 per bed at district hospitals.³⁵ Overall, about 18 percent of hospital workers are contract staff, with the highest ratio of 22.2 percent at provincial hospitals. On average, there are 2 doctors and 3 nurses for every 10 hospital beds, a ratio of 1.5 nurses to every 1 doctor – well below the MOH target of 2.5 nurses per doctor.³⁶ For district health facilities, staffing norms are prescribed by regulations, originally promulgated in 1975 by Decision 07/QDUB, that are now outdated. New staffing standards were issued in June 2007.³⁷ The staffing norms for facilities were increased, as were the expected ratios of nurses and technicians to doctors, which are now set at 3 to 3.5 nurses per doctor. Achieving these new ratios will take a significant effort. For example, increasing the number of doctors to 0.7 per 1000 population, and increasing the ratio of 3.5 nurses per doctor, will require these two

³⁰ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006, pp. 40-41.

³¹ MOH, *Health Statistics Yearbook, 2005*, MOH, 2006.

³² MOH, *Viet Nam Health Report 2006*, Medical Publishing House, 2007.

³³ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006, p. 13.

³⁴ Ministry of Health, "Health Statistics Yearbook 2005, HSID, Planning – Financial Department, S. R. Vietnam.

³⁵ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), pp. 190-191.

³⁶ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 191.

³⁷ MOH, Circular No. 08/2007/ttt-BYT-BVN, Regulations on personnel at all types of state owned health facilities, June 5, 2007.

categories to grow at a combined 3.6 percent per annum, much faster than the current growth of the workforce as a whole.

38. The MOH workforce currently includes a relatively low proportion (27 percent) of staff with university level qualifications, but the numbers are growing fairly rapidly. From 2001-2005, there was a 21 percent increase in the number of health workers with university level qualifications, and an 18 percent reduction in the number with only elementary level qualifications. In 2005, of 65,764 staff employed at the district level, 28 percent held university degrees, 29 percent graduated from secondary medical schools, and 23 percent received only elementary training. Health workers holding advanced degrees are concentrated in urban areas.

39. Importantly, there are no established standards for continuing education for staff at any level, including doctors. As a result, throughout the health system, and certainly within hospitals, there are serious gaps in the knowledge and behavior of health workers regarding evidence-based treatment protocols, sanitation, infection control, waste management, and other topics that impact on quality of care. In addition, there are no established guidelines for professional licensure or institutional accreditation - although policies addressing these issues are in development.³⁸ The Government has stated its intent to introduce policies on continuing education for those already in the work force, and the geographic distribution of health workers – introducing measures to strengthen staffing at local levels, especially in remote and disadvantaged areas.³⁹ These goals are consistent with ADB's Country Strategy and Program.⁴⁰

40. Improving the quality of health care provided, by both the individual health worker and the institution, is an important aspect of human resources training. An emphasis on short-term, skills-based training has the advantages of impacting directly on worker performance and limiting the time required away from work. Skills-based training focuses on those skills most needed to improve the quality of care provided by health workers at every level of the system – utilizing training modules for Emergency Obstetrical Care (EOC), Neonatal Emergency Care (NEC), and other materials developed by WHO and other international authorities and already adapted and proven in Viet Nam. Quality improvement theory and methodologies need to be introduced in the educational curricula of all health workers, and short-term continuing education programs are needed for those already graduated. Physicians and nurses need schooling in treatment protocols, infection control, and quality performance. All health workers need training in the handling and disposal of hazardous medical waste.

3. Access to Quality Health Care for the Poor and Ethnic Minorities

41. For the rural poor, access to health care remains problematic. Maternal deaths illustrate the problem. In a 2000-2001 study of maternal deaths, 76.3 percent were attributable to direct causes – primarily hemorrhage, eclampsia, and infection. While many deaths reflect the risks of living in remote areas, nearly half were due to delays in decision making, identifying at-risk mothers and providing essential treatment.⁴¹

³⁸ The Ministry of Health is developing a proposed “Law on Examination and Treatment,” planned for introduction in late 2007 or early 2008.

³⁹ The Department of Science and Training is working on a “Master Plan for the Training System” to be introduced in late 2007.

⁴⁰ Asian Development Bank, “Country Strategy and Program: Viet Nam 2007-2010,” ADB, October 2006, p. ii.

⁴¹ Ministry of Health, “Vietnam Health Report 2006,” Medical Publishing House, 2007 (draft), p. 14.

42. Certainly the remoteness of many rural communities and the unavailability of skilled health workers contribute significantly to their poverty and poor health status. But other factors are also important. For one, ethnic minorities tend to seek healthcare services less often, averaging 2.3 outpatient visits per year, compared to 3.5 for Kinh/Chinese. Language and literacy also contribute, especially for minority women, with one in four unable to read. Traditions, and a level of mistrust of others, are also factors.

43. A major thrust of the Government's health sector plan is, "to consolidate and complete the grass-roots health network...to carry out primary health care services."⁴² Plans include upgrading the facilities, equipment, and staffing of Commune Health Stations. One goal, for example, is to have 1 to 2 health workers in each hamlet or village, and to have a doctor in 80 percent of all Commune Health Stations by 2010 (compared to 60 percent in 2003), and in 100 percent by 2020. Importantly, the Government has set a goal to improve the training of those who work in Commune Health Stations, stressing basic techniques in ophthalmology; dental care; ear, nose and throat; reproductive health; and child health. All of these efforts have the potential to improve access to quality health care.

44. While other factors influence access, the out-of-pocket cost of health care is the most significant constraining factor. The utilization of both outpatient and hospital inpatient services show a strong link between economic status and access. The following table illustrates the use of outpatient services:

Utilization of Public Outpatient Services
Percent of Sample

| | CHS/Regional Polyclinics | District Hospitals | Provincial and Central Hospitals |
|------------------------------|-------------------------------------|-------------------------------|---|
| Overall | 50.2 | 24.0 | 25.8 |
| Poor | 63.8 | 23.3 | 12.9 |
| Average | 56.7 | 26.0 | 17.3 |
| Rich | 37.3 | 22.4 | 40.3 |
| With Health Insurance | | | |
| Overall | 34.3 | 33.0 | 32.6 |
| Poor | 46.7 | 39.4 | 13.9 |
| Average | 44.8 | 39.1 | 16.1 |
| Rich | 26.0 | 28.4 | 45.6 |
| No Health Insurance | | | |
| Overall | 54.4 | 22.0 | 23.6 |
| Poor | 64.1 | 21.6 | 14.3 |
| Average | 58.2 | 23.7 | 18.0 |
| Rich | 44.0 | 20.1 | 35.9 |

Source: VVHS 2001-02, as adapted from Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), Table 11.2, p. 126.

⁴² Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30, 2006, pp. 35-37.

45. As with outpatient services, those with greater economic resources tend to use higher level hospitals, including private hospitals, when they seek hospital inpatient care. The following table illustrates:

Hospital Inpatient Utilization by Economic Status
Percent

| Quintile | CHS/Regional Polyclinic | District Hospital | Provincial Hospital | Central Hospital | Other Public Facility | Private Facility | Total |
|-------------------|-------------------------|-------------------|---------------------|------------------|-----------------------|------------------|-------|
| Overall | 15.8 | 33.3 | 34.5 | 7.6 | 4.5 | 4.3 | 100.0 |
| Poor | 24.4 | 42.0 | 23.4 | 3.9 | 2.3 | 4.0 | 100.0 |
| Near Poor | 22.8 | 36.9 | 26.4 | 5.9 | 3.5 | 4.5 | 100.0 |
| Average | 15.6 | 37.4 | 33.1 | 5.5 | 4.2 | 4.2 | 100.0 |
| Better Off | 10.1 | 32.4 | 39.4 | 9.3 | 5.3 | 3.6 | 100.0 |
| Rich | 5.4 | 16.9 | 51.0 | 13.8 | 7.5 | 5.4 | 100.0 |

Source: VVHS 2001-02, as adapted from Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), Table 11.1, p. 125.

46. The predominance of user fees at all levels of the health system, coupled with the cost of drugs and indirect expenses for travel and accompanying family members, can be a devastating financial burden for those surviving at a subsistence level. The introduction of health insurance, especially the Health Care Funds for the Poor (HCFP), is beginning to mitigate these financial burdens.

47. In 1992, after an initial period of experimentation, Decree 299 established a two-part national health insurance scheme.⁴³ A compulsory scheme (CS) covered active and retired civil servants, employees of state-owned enterprises, and private employers with more than ten employees. A voluntary scheme (VS) targeted dependents of CS members, farmers, and workers in the informal economy. In 1998, with the issuance of Decree 58, management of the health insurance schemes was centralized under the Viet Nam Health Insurance Agency (VHIA). In 2002, with Decree 100, the VHIA was merged into Viet Nam Social Security (VSS).

48. Also in 2002, Prime Minister Decision 139 established Health Care Funds for the Poor (HCFP), extending coverage to the poor, ethnic minorities in 12 mountainous provinces, and residents of socio-economically disadvantaged communes.⁴⁴ The funds were to be financed 75 percent by central government and 25 percent by local and international sources.⁴⁵ Subsequent decisions required the purchase of health insurance cards for all beneficiaries, raised the poverty line and thereby expanded the number of those who were eligible for coverage and expanding the benefits package to reimburse travel costs on referral.⁴⁶

⁴³ Axelson, Henrik, "The Evolution of Health Insurance Policy in Vietnam," World Health Organization, (Draft) March 2, 2007, p. 4.

⁴⁴ Axelson, Henrik, "The Evolution of Health Insurance Policy in Vietnam," World Health Organization, (Draft) March 2, 2007, p. 15.

⁴⁵ Knowles, James C., "Some Key Health Insurance Policy Issues in Viet Nam," Report to the Asian Development Bank, March 2007, p. 11.

⁴⁶ Axelson, Henrik, "The Evolution of Health Insurance Policy in Vietnam," World Health Organization, (Draft) March 2, 2007, p. 22.

49. HCFP enrollment has increased rapidly. In 2003, when HCFP was launched, 3.3 million people were enrolled, out of an estimated 14 million who were eligible.⁴⁷ Enrollment increased to 3.9 million in 2004, 4.8 million in 2005, and an estimated 14.9 million in 2006 – accounting for 44 percent of the 34.5 million subscribers of all health insurance schemes.⁴⁸

50. But even with its rapid growth, the potentials of HCFP have yet to be fully realized. Administration of the funds, at the provincial level, has been inconsistent. Some provincial authorities have been slow in issuing cards and administration errors occasionally exclude legitimate claims. In addition, enrollees sometimes lose their enrollment cards, or they do not always understand their eligibility, or how to access health services. Efforts to address these administrative issues have been frustrated by weak managerial capacities and conflicting incentives.

4. Management Capacity

51. Given the high levels already achieved and the growing complexity of health system technology and finance, further improvements in health status will be more challenging, requiring increased management sophistication in planning and executing targeted programs designed to reach entrenched populations of the poor and underserved. With the move toward decentralization, provincial health authorities are assuming increasing responsibility for financing and managing the health system but often lack the tools, training, and experience to do so effectively.

52. Historically, Viet Nam's health system has been strongly hierarchical, with organizational and financial control centralized at the top. But beginning in 1996, with the introduction of the State Budget Law, and revised in 2002, provincial authorities were given increased autonomy in organizing the budgets for districts and communes.⁴⁹ In the health sector, central authorities retain responsibility for spending on centrally-managed health services, research, and national health programs. Provinces have the authority to spend on provincial-level health services, with districts and communes having responsibilities for services delegated to them by the province. Subsidies are provided to the provinces from the Central budget, intended to resolve imbalances by increasing the financial capacity of poorer provinces. The formula used to calculate the subsidies is based on geographic and social development factors and is applied for a 3 to 5 year period. Provincial authorities have some discretion in determining how the subsidies are allocated to district and commune budgets.⁵⁰

53. Policy changes were also introduced to promote institutional independence, beginning in 2002 with the approval of the Master Plan for the development of the hospital network in Viet Nam, 2005-2010 (MOH Decision 1047/QD-BYT). The Decision called for reforms aimed at systematizing and rationalizing the system and encouraging greater financial autonomy in hospitals.⁵¹ Of particular relevance, Decree 10 introduced mechanisms to encourage hospitals to raise their own revenues.⁵² Hospitals were authorized to recruit, hire, and terminate employees in order to promote effectiveness and quality of work. In addition, hospitals were

⁴⁷ Axelson, Henrik, "The Evolution of Health Insurance Policy in Vietnam," World Health Organization, (Draft) March 2, 2007, pp. 15-16.

⁴⁸ Axelson, Henrik, "The Evolution of Health Insurance Policy in Vietnam," World Health Organization, (Draft) March 2, 2007, p. 16, Table 1.

⁴⁹ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 209.

⁵⁰ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 209.

⁵¹ Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 203.

⁵² Ministry of Health, "Vietnam Health Report 2006," Medical Publishing House, 2007 (draft), p. 206.

permitted to mobilize funds, and arrange loans, and were given greater flexibility on how those funds were used, including carrying over budget excesses to the following year.

54. While implementation of Decree 10 has addressed some problems it has created others. In some hospitals, incentives to raise revenues has stimulated over use of revenue producing services. And some hospitals have used revenues to enhance salaries but have neglected needed maintenance. In 2006, to help address these problems, the Government replaced Decree 10 with the issuance of Decree 43 which expanded institutional rights while imposing certain constraints. Under this policy, hospitals are rated according to their capacity to mobilize revenues. There are three categories: (1) hospitals with complete autonomy can manage their regular expenditure; (2) hospitals with partial autonomy have some discretion; and (3) hospitals with small revenue are allocated their regular expenditure allowances from the State budget. Hospitals in category 1 and 2 were given greater freedom to set user fees but were held responsible for covering all operating costs before using revenues to establish investment funds or to increase staff wages.

55. In the process of decentralization, managerial roles are changing and uncertain, and managers often lack the financial resources, information, training, and experience to carry out their new responsibilities effectively. Managers at the central level are reluctant to give up their authority, or unsure how to do so without abdicating their own obligations. The willingness of provincial health departments to exercise their authority reflects their continuing dependence on national subsidies. And hospital directors are unsure how to balance limited resources with competing priorities.

58. The need to make managerial decisions will increase the need for more sophisticated data collection and processing technologies. On a trial basis, management information systems have been introduced in a number of provinces with good success. And in those provinces where major donor projects have been most active, provincial health officers have demonstrated a growing capacity for planning, decision-making, and management.

59. Appropriately, in its Comprehensive Development Design for the Health System, the Government has recognized the need to strengthen managerial capacity at all levels of the health system – bureaucratic and institutional.⁵³ A number of initiatives will be required including: introducing the technology, hardware, and training needed for modern management information systems; both graduate and post graduate training in institutional and health systems planning, finance, and decision-making; and the introduction of performance monitoring methodologies.

5. External Assistance

60. Health sector financing has improved substantially in recent years, in particular in the more wealthy provinces, and external assistance now accounts for a small, but important, share (about 5 percent) of total spending in the sector. With increasing income, progress in poverty reduction, provinces attracting funding, and increasing sector capacity, the MOH is seeking ways to improve the cost effectiveness of external assistance. It is considering alternative aid modalities, in particular program assistance, budget support, and sector wide approaches, which improve coordination and reduce transaction costs.

⁵³ Government of Viet Nam, "Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020," Ha Noi, June 30,2006, p. 40.

61. Some building blocks in this direction have been initiated, including the development of comprehensive provincial plans and medium term expenditure frameworks done in preparation of this Project, which will improve transparency on sources and uses of funds, enhance ownership and accountability, identify priorities and financing gaps, help mobilize resources, facilitate policy compliance and standard setting, and monitor sector performance. The plans have clearly shown the need for more balanced spending. Provincial project assistance will be needed to upgrade provincial health systems, but should be done in a more systematic and balanced manner based on clearly articulated national and provincial policies and priorities.

62. At present, ADB supports five projects in Viet Nam,⁵⁴ including provincial health systems 800 seats through two projects – the 2004 Health Care in the Central Highlands Project and the 2000 Rural Health Project now nearing completion. The Rural Health Project, for example, has provided loan support for 117 projects in 14 provinces, upgrading and constructing district hospital facilities. The World Bank is supporting similar projects in the Northern Mountains and the Mekong regions. Both banks have been asked by the Government to support similar projects along Viet Nam's central coast – an area lagging in health status indicators (women and children and ethnic minority populations) and that has persistently poor access to health services.⁵⁵ The World Bank has agreed to target the North Central Coast Region and ADB will target the eight provinces in the South Central Coast Region – the focus of the Project.

63. In the target provinces, other agencies support mainly hospitals and communicable disease control (see Appendix 5). Support for provincial hospitals has been provided by Belgium, JBIC, KfW, Korea and New Zealand. GAVI will support the training of village health workers in Binh Dinh province. The World Bank is supporting the strengthening of health systems management, while the EU is providing provincial program support. ADB, AusAID, the EU group, WHO and the World Bank are preparing a joint partnership investment, for possible ADB support in 2009. ADB is already supporting the 2005 Preventive Health Systems Support Project, helping to finance the upgrading of preventive medicine centers and providing new equipment and training for 46 provincial and 4 national institutes; and the Greater Mekong Subregion Regional Communicable Diseases Project, which is supporting surveillance and response systems, the control of neglected endemic diseases, and regional cooperation.

64. **Donor Harmonization.** Currently, health service provision is relatively fragmented in terms of policy, management and service delivery systems, leading to inefficient use of available resources. Donors have contributed to this situation through Project approaches that require separate management, monitoring and reporting mechanisms. Fragmentation of service provision and lack of harmonization are present in other sectors as well as in the health sector, and the Government is currently working to overcome these problems. Nationally, a number of initiatives are underway that have the potential to significantly improve the coordination within sectors. Harmonized Monitoring Tools are being developed which will reduce the amount of time and effort service delivery units spend on reporting. A Country Financial Accountability

⁵⁴ ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Viet Nam for the Rural Health Project*. Manila; ADB. 2004. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Viet Nam for the Health Care in the Central Highlands Project*. Manila; ADB. 2005. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to Viet Nam for the Preventive Health System Support Project*. Manila; ADB. 2005. *Report and Recommendation of the President to the Board of Directors on a Proposed Grant to Viet Nam for the Preventive Health System Support Project*. Manila; ADB. 2005. *Report and Recommendation of the President to the Board of Directors on a Proposed Grant to Viet Nam for the Greater Mekong Subregion Regional Communicable Diseases Control Project*. Manila; ADB. 2006. *Report and Recommendation of the President to the Board of Directors on a Proposed Grant to Viet Nam for the HIV/AIDS Prevention Among Youth*. Manila;

⁵⁵ Asian Development Bank, "Country Strategy and Program: Viet Nam 2007-2010," ADB, October 2006, p. 36.

Assessment 2007 update of several pilot Ministries is being undertaken by the Ministry of Finance and others, to identify financial governance problems that need to be addressed before Sector Wide Approaches to development assistance can be implemented.

65. Within the health sector, several recent changes present opportunities for improvement. The Health Partnership Group (HPG), chaired by the MOH and including representatives of donors and other agencies working in the health sector, was established in 2004 to increase the coordination and efficiency of development assistance. Its terms of reference have recently been broadened to enable it to contribute more effectively to health policy and strategy development, and to guide the Joint Annual Health Review (JAHR). Its regular meetings facilitate stronger links between the MOH and development partners, support sector wide policy dialogue and seek to ensure the effective and efficient utilization of all resources and contributions to the health sector. The first Joint Annual Health Review (JAHR) is underway. This review, and subsequent reviews, will ensure that MOH and donors share the same understanding of the health situation, and plan and work collectively toward improving it. A series of joint performance indicators will be developed to be used by the MOH internally and by external agencies.

66. The Project can both contribute to these efforts to harmonize support for the health sector, and also benefit from them. Project activities to strengthen management, training and quality of care in the target provinces will provide valuable lessons on different approaches to improving health services. By participating in forums such as the HPG and sharing these lessons, the Project will contribute to policy development that is informed by implementation realities. The MOH and others will be able to duplicate Project successes, and avoid potential pitfalls. Joining in the JAHR will ensure the Project responds to evolving MOH vision and goals, and uses an indicator framework which is integrated with that of MOH and other donors. Long term technical assistance will be required throughout the Project to guarantee that Project participation in these forums is meaningful and consistent.

67. **Lessons Learned.** Based on ADB's experience, and the experience of other donors, there are several lessons learned that have relevance for this project:

- Viet Nam's health system is fragmented, causing projects to be implemented in isolation, resulting in further fragmentation, repetition, and lack of sustainability of interventions. Its health services are lacking minimum standards against which performance can be measured. Health sector planning, financing, and aid coordination remain major challenges in Viet Nam's public health sector. Recent initiatives at national and provincial levels, including under the PPTA for this Project, help improve this.
- ADB support tends to be isolated and needs to be linked more strongly with national policies and plans and local priorities. Participation of Project advisors in forums such as the Health Partnership Group and the Joint Annual Health Review will help to achieve this. ADB projects should be better interlinked to build on experiences and maximize development results.
- Provincial authorities have limited capacity in health system development and improving services to reach the poor. Experience suggests that provincial plans often fall short of targeted interventions to reach underserved rural communities.

- Based on the experience of ADB's Rural Health Project, attention should be given to build capacity for project implementation prior to project launch.
- Planning for upgrading of public hospitals needs to be carefully justified given the improvement of communication, current inefficiencies in hospital services (long stay, high bed population ratio, and high self-referrals), and likely deregulation of private hospital development by 2010.
- In ADB's Rural Health Project, it is evident that newly constructed hospitals are not always well designed nor properly constructed. Design and construction standards should be reviewed and updated, and construction projects closely supervised.
- Experience in the Rural Health Project indicates that training efforts are often shallow, and have little real impact on skills development. Training needs to be more practical and less theoretical, more hands-on and experiential, using adult learning methodologies and materials. AusAID's Primary Health Care for Women and Children Project (2003) demonstrates the success of combining technical training and systematic approaches in Integrated Management of Childhood Illnesses and Emergency Obstetric Care training programs, combined with systems that improve the quality of service provided (COPE). Training programs that emphasized follow-up supervision, workplace assessment, and on-the-job training, greatly increased the retention of the training content. AusAID's experience also suggests that community mobilization, IEC, and health education, if systematically implemented through local structures - such as the People's committees – commune health workers and village volunteers can improve health seeking behavior and overall population health.

III. THE PROPOSED PROJECT

68. The objective of the proposed Project is to improve the health status of the poor, women, children, ethnic minorities, and other vulnerable groups, and strengthen health systems in eight provinces in Viet Nam's South Central Coast Region.

A. Impact and Outcome

69. The Project will improve the health status of the poor, women, children, ethnic minorities, and other vulnerable groups in eight provinces in the SCCR, namely Da Nang, Quang Nam, Quang Ngai, Binh Dinh, Phu Yen, Khanh Hoa, Ninh Thuan, and Binh Thuan, towards achieving Viet Nam Development Goals (VDGs) by 2015. The Project will support the Government's efforts to develop comprehensive and well managed provincial health system that preserves the gains in health status already achieved, extends those gains to the poor and underserved, and is better able to address emerging challenges and changing demands. Major project outcomes are (i) upgraded district hospital services providing expanded and better quality health services; (ii) improved provincial capacity for human resource development (HRD), better skilled staff, and more staff minorities; (iii) improved access to quality health care for the remote poor, in particular women and children; and (iv) improved management of the provincial health system in terms of equity, efficiency, and effectiveness. The Design and Monitoring Framework is in Appendix 1.

B. Outputs

70. During Project Preparation, each of the eight provinces improved its provincial five year plan and medium term expenditure framework and identified investment priorities. Based on a participatory planning process, priority investments were grouped in four components, including (i) upgrading hospitals, (ii) human resource development, (iii) improving access for the poor, and (iv) strengthening management of services. The Project will focus on improving the use and quality of health care and strengthen the capacity of the provincial health systems.

1. Component One: Upgrading Provincial, Regional and District Hospitals

71. The Project will focus on improving the quality of care and utilization of services that address the basic health needs of the poor and vulnerable. The Project will help strengthen the capacity of the provincial health systems to maintain and extend the gains achieved in health status, while meeting the changing demand for health services resulting from the introduction of health insurance and emerging patterns of illness and injury. The Project will strengthen selected provincial, regional, and district hospitals in the eight target provinces to increase access and improve the quality of services. While no Commune Health Stations have been included, the Ministry of Health has assured that these facilities will be included in another near-term project. The Project will finance (a) civil works; (b) medical equipment, furniture and essential drugs and supplies; and (c) safe water, sanitation, and waste management systems. The Project will provide the inputs required to bring each facility up to specified standards, and will ensure that these services are sustainable.

a. Civil Works

72. The Project will upgrade or construct a total of 30 hospitals - including 18 district hospitals, 4 regional hospitals, 3 specialty hospitals, 1 provincial hospital, and 4 preventive health centers. A list of projects is provided in Appendix 14. The institutions were selected on the basis of priorities identified by provincial health authorities, surveys during project preparation (including an assessment of environmental and resettlement issues), and evaluation by ADB and MOH to assure consistency with Project goals, national plans, and guidelines. However, the Project will update the requirements at inception to account for potential changes and conditions including unresolved resettlement issues, the creation of new districts and communes, unforeseen contingencies, and alternative sources of funding. In coordination with the provinces, a schedule will be developed for each civil works project that will set out benchmarks for acquiring and clearing land, resolution of any resettlement issues, completion of hospital program description and architect plans, completion of bidding documents, and other measures of progress.

73. The Project will support the engagement of architecture and civil engineering expertise to assist the MOH in re-evaluating and upgrading national hospital design and construction guidelines⁵⁶ to assure their conformance with modern standards and their consistency with those used in other externally aided projects. Among other criteria, the design guidelines will address safe water, sanitation, and waste management; separation of clean and contaminated areas; access for the disabled; barriers to traffic flow; and visual and auditory privacy for patients. The Project will also support the services of a qualified hospital architect to work, in collaboration with local authorities and hospital personnel, to define programmatic goals and

⁵⁶ Ministry of Health, "Implementation Guidelines for Upgrading District and Interdistrict Hospitals, 2005-2008," Hanoi, 2005.

design architectural plans for each civil works project, based on the revised and updated design standards.

74. The Project will also support the services of a qualified construction manager to oversee the construction of the civil works projects to assure their conformance with construction standards and timely completion. Indigenous materials that are easily maintained will be utilized whenever possible. Where only selected services will be upgraded or constructed, priority will be given to obstetrical and gynecological services, pediatrics, surgery, emergency, laboratory, and diagnostic services. The Project will also support HIV awareness training for the workers involved in the construction of each civil works project.

75. Once completed, newly constructed and renovated facilities need to be properly maintained if their benefits are to be fully realized and the substantial investments are to be justified. The Project will support the preparation of guidelines for preventive maintenance, the collection and translation of technical manuals, and the training of hospital personnel in preventive maintenance procedures. The Government will assure on-going financing of recurrent maintenance costs.

b. Equipment and Supplies

76. The Project will finance the procurement of equipment for the upgraded or newly constructed hospitals, and other institutions identified by provincial authorities as serving target populations. The Project will also support the purchase of an initial inventory of reagents and other supplies needed to properly utilize the new equipment. A total of 44 institutions will receive equipment, including 36 district, 4 regional, and 4 provincial hospitals. Equipment purchases will be in accordance with established MOH standards and will: (i) replace old and non-functioning equipment; or (ii) upgrade technology for existing procedures; or (iii) seek to provide new services. An indicative list of major medical equipment for a district hospital is provided in Appendix 15. Procurement and supply of equipment will be closely coordinated with civil works.

77. The Project will ensure that health personnel are properly trained to use the equipment, and that operating manuals are supplied in Vietnamese. The Government, as documented in provincial planning documents, has assured that the supplies needed to operate the equipment, as well as the costs of maintenance, will be provided during and beyond the project period through adequate increases in operation and maintenance budgets.

c. Safe Water, Sanitation, and Waste Management Systems

78. Investments will be made as needed to assure that all facilities included in this Project have adequate safe water, sanitation, and medical waste management systems, including waste water systems, proper containers to segregate contaminated and hazardous waste, proper collection and storage facilities, and access to modern medical waste incineration and/or disposal facilities. Hospital personnel in all facilities will be trained in the theory, methodologies, and supervision of modern waste management practices. In addition, the Project will support consulting assistance to work with authorities in each target province to develop a province-wide plan for the management of medical waste.

2. Component Two: Provincial Human Resources Development

79. A major Project goal is to increase the capacity of health workers to provide quality health care in the eight provinces. Increasingly, the responsibility for recruiting, training, and managing human resources in health is a local concern, and a demanding obligation of provincial health authorities. The Project will support: (a) strengthening human resources planning and management; (b) building training capacity at provincial and district levels (c) training of district and commune health staff to improve quality of care; and (d) scholarships and research grants.

a. Improved Provincial Human Resources Planning and Management

80. The role of the MOH in implementing the Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020 includes “to direct, provide guidance to ... institutions ... projects [of] the national health programmes and provincial health facilities to implement the design”⁵⁷. In order to fulfill this role in the decentralized health system, the MOH needs to maintain close links with provincial, district and commune levels. This is particularly important in regard to human resources (HR), to ensure that the training, distribution and management of health workers is consistent with national policy directions, that the local levels are able to inform future policy making based on their implementation experience, and that the MOH has the capacity and information needed to develop a long-term HR Plan for the health sector. The Project will support the MOH Department of Organization and Manpower and the Department of Science and Training in implementing Government HR policies and building HR planning capacity at all levels by strengthening mechanisms for coordination and collaboration, and funding operational research.

81. The Project will provide assistance to each province to annually update and maintain its human resources (HR) Plan. The annual HR Plans will take into account national policy initiatives, including those currently being considered on licensure, certification, and continuing education. In addition to addressing staff management issues, the annual HR plans will consider the training needs of health providers in the province, and the availability of training resources in terms of trainers, training courses, training facilities and funds. Special attention will be paid to ensure proper linkages between the different training programs, assure participation of ethnic minorities and women, facilitate appropriate scheduling, and avoid overlaps. The plans will also include targeted strategies to increase the leadership role of qualified women personnel in the management of health services. The plans will provide for monitoring and evaluation of staff quantity and quality, and of training programs.

82. To help increase the number of women and ethnic minority health workers in targeted communities, the Project will provide assistance to each province to develop gender and ethnic minority action plans, including focused interventions designed to ensure they reach targets for women and ethnic minorities in training courses at all levels. Where appropriate, training courses offered through the Project will be provided in local languages of ethnic minorities. Language preparatory courses will be offered to ethnic minority staff who are selected to participate in courses that are only available in the Vietnamese language. Health workers serving ethnic minority communities will be given priority for training, and training programs will include topics that disproportionately affect ethnic minorities.

⁵⁷ Government of Viet Nam. 2006. *Comprehensive Development Design for the Health System in Viet Nam to 2010 and Vision by 2020*, pg 48 (English Version).

b. Strengthening Training Capacity at Province and District Levels

83. The Project aims to strengthen the relevance, accessibility, quality, and effectiveness of training in the 8 target provinces. The quality of pre-service education, and the availability of high level support for in-service training, will be improved by increasing the capacity of the 7 Secondary Medical Schools and the Technical Medical College in the Region. Leadership will be enhanced through provision of scholarships to ensure each School has at least two senior staff member with a Masters of Nursing. The quality of teaching and learning at the Schools will be improved by linking them with “centers of excellence” at medical Universities in Vietnam; supporting short-course training attachments and establishing ongoing supervisory and on-the-job training mechanisms. Equipment and materials will be provided to enable students to develop skills in demonstration rooms and laboratories before working with patients. Support will also be provided to enable Schools to evaluate graduate preparedness, as a mechanism for quality improvement of pre-service and post-graduate training.

84. The in-service training system will also be strengthened to support the introduction and/or expansion of skills-based training – an approach which has been proven to be very successful in improving health worker performance in several localities in Viet Nam. Skills-Based Training (SBT) is a simple, flexible approach based on the principle that training is complete only when the learner can demonstrate skilled performance. The SBT model involves several elements, including: (i) development of a skills checklist, based on MOH standards, and adapted to the needs of each province; (ii) training of trainers (TOT) on adult learning principles, inter-active learning, how to teach, and how to conduct workplace assessment; and (iii) on-the-job follow-up to assess the application of learned skills and knowledge, and to provide further coaching as required to gain proficiency.

85. To assist provincial health authorities to implement Skills-Based Training programs, the Project will support existing Provincial Training Working Groups (PTWGs), and encourage the formation of similar groups where they do not exist or are inactive. Provincial Training Working Groups (PTWGs) are composed of senior clinical and preventive health trainers from provincial and district levels, Secondary Medical Schools, reproductive health centers, Health Education Centers, and Provincial Committees for Population, Family and Children (PCPHC). The PTWGs play a key role in planning, developing, delivering, managing, and evaluating training activities. PTWG members will be trained as “Master Trainers” by senior training specialists who are experienced in SBT and interactive teaching methodologies. At the District level, the Project will support the strengthening of District training teams (DTWGs) who will take responsibility for planning and mobilizing training programs in their districts and local communities. In each province, a group of 8-17 Master Trainers, along with 5 District trainers from each district, will be trained as trainers (TOT). Capacity building will be further enhanced by the sharing of experiences between the 8 provinces, through regular meetings of an Inter-Provincial Training Working Group (IPTWG).

86. A package of in-service training materials will be developed and compiled for use by the PTWG and DTWGs, including an In-service Training Procedures Manual and range of SBT training modules addressing important health topics. Trainers will be oriented on these topics, and taught the skills necessary for training needs analysis (TNA), management and implementation of Skills Based Training, and evaluation of training outcomes. The Project will also support the purchase of equipment needed to enhance in-service training activities or otherwise strengthen training capacity. Equipment may include computers, software, projectors, screens, flip-charts, training aides, and other training materials and supplies.

This approach is founded on the understanding that in-service training needs are best determined at the local level. Relevance and efficiency of training is improved where Provinces and Districts have the discretion to plan in-service training based on their Training Needs Assessment, and to coordinate the implementation of training with service delivery needs.

c. Improving the Quality of Health Care

87. The Project will support training to improve the quality of care provided by doctors, nurses, midwives, and technicians working in commune health stations, district, regional and provincial hospitals, and provincial and district preventive medicine centers. Based on HR Plans developed by Provincial Departments of Health, and working with PTWGs, and DTWGs, the Project will support the mobilization of Master and District Trainers to train 100-275 doctors, nurses, midwives, and technicians in each province per year. Training programs will be short term (typically 5 to 10 days with on-the-job follow-up), and will emphasize skill-based training in priority topics identified in TNA. Supervisors will be trained to ensure they have the skills necessary to support trainees in applying new skills on the job. A list of training activities, and the estimated number of participants, is attached as Appendix 13. Support will also be provided for PTWGs and DTWGs to undertake evaluations of the impact in-service training has on the performance of health workers, as a mechanism for quality improvement.

88. The Project will also specifically address quality of care issues in remote and poor Commune Health Stations (CHS), where lack of staff is a problem. Recruiting staff from other areas has not been successful in addressing staff shortages, due to the challenging living and working conditions, and the cultural and social differences between ethnic groups. The Project will therefore provide scholarships for local school leavers to attend health worker training at provincial Secondary Medical Schools or Colleges in the Region. These scholarships will cover living expenses such as food and accommodation, uniforms, books, travel between home and School for holidays, extra tuition and preparatory courses if needed, and will supplement current government subsidies for tuition.

89. There is currently no requirement for health professionals to participate in continuing education in Viet Nam. The MOH is exploring options to encourage ongoing education as a part of registration and licensing of health professionals. While some in-service training is provided for Government health workers, there are few opportunities or incentives for those working in the private sector to participate. The Project will support the Secondary Medical Schools and College to offer subsidized professional education meetings which will be open to health workers from both the public and the private sector.

d. Scholarships and Grants

90. To assist provinces in achieving MOH staffing standards for health facilities, the Project will also support scholarships for prioritized specialized training, upgrading training or other advanced education in the health professions, based on Provincial HR Plans. Scholarships will be for study within Viet Nam, at the closest academic or technical institution with capacity to provide such training. Funding will be provided for tuition, accommodation, meals, travel, and other costs associated with completing the course. Preparation courses will also be covered if necessary. The Provincial Department of Health will work with the PPMU to select candidates, who must then be approved by the PPU at the MOH. Criteria will be developed to ensure that selection of candidates for scholarships is consistent with Project goals to increase the representation of ethnic minorities and women in senior positions within the health sector.

91. The Project will support 15 research grants for studies related to the development or implementation of policies on human resources planning, recruitment, retention, in-service and advanced education, and related issues. Research and study proposals will be processed by the Project Management Unit, upon the recommendation of a Provincial Project Management Unit, and review by an advisory committee composed of representatives of provincial and national health authorities. Annual meetings will be supported to enable sharing of research findings.

3. Component Three: Access to Quality Health Care for the Poor

92. Access to quality health care for the poor requires collaboration between a range of service sectors and community groups so that health is seen as an issue of communal concern, and not simply a technical issue for workers inside the health system. In the health system this is promoted by developing skills in community needs assessment, and improving outreach activities. At the community level, activities involve mass organizations, government officers from various commune-level departments, and community volunteers and staff from Commune Health Stations (CHS). Strengthening health services therefore focuses on district and commune levels, and includes the strengthening of clinical, communication, and supervisory skills.

93. This component will increase access to quality health care services for the poor, women, children and ethnic minorities by: (a) strengthening health care services in remote and ethnic minority communities, (b) improving health behavior through increased knowledge, awareness, and participation in community-based health promotion activities; and (c) reducing financial barriers to access.

a. Health Services in Remote and Ethnic Minority Communities

94. The Project will support the Government's policy of expanding and strengthening the grass-roots network of commune health personnel, village health workers, and other volunteers in remote and disadvantaged areas. Throughout the 83 districts in the eight provinces, there are 1,057 communities, 423 of which are remote or mountainous villages. 223 of these communities have been classified as poor (under Decree 135) and will be specifically targeted.

The Project will support the Provincial and District Training Working Groups (PTWG) in identifying and mobilizing trainers who will conduct training needs analysis (TNA), plan, design, develop, deliver, and evaluate SBT materials and courses for health workers at the commune and village levels, including VHW and TBAs currently working in remote areas, to upgrade the quality of health care provided in the targeted communities. Training courses will be based on the TNA, and address priority topics in maternal and child health, reproductive health and health promotion.

95. Selected Master and Core Trainers from Health Education and Reproductive Health Centers will provide training for members of mass organizations, population collaborators, and general community members - in Participatory Rapid Appraisal for Community Needs Analysis and Mobilization, Audience Analysis for Information, Education and Communication (IEC) Targeting, Community-based Health Promotion, Communication and Counseling; and Design and Implementation of Village Health Worker Networks. Training will be in the form of short-term training workshops, study tours and field practice. In all, the Project will finance training of a total of 846 community members on these topics.

96. About 450 volunteers, including village health workers Village Health Workers (VHWs), nominated by their communities, will be provided training based on MOH VHW training curricula, and adapted to the needs, ethnic groups, literacy levels, and situations in each targeted district. VHWs play a key role in facilitating community involvement in health issues since they live in the same village and share culture and language. Retired health personnel, members of mass organizations, population collaborators, and other community members can become VHWs - with training, monitoring and supervision from the commune health station and district trainers – and can serve as an effective link between the health system and the community. Village health workers – as well as commune station midwives and traditional birth attendants - will be trained to recognize local knowledge and understand health-seeking behaviors of ethnic minorities, including the use of traditional medicine, local reproductive health, and safe motherhood practices. In remote, ethnic minority areas, commune health workers and village health workers will receive training in the local languages of their communities. The Project aims to have at least one trained VHW in each of the 223 targeted villages by the end of the project period. The Project will train or retrain VHWs in communication skills, effective use of culturally appropriate IEC material, and basic reproductive and maternal and child health messages, utilizing the trainers and training materials mobilized through the Provincial and District Training Workers Groups.

b. Community Based Health Promotion

97. The Project will support improved capacity of health workers, members of mass organizations, community health workers and other volunteers to promote the health and nutrition of women and children through provision of appropriate and effective health promotion training and targeted IEC materials, and improved community knowledge, awareness, and participation through the design and implementation of village health worker networks.

98. Project activities will support health service providers and information on locally defined health priorities to be more accessible and responsive to the poor and ethnic minorities. District and commune health staff will become partners in the process of learning to work more effectively with local communities, thereby strengthening an important management linkage between the two levels. In collaboration with Provincial RH Centers, Participatory Rapid Appraisal (PRA) for community needs analysis and mobilization will be used to define local reproductive, maternal and child health priorities, and develop innovative, context-specific IEC messages and media to complement the training on health promotion and communication skills for health workers, health volunteers and members of mass organizations, especially in ethnic minority areas. Experiences from participatory appraisal activities, community workshops, study tours and the learning process will together be analyzed to produce clear strategies for community-based preventive health activities that seek to empower people about their choices about health, which in combination, compliment Project improvements to the delivery of health services, and thereby encourage greater and more discerning use of those services.

99. The Project will support the strengthening of Reproductive Health counseling services as an integral part of quality reproductive and maternal and child health care service provision. Specifically, the project will support the implementation of the counseling guidelines in the National Standards and Guidelines for Reproductive Health Care Services. This includes counseling on safe motherhood, antenatal and post-partum care; reproductive tract infections and sexually transmitted diseases; as well as gender components such as the need for men to take greater responsibility for contraception and family planning in general, addressing domestic violence issues, complications resulting from abortion and adolescent reproductive health awareness.

100. Lack of transport can be a significant impediment to successful outreach efforts. Based on an assessment of local needs and resources, the Project will support the purchase of up to 300 bicycles and 100 motorbikes for the use of village health workers, CHS staff, and volunteers providing outreach services.

c. Reducing Financial Barriers to Access

101. The Project will support MOH and the provincial Departments of Health in more effectively implementing Decision 139 on Health Care Funds for the Poor (HCFP). Under Decision 139, funds are allocated annually to the provincial HCFP to support the provision of health care services to the poor, near-poor (for catastrophic health care expenditures), ethnic minorities in mountainous provinces, and residents of disadvantaged communes.⁵⁸ Decision 139 has increased the utilization of health services and reduced the risk of catastrophic health care expenditures by the poor and ethnic minorities.⁵⁹ However, experience in the Central Highlands and elsewhere has identified a number of weaknesses and constraints in implementation. These include problems related to (i) awareness of beneficiaries concerning entitlements and requirements, (ii) distribution and replacement of health insurance cards, (iii) limits on coverage of health services and indirect costs such as transport and food, (iv) awareness and motivation of health care staff in providing covered services, (v) limited capacity of health care facilities and Viet Nam Social Security (VSS) to process reimbursement claims under the program, and (vi) general weaknesses in management and monitoring. Proposed revisions to Decision 139 and related directives are expected to address some but not all of these issues.

102. Project support for Decision 139 is intended to reduce the financial barriers to health care services for poor and ethnic minority households in the SSCR provinces by (a) increasing awareness of Decision 139 among the intended beneficiaries and other local stakeholders; (b) strengthening capacity in the SSCR provinces to manage the provincial HCFP; and (c) providing data and analysis to inform future policy-making by MOH related to Decision 139. In particular, the Project will support (i) locally appropriate materials and programs to inform poor and ethnic minority communities, local governments, mass organizations, and health workers about the entitlements and requirements of Decision 139; (ii) improvements in the procedures for issuing and replacing health insurance cards for Decision 139 beneficiaries;⁶⁰ (iii) streamlining of procedures and forms related to HCFP claims and disbursements, and training for local health administrators and VSS staff related to these procedures; (iv) improved coordination and problem-solving related to Decision 139 at provincial, district and commune levels; and (v) monitoring of the implementation and impact of Decision 139 through regular data collection by the provincial DOH, periodic household surveys, participatory assessments, and special studies.

103. Project interventions will build on lessons learned from the Health Care in the Central Highlands Project, and will be coordinated with ongoing projects supported by the World Bank

⁵⁸ These funds originally could be used to support the purchase of health insurance cards or to directly reimburse providers of health services to beneficiaries. Beginning in 2006, provinces are generally required to use the health insurance mechanism. Proposed revisions to Decision 139 include certain changes in the definition of target groups, but the net effect of these changes is expected to be an increase in the number of eligible beneficiaries.

⁵⁹ Wagstaff, Wagstaff, and Adams, "Health Insurance for the Poor: Initial Impacts of Vietnam's Health Care Fund for the Poor," World Bank Policy Research Working Paper 4134, February 2007, p. 17.

⁶⁰ The validity of the health insurance cards issued to Decision 139 beneficiaries in the project provinces will also be extended from one year to at least two years.

and others, particularly in the area of monitoring. Participatory methods will be used to involve community leaders, mass organizations, and Decision 139 beneficiaries (especially poor and ethnic minority women) in awareness-raising, problem-solving and monitoring activities. Awareness-raising activities related to Decision 139 will be coordinated with other IEC activities supported by the Project. Capacity-building related to the management of the provincial HCFP and the processing of HCFP claims and disbursements will emphasize skills-based training, and will be coordinated with other training activities supported by the Project.

4. Component Four: Strengthening Health Systems Management

104. The Project will help strengthen the capacity of provincial health departments and hospitals to better manage their increasingly complex responsibilities to plan, organize, direct, and finance the health system. Managers need to become more results-oriented, establishing minimum service standards, setting performance targets, and monitoring progress toward reaching their goals. The Project will support: (a) strengthening the management of provincial health systems; (b) strengthening the management of provincial and district hospitals; (c) equipment, software, and staff training needed to introduce health management information systems; and (d) the organization and operations of the national and provincial project management units.

a. Strengthening Management of Provincial Health Systems

105. With the move toward decentralization, provincial health authorities face an increasing management challenge. The array of programs and services they now oversee – at provincial, district, and village levels – is complex and diverse. Financial demands are unrelenting and, more often than not, sources of funding are varied, inadequate, and uncertain. Managing these demands requires increasingly sophisticated analytical, planning, and organizational skills.

106. For Provincial Health Departments, programmatic and financial planning are particularly demanding activities. Curative care programs and services, preventive health services, grass roots services, human resources, ethnic minority action plans, and other program activities need to be documented, prioritized, financed, and managed. The financial implications of these various program commitments are reflected in the Provincial Medium Term Expenditure Plans (MTEPs), prepared during Project Preparation with consultant assistance. For all eight provinces, the MTEPs show that projected financial resources are not adequate to support all of the programmatic commitments needed to achieve developmental targets. Necessarily, provincial authorities face difficult policy decisions, including: setting priorities for health sector investments, improving efficiency of service delivery, and insuring investments are balanced with incremental financing of recurrent costs.⁶¹

107. The Project will assist provincial health authorities in evaluating their priorities to help close the gap between programmatic obligations and financial resources. The Project will also support training for 48 provincial health officers designed to strengthen their skills in planning and management, with an emphasis on using financial resources efficiently and directing services to priority target groups. A series of workshops will be planned, focusing on planning, information-based problem-solving, leadership, team building, supervision, communication, financial management, and project monitoring. The workshops will use skills-based training techniques where lessons are directly applied to issues of current concern to the participants – namely, improving provincial plans and financial projections. Issues raised in the MTEPs will be

⁶¹ McLeod, Ross, *Provincial Health Expenditure and Medium Term Planning*, ADB, July 2007.

used as a basis for developing lesson plans. Workshop participants will apply their new learning to upgrading the various plans that underpin the MTEP for their province. Over the life of the Project, the MTEPs will become increasingly useful tools for managing the provincial health system and provincial health officers will become increasingly results-oriented and skilled in managing their complex responsibilities. Given the further development of annual planning targets, and more in-depth understanding among provincial managers, the MTEPs may eventually serve as a tool for monitoring Project results.

108. The Project will also support a study to examine the potentials of utilizing managers who have been formally trained in health systems or hospital management. As a trial, one individual from each province will be selected for scholarship support for advanced training in health services management. The feasibility of establishing a masters level course of study in these disciplines within Viet Nam will also be examined.

b. Strengthening Management of Provincial and District Hospitals

109. Hospitals, too, are increasingly challenged by the move toward greater autonomy. Decrees 10 and 43 have provided hospital managers greater administrative freedom based on their abilities to be financially self sufficient. But the challenges of being financially independent are daunting. Managers of provincial and district hospitals are typically doctors with little or no training in management. Most senior hospital managers divide their time between their managerial responsibilities and the demands of their medical practices. With only a few exceptions, hospital managers lack the time and the skills need to deal with increasingly complex expectations. As a result, hospitals are not well managed. The analytical and problem-solving skills of managers are not well developed. Even with overcrowding, inefficiencies in utilization of facilities and services are apparent. Communication links among departments, and from level to level within the organization, are weak. At the operating level, standards of cleanliness are poor and buildings and equipment are inadequately maintained. Operating procedures are not well defined nor clearly understood. Supervision tends to be more directive than instructive.

110. The Project will support short term skills-based training programs designed to upgrade the skills of 200 senior hospital managers, and 2,000 hospital department managers, in planning, information-based problem-solving, leadership, team building, supervision, communication, financial management, and project monitoring. The aim is to encourage hospital managers to be more results-oriented. In addition, as follow-up to management training courses, the Project will support on-site sessions on organizational development in 48 hospitals designed to help identify minimum standards of service, to develop performance goals, to develop work plans to reach those goals, and to design a system to monitoring progress.

c. Health Management Information Systems

111. In Viet Nam's increasingly complex health system, access to information is essential for planning and management. The Project will strengthen Health Management Information Systems in 40 hospitals in the eight target provinces. Improved HMIS will provide more accurate and timely information on the utilization of hospital services, personnel records, and financial accounts. Under a UNFPA project, software and detailed plans for improved HMIS have been successfully developed and implemented in several districts in Binh Dinh, a province in the South Central Coast Region. Based on that model, similar systems will be adapted for implemented in selected institutions in the eight targeted provinces.

112. The HMIS will be fully computerized at provincial and district levels and linked through the Internet. The Project will support the costs of computers, associated software, other HMIS office equipment, planning and training workshops, and the development of a homepage for each province. The Project will focus on improving the use of existing information. An attempt will be made to ensure that information is not only routinely collected but adequately analyzed and that the results of the analyses are shared at other levels within the organization.

d. Project Management

113. The Project will finance the purchase of vehicles, computers, software, office equipment and supplies needed to establish and operate Provincial Project Management Units (PPMUs) in each of the eight target provinces, and a national Project Management Unit (PMU). The PPMUs will be the principal units for implementation in each province. The national PMU will provide technical, coordination, and logistics support to the PPMUs and other departments in charge of implementation. Operating protocols for the PMU and PPMUs are detailed under Project Implementation, later in this report. To assure PMU and PPMU staff and consultants have access to all materials and reports produced during Project Preparation, the RRP and all supporting appendices will be translated and digitally recorded on CDs, DVDs, or other suitable media.

C. Special Features

114. The Project is based on an effort to develop a provincial program approach as a building block towards national program support. During the project preparatory TA, for each of the eight provinces, a provincial health account was undertaken examining all sources and uses of funds. This was followed by a provincial planning and budgeting effort to identify gaps and priorities in provincial health systems development. Based on the project modality, specific interventions will be supported with external aid. The MOH policy is now to seek external aid for major investments and those requiring innovation and international expertise. Accordingly, MOH has asked external agencies to upgrade hospitals while the Government will upgrade CHSs. In the future, based on evidence of results-based planning and strengthened management, it is expected that external aid can be provided as outcome-based program support.

115. Health systems and hospital management in Viet Nam is becoming increasingly complex, and managers, most of them with medical education, are ill-prepared for the task. The Project is unique in that it will strengthen provincial-level management in various critical areas, including: provincial health system planning and budgeting, hospital management, human resources planning, managing civil works, and waste management.

D. Project Investment Plan.

116. The total Project cost is currently estimated at \$80 million, as shown in the following table. Detailed Cost Estimates are in Appendix 20.

Table 1: Estimated Project Cost by Component
(\$ million)

| Item | Amount |
|--|-------------|
| A. Base Costs | |
| 1. Improving Hospital Services | 45.8 |
| a. Hospital upgrading and expansion | 42.5 |
| b. Hospital waste management | 3.4 |
| 2. Human Resource Development | 6.9 |
| a. Provincial human resource planning | 0.8 |
| b. Strengthening local training capacity | 1.5 |
| c. Improving quality of clinical health care | 3.3 |
| d. Scholarships, Fellowships, and Studies | 1.4 |
| 3. Access to Quality Health Care | 7.1 |
| a. Health services in remote communities | 2.4 |
| b. Improving health behavior | 4.2 |
| c. Reducing financial barriers to access | 0.5 |
| 4. Provincial Health Systems Management | 3.6 |
| a. Strengthening provincial health system management | 0.8 |
| b. Strengthening management of provincial and district hospitals | 0.8 |
| c. Health information management system | 0.7 |
| d. Project management | 1.3 |
| Subtotal (A) | 73.4 |
| B. Taxes and Duties | 4.2 |
| C. Contingencies | |
| 1. Physical Contingencies | 3.4 |
| 2. Price Contingencies | 6.8 |
| Subtotal (C) | 10.2 |
| D. Financing Charges | 2.2 |
| Total Cost (A+B+C+D) | 80.0 |

Source: Asian Development Bank estimates.

E. Financing Plan

117. The Government has requested ADB for a loan of \$60,000,000 from its Special Fund resources to help finance the Project (Table 2). The loan will have a 32-year term, including a grace period of 8 years, and an interest rate of 1% during the grace period and 1.5% per annum thereafter. The Government will contribute \$20 million through central and provincial counterpart contributions.

Table 2: Financing Plan
(\$ million)

| Source | Total Cost | % |
|------------------------|-------------------|------------|
| Asian Development Bank | 60.0 | 75 |
| Government | 20.0 | 25 |
| Total | 80.0 | 100 |

Source: Asian Development Bank estimates.

118. The Ministry of Health will be the executing agency for the Project. The 8 Provincial Health Bureaus will be Implementing Agencies and work under the guidance of the Provincial People's Party Committees. Within three months of loan effectiveness, a project steering committee (PSC) will be established and will provide project oversight. The PSC will be headed by the health minister, and will include senior officials from participating ministries and institutions. The PMU will work under the guidance of the PSC.

119. The Project will be implemented through a National Project Management Unit (PMU) and 8 Provincial Project Management Units (PPMUs).

120. The national Project Management Unit (PMU) will provide technical, coordination, and logistics support to the PPMUs and departments in charge of implementation. Relevant MOH departments will actively participate in implementing the technical aspects of the Project. The PMU, headed by a project director, will start operation with four additional staff with expertise in planning, accounting, procurement, and civil engineering. Additional staff, including clerical support, will be assigned depending on the workload during implementation.

121. The PPMUs will be headed by a manager who will report to the director of the provincial health department. Each PPMU will begin operation with three staff for planning, accounting, procurement, and contract administration. Additional staff, including clerical support, will be assigned depending on the workload during implementation and for activities such as organizing community participation and BCC activities to ensure community-based implementation.

F. Implementation Arrangements

1. Implementation Period

122. The Project will be implemented over an estimated 5-year period beginning 01 July, 2008 and ending 30 June, 2013. The project implementation schedule is in Appendix 3.

2. Procurement

123. Each participating province will prepare an annual plan and budget, including a procurement plan, and submit these for approval of the MOH steering committee before the start of each fiscal year. All ADB-financed procurement will be in accordance with ADB's *Procurement Guidelines* (2007), as amended from time to time. Procurement of goods will use international competitive bidding procedures if over \$1 million, national competitive bidding if \$1 million or less, or shopping for goods less than \$100,000. Civil works will use national

competitive bidding procedures. Vehicles will be procured through the United Nations system, which uses procurement procedures acceptable to ADB. The PMU will be responsible for international competitive bidding procurement, shopping, and engagement of national consultants. The MOH has requested ADB to assist in the engagement of a firm for international consultants. The PPMUs will be given responsibility for national competitive bidding and training. Indicative lists of training activities (Appendix 13), civil works (Appendix 14), and equipment (Appendices 15 and 16) are attached.

3. Consulting Services

124. The Project will use 106 person-months of international consulting services and 602 person-months of national consulting services. A schedule of consultants is attached as Appendix 11. All consultants will be recruited and engaged centrally by the PMU. Consultants will be recruited from consulting firms or as individuals as needed. Consulting firms will be selected using quality- and cost-based selection in accordance with ADB Guidelines on use of consultants by ADB and its borrowers. The PMU and PPMUs may use contracted staff instead of, or in addition to, national consultants, depending on the organization of work. International consultants comprise an architect, civil engineer, human resources development specialist, public health expert with background in quality of care, health finance specialist, health management specialist, and an expert in monitoring and evaluation. The PPMUs may engage contract staff or national consultants as needed to assist with building design, bidding, progress monitoring, and site supervision.

4. Technical Assistance

125. During project preparation, the eight provinces prepared 5-year plans and MTEFs as roadmaps for provincial health system development. While these plans were a major improvement, they also showed weakness, in that they were input-driven and hospital-focused. The MOH has requested ADB to consider a TA⁶² 'piggy-backed' to the Project for strengthening provincial health planning and budgeting capacity. The TA will help develop guidelines and a format for comprehensive, results-based provincial 5-year plans and MTEF, pilot these instruments, and build the capacity of provincial health teams in their use (Appendix 12).

126. The total amount will be \$800,000 equivalent. A development partner will be requested to finance \$650,000 on a grant basis to be administrated by ADB, and the Government will contribute balance of \$150,000 in kind. The EA for the TA will be the MOH with the Department of Planning and Finance responsible for implementation. ADB will engage two qualified international experts and two national experts for a total 40 person-months. The consultants will be engaged by ADB in accordance with its *Guidelines on the Use of Consultants*. The TA will be implemented over a 12-month period commencing about 01 April 2008 and ending 31 March 2009.

5. Advanced Action

127. The MOH will take advance action to expedite establishment of the PMU, PMU staff training, and the hiring of consultants. ADB concurrence to advance action does not commit ADB to finance related expenditures under the Project or to finance the Project.

⁶² The inclusion of this TA has been requested in the Viet Nam Country Operations Business Plan 2008-2010.

6. Disbursement Arrangements

128. The project grant proceeds will be disbursed in accordance with ADB's Loan Disbursement Handbook (2007), as amended from time to time. The MOH will open a national project imprest account, and each DOH a second-generation imprest account to manage project funds at any bank that is acceptable to ADB. The initial amount to be deposited by ADB in the national project imprest account will be based on the estimated project expenditure for the first 6 months of project implementation; or \$4,000,000, whichever is lower. Similarly, second-generation imprest account will be established in each project province with an initial advance based on the estimated provincial expenditures for the first 6 months of project implementation; or \$250,000, whichever is lower. The direct payment procedure will be used for payments over \$100,000. Lesser payments may be channeled through the imprest account. The statement of expenditure (SOE) procedure may be used to reimburse eligible project expenditures and to liquidate or replenish imprest account advances. The SOE procedure is applicable to individual payments not exceeding \$100,000 equivalent per payment and to liquidate advances made into the imprest account as per covenants. The MOH will ensure timely release of funds to the provincial accounts. Detailed arrangements to establish the imprest account and SOE procedure will be made in accordance with ADB's Loan Disbursement Handbook (2001) as amended. Sufficient supporting documentation, as defined in the Loan Disbursement Handbook, must be kept at each level to substantiate all expenditures incurred from the loan proceeds. The release of funds will be subject to the project accomplishment reports of the provinces and national level.

7. Accounting, Auditing, and Reporting

129. The MOH and the departments of health in the eight provinces will maintain separate project records and accounts that are adequate to identify goods and services financed from the proceeds of the ADB loan. The EA has implemented similar projects financed by ADB and others during the last 10 years, and its financial management capacity is considered adequate. The EA will hire an accounting firm to carry out the financial management.

130. Certified auditors will annually audit all accounts and financial statements, SOEs and revenues, and imprest account related to the Project, in accordance with auditing standards acceptable to ADB and using international accounting and auditing standards as a benchmark. Audited financial statements and project accounts, together with the report of the auditor, including the auditor's opinion on the use of loan proceeds, compliance with covenants, and the use of the imprest account under ADB's SOE procedure, will be submitted within 6 months of the close of the financial year.

131. The MOH, as the EA, will provide ADB will an inception report and updated project administration memorandum within 3 months of loan effectiveness. Thereafter, the MOH and the provinces will provide ADB with quarterly and annual progress reports and plans for project implementation within 30 days of each calendar quarter period. The progress reports and plans will be in English and summarize (i) PMU capacity, coordination and issues; (ii) progress made against established targets, including aspects of quality; (iii) problems encountered and actions taken to resolve issues; (iv) compliance with loan covenants including counterpart funds; (v) updated implementation schedule of activities to be undertaken during the next 3 months; and (vi) operations and maintenance support.

8. Anticorruption Policy

132. ADB's Anticorruption Policy (1998) was discussed with the EA and implementing agencies. Consistent with its commitment to good governance, accountability and transparency, ADB reserves the right to investigate, directly or through its agents, any alleged corrupt, fraudulent, collusive, or coercive practices relating to the Project. Relevant provisions of ADB's Anticorruption Policy are included in the loan regulations and the bidding documents for the Project. In particular, all contracts financed by ADB in connection with the Project will include provisions specifying the right of ADB to audit and examine the records and accounts of the EA and all related parties.

133. The MOH has handled seven ADB projects, and is familiar with ADB procedures and anticorruption measures. These projects helped establish clear procedures and practices for procurement of equipment and civil works. There have not been any major audit issues or suspicion of fraud. Governance related risks will be further minimized by using annual plans and budgets, conducting detailed planning of activities, holding weekly meetings to plan and monitor all activities, and providing information and training for MOH staff not familiar with ADB's policy and procedures. The adherence to the Policy will also be checked during loan review.

9. Involuntary Resettlement

134. The Project will support civil works in 30 locations, including 1 provincial general hospital, 3 specialized hospitals, 4 regional (inter-district) hospitals, 18 district general hospitals, and 4 preventive medicine centers. An assessment was done of possible resettlement issues, as summarized in Appendix 7. Construction of new facilities will, as a priority, be carried out only on vacant and idle land owned by the Government that is free from all encumbrances, habitation, dispute or controversy. However, since the final site for each subproject has yet not been agreed, MOH has prepared a detailed resettlement framework, in accordance with ADB's *Policy on Involuntary Resettlement*, to guide in the preparation of a resettlement plan should there be any land acquisition impacts (Supplementary Appendix I). The resettlement framework sets out the resettlement policy, and screening and planning procedures that the Project will follow when preparing a resettlement plan. Of the 14 new sites, 6 are privately owned agricultural land. Only one plot is owned by a company and consists of vacant stores, while another plot is partly a cemetery and is to be replaced. Sites for the preventive medicine centers have not yet been identified and may require a new, small plot.

10. Environmental Assessment

135. The Project's environmental impacts were reviewed using the Rapid Environmental Assessment, and no significant adverse impacts were identified (Appendix 6 and Supplementary Appendix I). The Project will support the construction of health facilities based on MOH standards and guidelines, include safe water, sanitation, and environmentally-sound medical waste treatment, and will incorporate features needed to assure appropriate handling, collection, and disposal of hazardous medical waste at that site. Activities resulting from the Project will minimize pollution and health hazards. Any asbestos roofing materials will be removed following international practice to protect workers and residents. The site selection, design, construction, replacement work and operation of health facilities will be implemented in accordance with the relevant regulations and standards of the Government, defined in international good practices, or referred in the ADB's *Environment Policy*. The Project will also support the development of a province-wide environmental management plan, and a waste

management plan for each hospital involved in construction or renovation. The Project is categorized as category B.

11. Project Performance Monitoring and Evaluation

136. In support of the development of a comprehensive provincial program approach, the project performance monitoring system will be integrated with and strengthen the Government's provincial HMIS (Component 4). In the spirit of contributing to the financing of the provincial health program, the Project will support health and health services surveys to assess the overall performance of the provincial health system. Measurement of outputs, activities and inputs will be disaggregated by source of funding. Particular attention will be given to monitoring the impact on the poor, women, children, ethnic groups, and other vulnerable group. Qualitative studies will also be undertaken for particular aspects (A summary and list of key indicator is in Appendix 2).

12. Project Review

137. The Government and ADB will jointly review project implementation twice a year, including related national policy activities and provincial planning, budgeting, and reforms; and will undertake a joint midterm review after 2 years of project implementation. Within three months of physical completion of the Project, the Government will prepare and submit to ADB a project completion report on the execution of the Project, including compliance with loan covenants.

IV. PROJECT BENEFITS, IMPACTS, ASSUMPTIONS, AND RISKS

A. Project Benefits and Impacts

1. Social Analysis

138. The Project does not have any adverse social impact. A Summary Poverty Reduction and Social Strategy is attached as Appendix 8. Some social issues that are addressed by the Project include:

2. Poverty

139. The Project is aimed at improving the health of the population, in particular the poor, women and children, and ethnic groups in the eight provinces of the South Central Coast Region of Viet Nam. The Project will improve access to quality health services for nearly 9 million people - about 4.6 million women and 4.4 million men – including 1.7 million poor people and nearly 500,000 ethnic minority peoples. Major Project outcomes include: (i) improved health service resources in the eight provinces, providing improved quantity and quality of health care; (ii) increased numbers and improved retention of skilled health staff providing quality health care services; (iii) improved access and quality of health care for the poor, near poor, and other vulnerable groups; and (iv) increased capacity to manage provincial health system in terms of equity, efficiency, and effectiveness. It contributes directly to poverty reduction with its focus on improving PHC for the poor and other vulnerable groups. Improved health reduces income losses and expenditures due to illness or disease, and indirectly protects the labor force and production of food and cash crops. The Project supports the Government's goals to achieve its health-related VDG targets by 2015. The Project will support Government

efforts to develop a comprehensive health system that further reduces maternal and child mortality while addressing emerging challenges, including the growing prevalence of non-communicable diseases and trauma.

3. Community Participation

140. Participation is integrated into the overall project design. During project design, MOH carried out initial consultations with different stakeholders, and held a number of regional workshops. The involvement of stakeholders will continue during project implementation. The Project will place a strong emphasis on gender-inclusive community participation, as well as coordination with mass organization working with vulnerable communities. Community consultation and participation - especially among the poor and ethnic minority groups - will be required to help identify special needs and to ensure their accessibility to health care services. Women's participation will be a central to the development, implementation and monitoring of project activities. Community participation will be integrated in the monitoring and evaluation of project activities.

4. Ethnic Minorities

141. The Project will improve access to quality health services for about 500,000 ethnic minority people living in the eight target provinces of the South Central Coast Region, thereby directly or indirectly improving their health status. Benefits will include: decreased infant mortality and neonatal mortality in these communities by 10 percent, decreased maternal mortality by 10 percent, and increased awareness of entitlements and the availability of health care services. Health providers will be trained to recognize local knowledge and understand health-seeking behaviors of ethnic minorities. The Project will increase the enrollment of ethnic minorities in Health Care Funds for the Poor and improve utilization of the card through enhancing awareness of their health care entitlements. An Ethnic Minority Development Plan (Appendix 9) has been prepared to highlight the specific health needs of ethnic minority groups, especially those living in the remote mountainous areas of the South Central Coast Region. Each province will be assisted in the development of its own ethnic minority development plan.

5. Training

142. The Project will support the training of over 11,000 health workers, upgrading their skills and their abilities to provide quality health care, thereby improving the health care directly and indirectly for the nearly 9 million people living in the eight targeted provinces. The Project will support efforts to strengthen local training capacities by funding the training of trainers and providing equipment and supplies needed to effectively deliver training programs.

6. Gender

143. The Project will improve access to quality health services for about 4.6 million women and 4.4 million men living in the eight target provinces of the South Central Coast Region, thereby directly or indirectly improving their health status. The Project will especially benefit 2.1 million women in the reproductive age group, nearly 500,000 people from ethnic minorities, 1.7 million poor people, and 800,000 children under five. A Gender Strategy (Appendix 10) has been prepared to highlight the different health needs of women and men in the targeted region. The gender strategy is based on a situational analysis and assessment that was prepared for the project, and is designed in accordance with the *ADB Policy on Gender and Development*. The Project will fully mainstreams gender concerns into its design to ensure that women share

proportionately in project benefits. The project will result in the following benefits for women and children: decreased infant mortality and neonatal mortality, decreased maternal mortality, decreased number of obstetrics complication rates, strengthened capacity in managing and implementing programs and policies on reproductive health and family planning. The Project will assure human resource development strategies are in place to enhance the capacity of female staff in the management of the system.

7. Policy Development

144. The Project will support policy development in four areas: updating national standards for the design and equipping of hospitals, administration of Health Care Funds for the Poor, human resources planning, and provincial-level planning and management. The Project will support international consultants, in architecture and civil engineering, to work with national authorities to update national hospital design and construction standards. The Project will pilot several administrative reforms in the provinces designed to improve enrollment and utilization of HCFP benefits. These initiatives will help inform evolving national policy on health insurance for the poor. The Project will work with provincial authorities to strengthen human resources planning and, through the experience, inform national policy makers on approaches for continuing education, certification, and licensure. The Project will also support the development of provincial-level Medium Term Expenditure Plans which document provincial planning goals, priorities, and financial demands and resources, demonstrating their utility as a management tool for other provinces. These policy initiatives are supported by development partners.

8. Economic

145. The quantitative cost-benefit analysis for the Project follows the methodologies outlined in *ADB's Guidelines for the Economic Analysis of Projects*.⁶³ The Project is estimated to lead to the avoidance of an average of 6.5 million work days per year in the south central coast, valued at nearly \$14 million per year. The economic internal rate of return from this impact is estimated to be 16%, and an economic net present value of \$13.4 million.

B. Project Assumptions and Risks

1. Land Acquisition and Resettlement

146. The level of involuntary resettlement is not significant. Resettlement will be limited to the acquisition of mainly agricultural land involving a total of some 88 households. All losses will be compensated at full replacement cost and current market value. Transition allowances will be provided and rehabilitation measures will ensure restoration of income-generating activities. A Summary Resettlement framework is provided in Appendix 7, and the full Resettlement Framework is included in Supplementary Appendix I.

2. Institutional

147. The Project will upgrade or construct a total of 30 hospitals in eight provinces - including 18 district hospitals, 4 regional hospitals, 3 specialty, 1 provincial hospital, and 4 preventive health centers - thereby improving the quantity and quality of health care availability to the

⁶³ Bloom, E. and Choynowski, P. (2003) *Economic Analysis of Health Projects: A Case Study in Cambodia*, ERD Technical Note No. 6, ADB, Manila and P. A. Musgrove (2003) *Health Economics in Development*, November 2003 by World Bank.

people of the South Central Coast Region. Full and efficient use of these improved facilities, is based on three assumptions. First, Government provides the necessary recurrent budgets to support ongoing operational costs. Second, financial barriers to access continue to decline as Health Care Funds for the Poor continues to grow. And third, hospital managers gain the skills needed to direct and operate these facilities to be more efficient and effective in delivering quality health care services. Major risks include potential delays in construction due to slow Project mobilization and implementation, and inadequate budgets for recurrent costs, particularly for preventive maintenance.

3. Technical

148. The Project will support the purchase of medical equipment for the upgraded or newly constructed hospitals, and other hospitals identified by provincial authorities as serving target populations. A total of 44 hospitals will receive equipment, including 36 district hospitals, 4 regional hospitals, and 4 provincial hospitals. The equipment will replace old and non-functioning equipment, upgrade technology for existing procedures, or will support needed new services, thereby improving the quality of health care provided in the target institutions. It is assumed that employees will be trained to use and maintain the equipment properly, an effort supported by the Project. It is also assumed that the recurrent costs of operating the equipment, such as the costs of essential reagents and supplies, are adequately funded. A major risk, however, is that recurrent costs will not be adequately covered and equipment maintenance will be neglected.

4. Environment

149. The Project will have no significant adverse environmental effect and will improve waste management practices in the targeted provinces. The Project will support the development of an environmental management plan (EMP), including a waste management plan, for each hospital involved in construction or renovation. Where applicable, this includes the removal of asbestos roofing material based on internationally accepted standard practices. The design of each civil works project will assure access to safe water and will incorporate features needed to assure appropriate handling, collection, and disposal of hazardous medical waste at that site. In each province, the Project will also support the development and/or refinement of a province-wide waste management plan that is consistent with national standards.

5. Financial

150. The Project will provide \$60 million in low interest loans to help finance provincial-level investments in civil works, equipment, training, and consultancy. These investments are provided on the assumption that the Government will provide the required counterpart funds needed to support both capital investments and recurrent costs. However, as noted in the provincial Medium Term Expenditure Plans, there is a real risk that financial resources will be inadequate to cover all expenditures planned over the next five years. Given that government budgets are insufficient to achieve the health and development targets, policy reforms are required. These include: setting priorities for health sector investment based on evidence-based interventions; improving efficiency of service delivery; ensuring investments are balanced with incremental financing of recurrent costs; increasing health's share of overall public expenditure to become more in line with international public health financing benchmarks; setting appropriate hospital fees; developing policies to authorize the use of non-state budget sources of funds; and developing insurance to mobilize resources while simultaneously enhancing access to health care.

6. Economic

151. The Project will support the MOH, the provincial DOH, and other key stakeholders in more effectively implementing Decision 139, thereby reducing financial barriers to accessing health care for about 1,700,000 people enrolled in Health Care Plans for the Poor in the eight targeted provinces. The Project will support information, education and communication (IEC) activities; management of the provincial HCFP; and monitoring of Decision 139 implementation and impact. A risk to success is the continuation of a weak system of incentives for efficient claims processing. Therefore, the Project will closely monitor certain aspects of HCFP in order to inform future policy-making related to HCFP organization and administration. To these ends, the Project will support supplemental household surveys, participatory assessments, and special studies on HCFP implementation in the South Central Coast provinces.

7. Project Management Risks

152. Projects in Viet Nam have experienced initial delay in implementation. This risk will be reduced by advance action, use of existing PMU, and detailed project preparation. Another project risk, in particular when using a PMU, is that the Project is implemented in isolation. Strong linkages with the MOH and the development partners are proposed.

V. ASSURANCES

A. Specific Assurances

153. In addition to the standard assurances, the Government and the Ministry of Health, as Executing Agency, have given the following assurances, which are incorporated in the legal documents:

- (i) The Government will ensure that ADB loan funds are transferred to MOH and the provincial DOH, and that reimbursements are made in a timely manner.
- (ii) The Government will ensure that all necessary counterpart funds for project implementation are provided in a timely manner.
- (iii) The Government will make timely and adequate budget allocations to the project provinces for the primary health care services including the upgrading of community health stations and the HCFP.
- (iv) Provincial governments will ensure that the annual budget allocation to the sector fully covers the operation and maintenance of all health facilities at provincial, district and commune levels based on projections agreed by the MOH and ADB.
- (v) Provincial governments will submit (i) updated 5-year plans and MTEFs, (ii) annual provincial plans and budgets for the provincial health sector and, (iii) annual provincial work plans for the project to the MOH and ADB as a basis for monitoring performance and determining annual allocations of loan funds to the provincial DOH. To work towards comprehensive and results-based provincial health system development, annual provincial plans and budgets must show balanced, pro-poor health system development reflecting needs at all levels, HRD activities, and proposed sources and uses of funds, including both capital and recurrent expenditures.

- (vi) The Government will ensure that the provincial gender action plans for the Project are incorporated in the provinces' annual operating plans; that activities identified in the plans are implemented in a timely manner and have adequate resources allocated for preparation and implementation; and that gender-related targets and indicators are included in the project monitoring system.
- (vii) The Government will ensure that the provincial ethnic minority development plans for the project are incorporated in the provinces' annual operating plans; that activities identified in the plans are implemented in a timely manner and have adequate resources allocated for preparation and implementation; and that ethnicity-related targets and indicators are included in the project monitoring system.
- (viii) The Government will ensure that the construction and operation of all health facilities under the Project comply with all applicable national laws and regulations and with ADB's environmental policies and regulations, specifically ADB's *Environment Policy (2002)*. ADB will be informed if the construction of any health facility requires the removal of hazardous materials including asbestos. International procedures will be followed for the safe removal of asbestos.
- (IX) The Government will ensure that all health facilities built or upgraded under the Project are located either on health facility sites or on vacant and idle land owned by the Government and free from any encumbrances, habitation, dispute or controversy. [If resettlement impacts are possible, additional assurances would be added relating to preparation of a resettlement plan in accordance with ADB's *Involuntary Resettlement Policy (1995)*.]

B. Conditions for Loan Effectiveness

154. The establishment of the national PMU and eight provincial PMUs shall have been confirmed by the Government.

DESIGN AND MONITORING FRAMEWORK

| Design Summary | Performance Targets/Indicators | Data Sources/Reporting Mechanisms | Assumptions and Risks |
|---|--|--|---|
| Impact | | | |
| Improve the health status of the poor, women, children, ethnic minorities, and other vulnerable groups, and strengthen health systems in eight provinces in the South Central Coast Region. | For the target groups: <ul style="list-style-type: none"> Decrease infant mortality and neonatal mortality by 5 percent Decrease maternal mortality by 5 percent Decrease maternal mortality rates among ethnic minority women by 15 percent. | <ul style="list-style-type: none"> Ministry of Health (MOH) service statistics National health survey (base 2005) | <p>Assumptions</p> <ul style="list-style-type: none"> Primary health care (PHC) in rural areas continues to be a Government priority Health insurance coverage for the poor continues to grow <p>Risks</p> <ul style="list-style-type: none"> Financial and staffing support for Commune Health Stations (CHS) stagnate or decline |
| Outcomes | | | |
| Improved health service resources in the eight provinces, providing improved quantity and quality of health care | <ul style="list-style-type: none"> Increased coverage of high risk deliveries in district hospitals by 5 percent Increased rate of antenatal care for women in target groups by 10 percent | <ul style="list-style-type: none"> Ministry of Health (MOH) service statistics National health survey (base 2005) | <p>Assumptions</p> <ul style="list-style-type: none"> National and Provincial commitments to provide matching financial support are realized <p>Risks</p> <ul style="list-style-type: none"> Delays in project mobilization and implementation |
| Increased numbers and improved retention of skilled health staff providing quality health care services | <ul style="list-style-type: none"> Increased staffing levels at provincial and district hospitals Increased number of CHS with skilled health staff | <ul style="list-style-type: none"> Provincial and district hospital staffing and accounting records National health survey (base 2005) | <p>Assumptions</p> <ul style="list-style-type: none"> Support for recurrent cost budgets, especially personnel costs, is improved <p>Risks</p> <ul style="list-style-type: none"> Disparities in public/private wage levels continue to increase |
| Improved access and quality of health care for the poor, near poor, and other vulnerable groups | <ul style="list-style-type: none"> Improved health indicators Increased numbers of patients treated at CHS Increased enrollment in Health Care Funds for the Poor Increased percentage of hospital patients who are poor or disadvantaged Reduced poor, non-poor gap in access rates to health services by 5 percent. | <ul style="list-style-type: none"> National health survey (base 2005) Provincial and district hospital service statistics | <p>Assumptions</p> <ul style="list-style-type: none"> Primary health care (PHC) in rural areas continues to be a Government priority Health insurance coverage for the poor continues to grow <p>Risks</p> <ul style="list-style-type: none"> Financial and staffing support for Commune Health Stations (CHS) stagnate or decline |
| Increased capacity to manage provincial health system in terms of equity, efficiency, and effectiveness. | <ul style="list-style-type: none"> Increased ratio of hospital outpatient visits to inpatient admissions Reduced inpatient | <ul style="list-style-type: none"> Ministry of Health (MOH) service statistics Provincial and | <p>Assumptions</p> <ul style="list-style-type: none"> National health financing policies are adjusted to encourage use of CHS |

| | | | |
|---|--|--|--|
| | <p>average length of stay</p> <ul style="list-style-type: none"> • Number of hospitals with computerized management information systems • Increased portion of provincial and district hospital budgets devoted to recurrent costs • Strengthened capacity in managing and implementing programs and policies on reproductive health and family planning. | <p>district hospital service statistics</p> <ul style="list-style-type: none"> • National health survey (base 2005) | <p>rather than hospitals</p> <ul style="list-style-type: none"> • Provincial health officers and hospital managers are responsive to training <p>Risks</p> <ul style="list-style-type: none"> • Continuation of financial incentives that promote hospital services over PHC. • National health policy constrains local managerial initiatives |
| Outputs | | | |
| <p>1. Component One: Upgrading Hospital Services</p> <p>Civil works</p> <p>Equipment and supplies</p> <p>Safe water, sanitation, and waste management systems</p> | <ul style="list-style-type: none"> • New and renovated facilities meet MOH construction and service standards • Equipment purchases meet MOH standards • New and renovated facilities meet standards for safe water, sanitation, waste water treatment and management of medical waste. • New and renovated facilities deliver higher quality maternal and child health care. | <ul style="list-style-type: none"> • Provincial Medium Term Expenditure Plans • Monitoring project management and construction progress • Visual inspection of facilities during and after construction • Project reports statistics | <p>Assumptions</p> <ul style="list-style-type: none"> • Construction projects are started in a timely manner • National and provincial covenants are fulfilled <p>Risks</p> <ul style="list-style-type: none"> • Delays in project mobilization • Delays in starting or completing construction |
| <p>2. Component Two: Provincial Human Resources Development</p> <p>Human resources planning</p> <p>Strengthen local training capacity</p> <p>Improving the quality of health care</p> <p>Scholarships and grants</p> | <ul style="list-style-type: none"> • Provincial HR plans in place that encourage the hiring, retention, and training of health workers, especially in the poorer districts and communes. • Policies, strategies and plans in place to increase the number of qualified ethnic minority healthcare professionals. • HR development strategies in place to encourage and enhance the capacity and role of female and ethnic minority staff in the management of the system. | <ul style="list-style-type: none"> • Provincial Medium Term Expenditure Plans • Provincial and district hospital staffing complements • Training program reports | <p>Assumptions</p> <ul style="list-style-type: none"> • Provincial staffing needs have been clearly defined • Provincial authorities support introduction of skill-based training approach and mobilization of core and master trainers <p>Risks</p> <ul style="list-style-type: none"> • Mobilization of Provincial Training Workers Groups (PTWGs) is delayed |

| | | | |
|--|---|--|--|
| | <ul style="list-style-type: none"> • Increased % of trained leaders and staff with comprehensive knowledge of gender responsive planning and management of the implementation of reproductive health care programs. • Recurrent budgets adequate to support staffing plans • Increased number of Master and Core Trainers prepared to apply skill-base training methods for teaching EOC, NEC, ICHI, and other priority courses. • 3000 district hospital staff and 3,500 CHS staff completing various clinical training programs | | |
| <p>3. Component Three: Access to Quality Health Care for the Poor</p> <p>Health services in remote and ethnic minority communities</p> <p>Community-based health promotion</p> <p>Reducing financial barriers to access</p> | <ul style="list-style-type: none"> • Reduced poor, non-poor gap between pregnant women obtaining pre-natal care by 10 per cent. • Integrated package of services available in 50 per cent of District health centers. • Strengthened VHW networks with fully-trained VHWs active in remote ethnic minority communities. • Increased IEC coverage of remote, ethnic minority communities. • Number of poor enrolled in health insurance fund increased by 10 percent • Number of poor seeking health care services increased by 10 percent • Health status indicators improved for target groups • Utilization patterns change for target populations • Number of poor enrolled in Health Care Funds for the Poor in each province • Reduced out-of-pocket | <ul style="list-style-type: none"> • Ministry of Health (MOH) service statistics • Provincial gender and minority plans • Provincial Medium Term Expenditure Plans • Provincial and district hospital service statistics • National health survey (base 2005) • Household surveys • Health fund reports • National Health Accounts | <p>Assumptions</p> <ul style="list-style-type: none"> • Short term, local training increases number of workers participating • Barriers to health fund enrollment and use are mitigated <p>Risks</p> <ul style="list-style-type: none"> • Provincial authorities do not administer health insurance funds adequately • The needs and desires of ethnic minorities are not well understood or respected |

| | | | |
|---|--|--|---|
| | expenditure of poor households spending on health care by at least 25% when accessing referred services. | | |
| <p>4. Component Four: Provincial Health Systems Management</p> <p>Strengthening provincial health systems management</p> <p>Strengthening management of provincial and district hospitals</p> <p>Health management information system</p> <p>Project management</p> | <ul style="list-style-type: none"> Number of provincial health managers who received training in planning, management, finance, and quality improvement Number of computers with Internet access in Provincial Health Offices Reduced ALOS in targeted hospitals Number of provincial and district hospitals with operating Management Information Systems | <ul style="list-style-type: none"> Provincial Medium Term Expenditure Plans Project monitoring reports Inventory of MIS systems in place Utilization of web-site resources for decision-making? Hospital service statistics Insurance fund reports | <p>Assumptions</p> <ul style="list-style-type: none"> National policies encourage greater local authority and autonomy Managers are allowed free access to web information resources <p>Risks</p> <ul style="list-style-type: none"> Conflicts between national and provincial priorities and expectations Limited Internet resources available in Vietnamese language |
| <p>Activities with Milestones</p> <p>Component 1: Upgrading Hospital Services</p> <p>1.1 Upgrading or new construction of 1 provincial, 3 specialized, 4 regional, and 18 district hospitals and 4 preventive medicine centers by 2010</p> <p>1.2 Procuring all hospital equipment by 2010</p> <p>1.3 Improving hospital water, sanitation, and waste management systems by 2010</p> <p>1.4 Formulation, introduction and monitoring of hospital service standard by 2009</p> <p>Component 2: Provincial Human Resources Development</p> <p>2.1 Formulation, implementation and monitoring of provincial human resources development plans by 2009</p> <p>2.2 Formulation, implementation and monitoring of training program in skills-based training methods by 2009</p> <p>2.3 Scholarships for ethnic minority staff each year</p> <p>Component 3: Access to Quality Health Care for the Poor</p> <p>3.1 Formulation, implementation and monitoring of plan to strengthen CHS and VHV services through preventive medicine centers in remote and ethnic minority communities by respectively 2008, 2009 and 2010</p> <p>3.2 Formulation, piloting, implementation and monitoring of community-based health promotion to improve reproductive health and nutrition behavior and other health-related behaviors by respectively 2008, 2009 and 2010</p> <p>3.3 Formulation, implementation and monitoring of a plan to improve management of the health care funds to reduce financial barriers to access for ethnic minorities by 2009</p> <p>Component 4: Provincial Health Systems Management</p> <p>4.1 Formulation, implementation and monitoring of management training program for provincial health system and hospital managers by respectively 2008, 2009 and 2010</p> <p>4.2 Formulation, application, and monitoring of new management standards of hospitals by 2010</p> <p>4.3 Formulation, application and monitoring of new provincial and hospital health management information systems by respectively 2008, 2009 and 2010</p> <p>4.4 Establish provincial project management units by March 2008.</p> | | | <p>Inputs</p> <p>Component 1:</p> <ul style="list-style-type: none"> ADB loan: \$33.0 million Government: \$14.5 million Subtotal: \$47.5 million <p>Component 2:</p> <ul style="list-style-type: none"> ADB loan: \$6.5 million Government: \$0.4 million Subtotal \$6.9 million <p>Component 3:</p> <ul style="list-style-type: none"> ADB loan: \$5.2 million Government: \$0.3 million Subtotal \$5.5 million <p>Component 4:</p> <ul style="list-style-type: none"> ADB loan: \$2.9 million Government: \$0.6 million Subtotal \$ 3.5 million <ul style="list-style-type: none"> Taxes \$4.2 million Contingencies \$10.2 million Financial charges \$2.2 million <p>Total \$80 million</p> |

PERFORMANCE INDICATORS

1. Based on the concept of developing a provincial health plan, budget and program, the Project aims to strengthen the overall monitoring and evaluation system of the provincial health system, and use this to the extent possible to monitor project inputs, activities, outputs, outcome and impact indicators based on the Design and Monitoring Framework in Appendix 1. The Project supports the services of an international monitoring and evaluation specialist for 12 person-months, who will be contracted through a firm.
2. To monitor aggregate health impact and outcome of key interventions, the Project will collect provincial statistics and verify these through two provincial household surveys in each province, in 2008 and 2012, using the United Nations Children's Funds (UNICEF) multi cluster method. Although specific indicators will help to assess project impact, the main purpose of the surveys is to provide the provinces with information on the overall health trend in the province as an input into the planning cycle. The sample size will be large enough to provide disaggregated data by residence, income, gender and ethnic group for each of the provinces. The number of indicators will be kept limited, focused on (i) perinatal, infant and child mortality; (ii) child malnutrition; (iii) episodes and types of illness and injuries; (iv) use of different types of health services in particular by women and children; and (v) expenditure on health services. Standard definitions and survey methods will be used to allow comparison of data. The monitoring and evaluation specialist will be responsible for survey design and management, and guiding the selection of a local firm for data collection.
3. As part of the inputs into the provincial planning process, the Project will support two health services surveys with a focus on the quality of health services. For Project specific interventions, the Project will monitor hospital statistics and conduct more detailed hospital performance assessment and patient satisfaction exit surveys before and after any major civil works. To assess the impact of the training programs on staff performance, staff and village health workers will be pre- and post-tested, and a sample of staff will be assessed in their duty station.
4. The Project will support social analysis, with emphasis on poverty, gender, and ethnic minority issues. In addition, qualitative methods such as focus group discussions will be used in the areas of the quality of health services, waste management, health services management, planning and budgeting, financial management, and access to health care funds.
5. To monitor project activities, the Project will use detailed Gant chart which will also help in preparing, planning and coordinating the project activities, assessing physical progress, and tracking inputs. Detailed monitoring of staff inputs and financial inputs using financial management tools will be used to track costs, so as to be able to calculate unit costs, which will be shared and used for planning future interventions.
6. Several indicators have been selected by the provinces and the Ministry of Health to measure overall provincial progress and major project achievement, as shown in Table A8.1 below.

Table: Indicative Performance Indicators

| Classification | Provincial Indicators |
|----------------|---|
| Impact* | 1. Birth rate and outcome |
| | 2. Neonatal, infant, and child mortality rates |
| | 3. Number of maternal deaths |
| | 4. Cause of infant death (by recall) |
| | 5. Hospital case fatality rate for acute respiratory infection, diarrheal diseases, hypertension, and traffic accidents |
| Outcome | 6. Use of health services in the past year |
| | 7. Percentage of children under five years with acute respiratory infection and diarrheal diseases in past year who were taken for treatment to a health facility |
| | 8. Percentage of deliveries in institutions |
| | 9. Percentage of households visited at home by health worker in the past year |
| | 10. Percentage of targeted population using health care fund |
| Output | 11. Total outpatient and inpatients per year by type of health facility |
| | 12. Total number of major surgery and caesarian sections in the past year |
| | 13. Bed occupancy rate and average inpatient days by service |
| Activities | 14. Number of health facilities upgraded |
| | 15. Number and % of health staff provided in-service training |
| | 16. Number and % of village health workers trained for at least 1 month |
| | 17. Number and % of commune health stations having doctor, female staff |
| | 18. Percentage of district health managers trained for at least 3 months |
| | 19. Number of health staff provided scholarship by residence, gender, and ethnic group |
| | 20. Percentage of provinces make comprehensive, results-based, pro-poor provincial health plans and medium term expenditure framework |
| Inputs | 21. Staff time and consulting services |
| | 22. Funds used |

*To the extent possible, disaggregated by residence, income, gender, and ethnic group.

HEALTH POLICY FRAMEWORK

| Title | Features | Project Implications |
|--|--|---|
| <p>Resolution No. 46 NQ/TW of the Political Bureau dated February 23, 2005 on health care for people</p> | <ul style="list-style-type: none"> ▪ Ultimate objectives: reduce mortality and morbidity, improve health and longevity, improve quality of life and quality of human resources... ▪ Key resolutions: <ul style="list-style-type: none"> - Overall healthcare system development - Renewal of health financing policies (HI, hospital fees...) - Human resource development (improvement of training institutions, training quota for disadvantaged areas, health management training, incentive policies...) - Enhance socialization (private sector...) - Improvement of IEC's impacts | <p>Supports Project Scope and Design:</p> <ul style="list-style-type: none"> ▪ Investment in training institutions (Secondary Medical Schools in project provinces) ▪ Training quota for ethnic staff ▪ Well balance of clinical, ME maintenance and management ▪ Initiatives to encourage health staff stay and work at advantaged areas ▪ Initiatives to engage private providers (training to private providers, contracting...) ▪ Initiatives to IECs activities (social marketing, branded and generic communication campaigns...) |
| <p>Decision No. 243 2005/QD-TTG dated October 5, 2006 issuing Government Action Plan to implement Resolution 46</p> | <p>Objectives to 2010:</p> <ul style="list-style-type: none"> ▪ Life Expectancy of Birth: >72 years ▪ Maternal Mortality Rate: <70/100,000 live births ▪ Infant Mortality Rate: <16 ‰ ▪ Children Mortality Rate: < 25‰ ▪ Malnutrition rate among children under 5: <20% ▪ 7 medical doctors/10,000 inhabitants ▪ 1 university pharmacist/10,000 inhabitants ▪ 60% medicines is locally produced ▪ Local made medical equipment satisfy 60% needs <p>Tasks:</p> <ul style="list-style-type: none"> ▪ Strengthen IEC activities ▪ Health system development (health system planning; development of preventive care system, curative care system, grassroots healthcare system...) ▪ Human resource development ▪ Development of pharmaceutical and medical equipment sector | <p>Supports Project Scope and Design:</p> <ul style="list-style-type: none"> ▪ Focuses on health system development as a whole rather than focuses on separate segments of the system (hardware and software investment) ▪ BCC is key to promote behavioral changes among target groups (poor, ethnic, adolescent, women, provider...) ▪ Human resource development is critical (selection, training, retention and use of health staff, training and non-training solutions for staff development) ▪ Provincial health objectives vs. national health objectives |
| <p>Decree 131 2006/ND-CP dated November 9, 2006 on management and utilization of ODA</p> | <ul style="list-style-type: none"> ▪ Process of preparation, appraisal and approval of ODA projects ▪ Management of ODA projects | <p>Project financing and role of provinces:</p> <ul style="list-style-type: none"> ▪ Provinces exert greater power on management and implementation of ODA project → urgent needs of PPMU capacity building (training, experience sharing, twinning, technical assistance...) |
| <p>Circular No. 61 2006/QD-BTC dated November 11, 2006 on expenditure norms for ODA projects; and Circular 23/2007/TT-BTC dated March 27, 2007 on norms for field visit and workshop/conference</p> | <ul style="list-style-type: none"> ▪ Specific expenditure norms | <p>Project costing:</p> <ul style="list-style-type: none"> ▪ Use to estimate project costs (operating cost, training cost...) |

| | | |
|--|--|--|
| <p>Decision No. 225 2005/QD-TTG approving “Upgrading District and Inter-District Hospitals Program”</p> | <ul style="list-style-type: none"> ▪ Objective: upgrade infrastructure, equipment and technical capacity of district hospitals and selective inter-district hospitals to move health services closer to population to better serve the poor and those living in mountainous and disadvantaged areas as well as to reduce patient congestion at higher-tier hospitals ▪ Budget: state budget, ODA project and local budget | <p>Component One: Upgrading hospitals:</p> <ul style="list-style-type: none"> ▪ Calls for upgrade of infrastructure (new construction, renovation), medical equipment and staff capacity of district (and regional) hospitals ▪ Emphasizes district hospitals in most disadvantaged or newly established districts; hospitals with severely deteriorated infrastructure and equipment; hospitals lie too far from provincial hospitals; and hospitals that are supposed to be upgraded to be regional hospital. |
| <p>Decision No. 153 2006/QD-TTG approving the Master Plan for Viet Nam Health Systems Development to 2010 and Vision to 2020</p> | <p>Specific objectives:</p> <ul style="list-style-type: none"> ▪ Invest in Preventive care systems to enable them to project, monitor, identify and control outbreaks/epidemics ▪ Invest in Curative care and Rehabilitative care systems: catchment-based rather than administrative unit-based; secure Medical Waste Management and Infection Control capacity; as of 2010, no. of beds to 10,000 inhabitants reach 20.5 (of which 2 from private sector)... ▪ Strengthen Grassroots health systems: as of 2010, 80% CHCs satisfy National Standards ▪ Develop pharmaceutical sector | <p>Component One: Upgrading hospitals:</p> <ul style="list-style-type: none"> ▪ Curative care systems development: District hospitals satisfy Grade III, Provincial hospitals meet Grade II, invest in Regional Hospitals in provinces of Binh Dinh and Khanh Hoa. ▪ Preventive care systems development: calls for investment in Nha Trang Pasteur Institution (in Khanh Hoa province), provincial Preventive Medicine Centers and district Preventive Medicine Centers ▪ Grassroots health systems development: calls for investment in commune health stations and village health workers (recruitment, training and retention of staff) |
| <p>Decree 84 2007/ND-CP Land use right</p> | <ul style="list-style-type: none"> ▪ Supplemental regulations on the grant of land use rights certificate ▪ Land recovery ▪ Land use rights implementation ▪ Sequence and procedures ▪ Compensation ▪ Assistance ▪ Resettlement upon land recovery by the State ▪ Solving complaints | <p>Component One: Sub-component a, civil works:</p> <ul style="list-style-type: none"> ▪ Regulations governing resettlement |
| <p>Decision 18955 1997/ QD-BYI, Chapter 4, Ministry of Health</p> <p>Standard TCVN 7382 2004</p> <p>Decision 2575 1999/QD-BYT dated April 27, 1999. Regulation of health care waste management</p> <p>Decision 62 2001 Ministry of Science, Technology and Environment</p> <p>Circular 2237 1999, Ministry of Science, Technology</p> | <ul style="list-style-type: none"> ▪ Assigns responsibilities and regulates waste management practices in hospitals ▪ Water quality, and waste water disposal, in hospitals ▪ Segregation, collection, off-site transportation, treatment and disposal of health care waste ▪ Technical requirements for incineration of health care waste ▪ Application of radioactive techniques in health care settings | <p>Component One, sub-component c, Safe water and waste management:</p> <ul style="list-style-type: none"> ▪ Numerous regulations and standards that govern construction standards for safe water and waste management systems in the health care industry. ▪ Prescribe waste management practices in hospitals and other health care facilities |

| | | |
|--|--|--|
| and Environment and Ministry of Health | | |
| Decree No. 139 2002/QD-TTG on Healthcare for the Poor | <ul style="list-style-type: none"> ▪ Primary beneficiaries (poor, those living in most disadvantaged communes, ethnic minorities in Central Highlands and 6 disadvantaged provinces in Northern Uplands), secondary beneficiaries (those incurred catastrophic healthcare cost). ▪ Establishment of provincial HFFP ▪ Budget allocation: 70.000 VND/person/year (State budget secures 75%, 25% mobilizes from local funds, individuals and organizations' contribution). ▪ Implementation arrangements: procure HI cards (with premium of 50,000 VND) or employ Direct Reimbursement | Component Three, Sub-component d, Administration of Health Care Funds for the Poor: <ul style="list-style-type: none"> ▪ VSS and HFFP management capacity building ▪ Initiatives to promote the role of VSS and HFFP as real health purchaser rather than just money channel ▪ Initiatives to strengthen advocacy capacity of provinces (to better mobilize additional funds for HFFP) ▪ Premium: is there a need to increase? |
| Decree No. 63 2005/ND-CP dated May 16, 2005 on Health Insurance | <ul style="list-style-type: none"> ▪ Expanded target groups of Compulsory HI Scheme and Voluntary HI Scheme ▪ Benefit package ▪ Contracted providers (inclusion of private providers) ▪ Premium (50,000 VND for the poor) ▪ Responsibilities of concerned partners (provider, purchaser, user) | Component Three, Sub-component d, Administration of Health Care Funds for the Poor: <ul style="list-style-type: none"> ▪ VSS management capacity building (staff development, computerized claim processing system...) ▪ Initiatives to promote the role of VSS as real health purchaser rather than just money channel (accreditation, negotiating power on behalf of HI enrollees...) ▪ Premium for the poor: is it enough? |
| Decree No. 10 2002/ND-CP | Decentralization of hospitals <ul style="list-style-type: none"> ▪ Introduced methods for local hospitals to raise their own revenues ▪ Staffing autonomy (staffing norm, selection, contracting and use of staff) ▪ Financial autonomy (revenue generation and use, development of internal expenditure norms) | Component Four, Strengthening management: <ul style="list-style-type: none"> ▪ Started process of decentralization |
| Decree No. 43 2006/ND-CP dated April 25, 2006 on public entities' autonomy and its implementing paper – Circular 71/2006/TT-BTC dated August 9, 2006 | Decentralization of hospitals <ul style="list-style-type: none"> ▪ Replaced Decree No. 10. ▪ Staffing autonomy (staffing norm, selection, contracting and use of staff) ▪ Ranks hospitals at three levels of financial autonomy, prescribing related authorities | Component Four, Strengthening management: <ul style="list-style-type: none"> ▪ Require more investment in planning and management capacity building (at provincial and district level) ▪ Possible risk of over provision of good revenue generation services, staff behaviors towards different user groups (poor vs. affluent...) |
| Decree No. 172 2004/ND-CP dated September 29, 2004 on organization of entities belongs to District People Committees | <ul style="list-style-type: none"> ▪ Establish District Health Bureau to take governmental management of healthcare in the district. (It is under the direct management of District People Committee rather than Provincial Health Department, and oversees Commune Health Stations). | Component Four, Strengthening management: <ul style="list-style-type: none"> ▪ More complex district health system that requires better coordination ▪ More staff required at district level to accommodate newly established entities (District Health Bureau, District Preventive Care Center) |
| Resolution No. 46 2005/ND-CP dated April 18, 2005 on enhancement of socialization in | <ul style="list-style-type: none"> ▪ State budget secures to cover public health, basic healthcare for disadvantaged groups (poor, children under 6), preventive care, grassroots healthcare... | Component Four, Strengthening management: <ul style="list-style-type: none"> ▪ Build up capacity on service planning at provincial and district level ▪ Hospital fees as efficient tool to correct |

| | | |
|---|---|---|
| education, healthcare, culture and sport activities | <ul style="list-style-type: none"> ▪ Expand health insurance coverage and contracted providers ▪ Increase hospital fees to properly reflect real direct costs ▪ Encourage private sector | <p>system flaw</p> <ul style="list-style-type: none"> ▪ Engage private providers |
| <p>Decision 122 2001/QD-TTG dated July 27, 2001 approving "Computerized state administrative management" program period 2001-2005</p> | <p>Specific objectives:</p> <ul style="list-style-type: none"> ▪ Establish computerized system used in state administrative management ▪ Construct national databases (firstly at targeted Ministries i.e. MPI, DOLISA, SBV, Customs Office, MOC, MOH, MOTE etc. ▪ Computerizes public services to enable state management agencies to better serve people and business ▪ Provide informatics training for civil servants at district and higher level. <p>The program entailed several sub-programs:</p> <ul style="list-style-type: none"> ▪ Computerized administrative management at Ministries and Ministerial-level agencies ▪ Computerized administrative management at Provincial People's Committees ▪ Construction of national databases ▪ Provision of informatics training for civil servants | <p>Component Four, sub-component c, Health Management Information Systems:</p> <ul style="list-style-type: none"> ▪ Generally, the program failed to achieve its objectives although sizable investment was made (for procurement of hardware and training for staff). <p>Although detailed assessment on the implementation of the program has yet been carried out, there may be some anecdotal reasons:</p> <ul style="list-style-type: none"> ▪ Much effort was made to procure hardware whereas less effort was made to design, pretest and customize user-friendly software ▪ Training program was not well designed and monitored ▪ No or little incentive was made to encourage the use of computerized system to informing programming and decision making ▪ Less effort was made to make sure continuous improvement of the system |
| <p>Circular 03 2007/TT-BKH dated March 12, 2007 on guidance, functions, and organization of Project Management Unit of ODA project</p> | <ul style="list-style-type: none"> ▪ Specific guidance on functions, organization and implementation arrangements of ODA-financed project's PMU | <p>Component Four, sub-component d, Project management:</p> <ul style="list-style-type: none"> ▪ Use to guide the establishment of CPMU and PPMUs |

EXTERNAL ASSISTANCE

**Table 1: National Program Assistance to the Health Sector
Committed Budget for Multi-year Projects in the Year 2005
(\$ million)**

| Main Programs | Partners | Committed Budget |
|--|---------------------------------------|---------------------|
| A. Health Policy, Planning, Management and Evaluation | European Commission | 25.9 |
| | Germany | 6.7 |
| | Japan | 3.1 |
| | Luxembourg | 6.3 |
| | Sweden | 12.1 |
| | United Nations Populations Fund | 5.3 |
| | World Health Organization | 6.9 |
| | Others | 12.5 |
| | Subtotal (A) | 78.8 |
| B. Primary Health Care | Asian Development Bank | 89.3 |
| | Belgium | 2.6 |
| | Canada | 4.5 |
| | Finland | 3.8 |
| | Netherlands | 7.7 |
| | RC Denmark | 2.1 |
| | Sweden | 8.7 |
| | United Nations Children's Fund | 2.6 |
| | World Bank | 84.4 |
| | Others | 11.1 |
| | Subtotal (B) | 216.8 |
| C. Hospital Services | Finland | 7.7 |
| | Germany | 23.6 |
| | Health Support – Social Development | 2.0 |
| | Italy | 7.4 |
| | Japan | 127.3 |
| | Luxembourg | 3.7 |
| | Spain | 5.7 |
| | World Bank | 36.3 |
| | Others | 41.7 |
| | Subtotal (C) | 255.4 |
| D. Pharmaceuticals and Biological Products | International Development Association | 4.9 |
| | Korea | 28.5 |
| | Subtotal (D) | 33.4 |
| E. Traditional Medicine | Spain | 5.1 |
| | Subtotal (E) | 5.1 |
| F. Communicable Diseases Prevention and Control | Asian Development Bank | 27.9 |
| | Canada | 44.0 |
| | Life-GAP | 2.8 |
| | Finland | 3.3 |
| | France | 2.9 |
| | Japan | 2.5 |
| | Netherlands | 8.6 |
| | United Kingdom | 6.6 |
| | United Nations Children's Fund | 2.3 |
| | United States of America | 15.5 |
| | World Bank | 40.2 |
| | World Health Organization | 10.8 |
| | Others | 10.9 |
| | | Subtotal (F) |

| | | |
|--|---------------------------------|--------------|
| G. Non-communicable Diseases Prevention and Control | Belgium | 0.3 |
| | Subtotal (G) | 0.3 |
| H. Mother and Child Health | European Commission | 23.2 |
| | Germany | 8.5 |
| | Japan | 6.5 |
| | Netherlands | 4.5 |
| | United Nations Populations Fund | 17.9 |
| | United Nations Children's Fund | 4.9 |
| | Others | 1.4 |
| | Subtotal (H) | 66.9 |
| I. Nutrition | Netherlands | 2.6 |
| | United Nations Children's Fund | 2.4 |
| | Others | 1.5 |
| | Subtotal (I) | 6.5 |
| J. Disability and Rehabilitation | Czech Republic | 45.0 |
| | Germany | 12.4 |
| | United States of America | 10.3 |
| | Others | 0.6 |
| | Subtotal (J) | 68.3 |
| K. Healthy Environment | United Nations Children's Fund | 5.5 |
| | World Health Organization | 1.5 |
| | Others | 1.8 |
| | Subtotal (K) | 8.8 |
| L. Health Training | Netherlands | 2.4 |
| | Others | 2.4 |
| | Subtotal (L) | 4.8 |
| M. Equipment and Technology | Luxembourg | 10.7 |
| | Spain | 19.7 |
| | Others | 1.0 |
| | Subtotal (M) | 31.4 |
| N. Research and Studies | Sweden | 5.6 |
| | Others | 1.1 |
| | Subtotal (N) | 6.7 |
| O. Others and Non-classified | Denmark | 2.1 |
| | France | 2.3 |
| | United Nations Children's Fund | 2.3 |
| | Others | 0.9 |
| | Subtotal (O) | 7.6 |
| Total | | 969.0 |

Source: European Commission in Viet Nam, 2005.

Table 2: Provincial External Coordination Matrix

| Province | Subsectors | Partners |
|-----------------|------------------------|---|
| Da Nang | Health Planning | Canada, EC, Luxembourg, Netherlands, UNICEF |
| | Hospitals | Italy, Belgium, Japan, |
| | CDC | Belgium, HI |
| | Disability | Belgium |
| | Healthy Environment | Sweden |
| | Health Training | EC |
| Quang Nam | Health Planning | Sweden |
| | PHC | ADB |
| | Medical Equipment | Spain |
| | CDC | Australia, UNAIDS, HI, Belgium |
| | Disability | Belgium, USA |
| | Health Education | UNICEF |
| | MCH | UNFPA |
| Quang Ngai | PHC | ADB |
| | Medical Equipment | Spain |
| | CDC | Australia |
| | Disability | Belgium, USA |
| | Health Education | UNICEF |
| | PHC | Japan, Netherlands, World Bank, Sweden |
| Binh Dinh | Hospitals | Japan |
| | CDC | Belgium, USA, Japan, World Bank |
| | Health Project | New Zealand |
| Phu Yen | PHC | Japan, Netherlands, World Bank, Sweden |
| | Hospitals | Belgium |
| | CDC | Belgium |
| Khanh Hoa | Health Planning | Sweden |
| | PHC | ADB |
| | Hospitals | Belgium |
| | CDC | MCNV, GF, Belgium, HI, LG, DFID, WB |
| | MCH | SAP, EC, UNFPA |
| Ninh Thuan | Health Planning: | Canada, EC, Norway, UNICEF, USA |
| | PHC | Japan, Netherlands, World Bank, Sweden |
| | CDC | Belgium, Luxembourg, UNICEF |
| Binh Thuan | Health Planning | EC |
| | PHC | Australia |

Source: European Commission.

ADB = Asian Development Bank, CDC = communicable diseases control, DFID = Department for International Development, EC = European Commission, MCNV = Medical Committee Netherlands-Viet Nam, PHC = primary health care, UNAIDS = Joint United Nations Programme on HIV/AIDS, UNFPA = United Nations Populations Fund, UNICEF = United Nations Children's Fund, USA = United States of America, WB = World Bank.

SUMMARY INITIAL ENVIRONMENTAL EXAMINATION

A. Introduction

1. The Project is classified under environmental category B. The summary initial environmental examination (IEE) is based on field visits during project preparation, review of literature and government guidelines, discussions with staff at implementing agencies and other organizations, and consultant reports.

B. Description of the Project

2. The Project will support the health system in the provinces of Đà Nẵng, Quảng Nam, Quảng Ngãi, Bình Định, Phú Yên, Khánh Hòa, Ninh Thuận, Bình Thuận. The Project supports the construction of facilities and upgrading equipment, development of provincial human resource, increasing accessibility to quality healthcare for the poor, and strengthening provincial health system management. The Project will improve the management of medical waste in the South Central Coast region. The Project will safeguard the environment and mitigate potential negative effect by upgrading waste management facilities to meet government standards. All civil works will include capital investments to improve management of medical solid wastes, including infectious, clinical, and toxic wastes, as well as nonhazardous domestic waste and wastewater.

C. Description of the Environment

3. South Central Coast Region is a narrow and long territory. Total area is about 4426 km², shares 13.4 % Vietnamese area. Regional terrain inclines from the West to the East: high mountainous area that shares 2/3 of total area is in the West, the coast with the length of 1100 km is in the East and a narrow strip of plain is in the between. The region has tropical monsoon climate with high temperature and much sunlight. The year is divided into two seasons: dry season from February to August and rainy season from September to January. Surface water contained in rivers and springs is plentiful in rainy season but the flow remarkably reduces in dry season. Therefore, the region is often suffered from natural calamity (such as typhoon, flood e.g.) in the rainy season, and in dry season, some districts in Ninh Thuận and Bình Thuận provinces may experience shortage of water. The soil in the region are mainly yellow red soil, sandy soil and grey soil, suitable for commercial crops such as peanut, sugar cane, tobacco e.g. Forest covers about 40% of total land, natural forest mostly concentrate in Laos border and side of Central Highlands. Fauna and flora in forest are diverse, many kinds of them are rare and value. The economy is mainly based on the sector of agriculture – forestry - fishing and the sector of commerce – service which account for around 70% of regional gross domestic product (GDP)

D. Screening of Potential Environmental Impacts

1. Civil Works

4. The Project supports civil works to upgrade 23 hospitals including 1 provincial general hospital, 2 provincial specialized hospitals, 5 regional general (or inter-district) hospitals and 15 district general hospitals. Most of these health facilities are located in urban areas and on plains or plateaus. They are located at ground level, with reasonable potential for natural drainage.

5. **General and specialized hospitals** include inpatient, diagnostic, and treatment facilities, as well as other clinical support facilities. A hospital is typically located in an urban area with access to existing water and electricity supplies. The district hospital and specialized hospital typically have 50 to 100 beds, and produce approximately 0.15 kilograms (kg) of hazardous healthcare waste per bed per day. The regional general hospital typically has 200 to 300 beds, produce approximately 0.2 kilograms of hazardous healthcare waste per bed per day. The provincial general hospital typically has 500 to 700 beds, produces approximately 0.2 kilograms of hazardous healthcare waste per bed per day. The Project supports civil works for 1 provincial general hospital, 2 provincial specialized hospitals, 5 regional general hospitals and 15 district general hospitals. Support for improved solid waste treatment and disposal, wastewater collection and treatment as well as water and sanitation systems, will be provided for all of these hospitals. A budget of 2.7 billion VND has been allocated per hospital having 50 – 150 beds and a budget of 3.95 billion VND has been allocated per regional or provincial general hospital to cover the costs of improving solid waste management, wastewater treatment, and safe water supply.

2. Other Project Components

6. An annual 3-day training course on waste management and infection control will take place every year in each hospital to improve handling of medical waste. This course will focus on proper sorting, storing, and disposal of potentially hazard waste, as well as instruction on government policy. The course will also emphasize on universal precautions and additional precautions. Given its importance, it will be offered every year to reinforce lessons and update staff on the latest practices. Additional training may be offered, depending on the project-supported waste management equipment. Other project components—training, management supervision, and health financing—are expected to have no marginal impact on the environment.

E. Assessment and Recommendations

1. Environmental Assessment

7. Medical solid waste—glassware, syringes, dressings, bandages, plasters, plastic syringes, and test swabs—accounts for 10-15% of hospitals' solid waste. Most health facilities have limited resources for waste disposal. Health providers generally know to sort and separate medical waste from conventional waste; however, there are problems with storage and disposal of hazardous materials. Medical waste is usually taken to landfill sites and mixed with other waste or burned in the open air. Liquid clinical waste is discharged without proper treatment, and health centers lack basic wastewater facilities. Challenges to effective waste management include (i) inappropriate technology, (ii) lack of training and awareness among staff, (iii) geographical remoteness of health centers, and (iv) high cost of treatment systems.

8. The Ministry of Health (MOH) has increasingly recognized the importance of improving waste management in the health sector and that the proper disposal of hazardous medical waste is essential to avoiding adverse environmental and health impacts. In response to this challenge, MOH has developed a series of regulations and a plan to improve the handling of medical waste. The regulatory framework provides clear guidelines for proper medical waste management and follows international practice.¹ MOH is also in the process of finalizing a 10-year master plan to improve medical waste management.²

2. Recommendations

9. Because project activities are decentralized and need to be flexible, the Government will undertake the following four steps as part of the environmental review framework:

- (i) For each DHC, the Provincial Health Department will develop an environmental management plan (EMP) focused specifically on medical waste management before it awards contracts for civil works. The outline of this plan is in Supplementary Appendix I.
- (ii) The EMP will be submitted to MOH, other related government agencies, and Asian Development Bank (ADB) for review and concurrence. ADB will ensure that the EMP is consistent with ADB's environmental policy.
- (iii) Provincial health departments will carry out site-specific IEEs based on a review of the EMP and local environmental conditions. The site-specific IEE will carefully examine the environmental consequences of the proposed investment in waste management and will make further recommendations. For sites that use medical waste incinerators, special care will be taken to ensure that the engineering specifications minimize harmful environmental impact. The IEE will be developed according to ADB's environmental policy and will (a) identify potential environmental impacts, including both indirect and cumulative effects, and assess their significance; (b) evaluate the cost effectiveness of the proposed EMP; and (c) develop appropriate environmental monitoring plans to ensure compliance. The IEE will follow government regulations on medical waste management and will be reviewed by ADB before civil works are approved.
- (iv) Hold site-specific public consultations with potentially affected groups on the IEE and the EMP before awarding civil works contracts.

10. **Solid Waste** The Project will emphasize the main principles of medical solid waste management: minimizing the generation of solid waste, early separation of hazardous and non-hazardous waste at health facilities, safe storage of hazardous waste, and proper disposal. It will support continuous management training for health care staff handling waste and operating equipment. The Project will improve the current management of infectious and chemical waste according to ADB's environmental policy. The Project will make a major contribution to support implementation of the proposed National Master Plan for Health Care Solid Waste Treatment in the Central South Coast Region.

11. Each DHC will develop a site-specific EMP that is consistent with national regulations on medical waste and with the Master Plan for Health Care Solid Waste Treatment. The local waste management will also require approval by ADB with appropriate public consultation. The local EMP will identify the DHC's procedures for identifying and separating medical waste from other waste, guidelines for transportation and storage, and final disposal. It will identify the roles of individual staff members within each DHC in managing medical waste, and will include a training plan for key staff.

12. The summary IEE has identified four broad options that DHC have in disposing of hazardous medical waste: (i) transportation of medical waste for disposal at an approved and dedicated disposal facility such as a provincial hospital; (ii) permanent burial in specially

designed, secure landfills; (iii) sterilization using either chemicals or steam; and (iv) incineration using an approved incinerator designed to mitigate hazardous emissions.³

13. **Liquid Waste** The Project will support better liquid waste management at each DHC. Technology for liquid waste disposal will vary based on local conditions and practices. Depending on the type of waste and the organisms in it, risk waste will be inactivated and rendered safe before final disposal. Liquid clinical waste normally comes from laboratories and utility rooms where chemical and active solutions are stored.

14. The Provincial Health Department will set up Healthcare waste management steering Committee in accordance with MoH's regulations on healthcare waste management. This committee will have to consider several factors in their decision, including capital and operation costs, the quality of the road network (for the transportation to a dedicated site), the availability of necessary inputs, ease of implementation, training required, and public opinion. There is no perfect solution to the problem of medical waste: all options require trade-offs and carry risks.

F. Institutional Requirements and Environmental Monitoring Plan

15. The provincial project management unit (PPMU) will be responsible for meeting Government and ADB environmental standards. To ensure compliance, a domestic environmental specialist (12 person-months) will provide overall technical guidance and help prepare detailed civil works plans, particularly the environmental mitigation component, to ensure that all relevant standards are met.

16. The key elements of this summary IEE and the proposed waste management plan are included as specific assurances in the loan agreement. This includes both the required actions in the waste management plan and financing of the associated recurrent costs. ADB will also include a specific assurance about submitting the National Master Plan for Health Care Solid Waste Treatment to the Government for approval.

17. Monitoring will be mainstreamed, with each PPMU preparing semiannual updates on compliance environmental standards as part of regular reporting. The midterm review will provide a detailed investigation of project compliance with environmental standards.

G. Public Consultation and Disclosure

18. Public consultation will continue throughout the project and will play an important role in design of civil works. The Government will provide information on the Project's environmental issues in a form and language suitable to the population. The environmental specialist will hold consultations with relevant groups to explain the financial and non-financial costs and benefits of proposed measures to mitigate environmental harm caused by medical waste.

H. Conclusion

19. The Project will help improve the environment by upgrading existing waste management facilities to meet Government and ADB environmental standards. Both new and upgraded facilities will include investment to improve medical solid waste management and wastewater disposal. Based on the summary IEE, a detailed environmental impact assessment for the Project is not required.

SUMMARY RESETTLEMENT FRAMEWORK

1. **Introduction.** The Project will support civil works in 30 locations; including 1 provincial general hospital, 3 specialized hospitals, 4 regional (inter-district) hospitals, 18 district general hospitals, and 4 preventive medicine centers. An assessment was done of possible resettlement issues, as summarized in Table 1. There are 14 new sites, mostly vacant Government-owned land or agricultural plots. Only one plot has vacant stores owned by a company, and one plot is a cemetery and has been rejected. Sites for the preventive medicine centers have not yet been identified and may require a new, small plot. A detailed resettlement framework (RF) has been prepared for the Project because compensation for loss of agricultural land and other resettlement issues have not been finalized and detailed designs of civil works are still to be prepared (Supplementary Appendix I). The RF sets out the resettlement policy, and screening and planning procedures that the Project will follow when preparing a resettlement plan. The list of civil works and possible resettlement issues is in Table A13.1

2. **Legal and Policy Framework.** The policy framework and entitlements are developed from the relevant laws, decrees and regulations of the Government of Viet Nam and Asian Development Bank's (ADB) *Policy on Involuntary Resettlement* (1995) guided by Operations Manual on Involuntary Resettlement (OM/F2, 2006). Provisions and principles adopted in the RF will supplement the provisions of relevant decrees currently in force in Viet Nam wherever a gap exists. Key strategies to reconcile the differences will be included in the resettlement plan that will be prepared.

3. **Site Selection and Resettlement Plan Preparation.** Site selection and detailed design will, to the extent feasible, explore all viable options to avoid, and if not, reduce the requirements for land acquisition and resettlement. As a priority, vacant and idle public land will be used. If private land has to be acquired, criteria for acquiring private land to minimize resettlement impacts, procedure for the resettlement plan preparation, and project entitlements are provided in Supplementary Appendix I. Voluntary contributions of land or other assets will not be permitted.

4. **Participation and Grievance Redress.** Consultation will be undertaken prior to finalization of detailed design to incorporate affected persons' requests and suggestions to minimize resettlement impacts into the design, as possible. Separate consultations with poor and vulnerable groups will be carried out to identify and address the specific needs or concerns of these groups. A grievance mechanism will be established to ensure that affected persons' concerns and grievances are addressed and resolved in a timely and satisfactory manner. Affected persons will be made fully aware of their rights verbally and in writing during consultation, survey, and time of compensation.

5. **Implementation Arrangements.** At the central level, the project office of the Ministry of Health will provide overall guidance and technical support to the provincial resettlement committees. National and provincial project management units will be assisted by the supervision consultants. A national resettlement specialist will provide full-time assistance during resettlement preparation and implementation. Village resettlement committees will be established, as required.

6. **Monitoring, Budget, and Implementation Schedule.** The project management units will be responsible for internal monitoring of resettlement. Progress reports will be submitted to ADB on a quarterly basis. The budget will cover compensation for land acquisition and

rehabilitation costs, management costs, and contingency. All resettlement activities will be coordinated with the civil works schedule. ADB will not approve award of civil works contract until all resettlement activities has been satisfactorily completed and agreed rehabilitation assistance is in place and the site is free of all encumbrances. Resettlement implementation cannot commence until the resettlement plan has been reviewed and approved by ADB.

7. Disclosure of Resettlement Planning and Monitoring Documents. Project management unit and resettlement committees will be responsible for the disclosure of the resettlement plan to the affected persons prior to submission to ADB. The draft resettlement framework has been uploaded on the ADB website, and the final resettlement plan and resettlement progress reports will also be uploaded on ADB's website.

Table 1: Summary of Civil Works and Possible Resettlement Issues

| | Facility | New Site | Resettlement Issues |
|----------------------------|-------------------------------------|----------|--|
| Danang Province | | | |
| 1 | Hoa Vang District Hospital District | X | Acquire land owned by pharmaceutical company with seven vacant storage units |
| 2 | Nursing & Rehabilitation Hospital | | None, upgrade |
| Quang Nham Province | | | |
| 3 | Bac Tru My District Hospital | | None, upgrade |
| 4 | Quang Nam Regional Hospital | | None, upgrade |
| 5 | Preventive Medicine Center | X | Site not identified |
| Quang Ngai Province | | | |
| 6 | Ba To District Hospital | X | Acquire 1.2 hectares of agricultural land |
| 7 | Son Tay District Hospital | X | Acquire adjacent agricultural land |
| 8 | Tay Tra District Hospital | | None, replace |
| 9 | Tra Bong District Hospital | | None, replace |
| 10 | Preventive Medicine Center | X | Site not identified |
| 11 | Preventive Medicine Center | X | Site not identified |
| Bin Dinh Province | | | |
| 12 | Provincial General Hospital | | None, upgrade |
| 13 | Phi Cat District Hospital | | None, upgrade |
| 14 | Phu My District Hospital | | None, upgrade |
| 15 | An Lao District Hospital | | None, upgrade |
| 16 | Van Canh District Hospital | | None, upgrade |
| 17 | Vinh Thanh District Hospital | | None, upgrade |
| 18 | Tuberculosis Regional Hospital | | None, renovate |
| 19 | Regional Mental Hospital | | None, renovate |
| Phu Yen Province | | | |
| 20 | Tuy An Regional Hospital | X | <10 households affected |
| 21 | Tay Hoa District Hospital | X | Acquire adjacent agricultural land |
| Khanh Hoa Province | | | |
| 22 | Ninh Diem District Hospital | X | None identified |
| 23 | Van Ninh District Hospital | | None, upgrade |
| 24 | Dien Khanh District Hospital | X | Acquire adjacent agricultural land |
| 25 | Preventive Medicine Center | X | Site not identified |
| Ninh Thuan Province | | | |
| 26 | Thuan Bac District Hospital | X | Acquire agricultural land |
| 27 | Ninh Hai District Hospital | X | Acquire agricultural land |
| Binh Thuan Province | | | |
| 28 | Duc Linh Regional Hospital | | None, upgrade |
| 29 | Ham Tan District Hospital | X | Cemetery on site, not accepted |

| Summary | | | |
|----------------|------------------------------------|-----------|-----------|
| | Provincial Hospitals | | 1 |
| | Specialized Hospitals | | 3 |
| | Regional Hospital (Inter-district) | | 4 |
| | District Hospitals | | 18 |
| | Preventive Medicine Centers | | 4 |
| | Total | | 30 |
| | New construction sites* | 14 | |

*On vacant Government owned land or on private agricultural land (total 15.3 hectares, excluding sites for preventive medicine center). In total, 88 households require compensation of loss of farm land. No relocation of households required.

SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

| Linkages to the Country Poverty Analysis | | | |
|--|--|--|--|
| Is the sector identified as a national priority in country poverty analysis? | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | Is the sector identified as a national priority in the National Poverty Reduction Strategy? | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>Contribution of the sector or subsector to reduce poverty in Viet Nam:</p> <p>Health is a key factor in achieving sustained economic growth, poverty reduction, and gender equality. The Project is aimed at improving the health of the population, in particular the poor, women and children, and ethnic groups in the eight provinces in Viet Nam's South Central Coast Region. The Project will improve access to quality health services for nearly 9 million people -- about 4.6 million women, 4.4 million men and nearly 500,000 ethnic minority peoples -- living in the eight target provinces, thereby directly or indirectly improving their health status. Major Project outcomes include: (i) improved health service resources in the eight provinces, providing improved quantity and quality of health care; (ii) increased numbers and improved retention of skilled health staff providing quality health care services; (iii) improved access and quality of health care for the poor, near poor, and other vulnerable groups; and (iv) increased capacity to manage provincial health system in terms of equity, efficiency, and effectiveness. The Project contributes directly to poverty reduction with its focus on improving PHC for the poor and other vulnerable groups. Improved health reduces income losses and expenditures due to illness or disease, and indirectly protects the labor force and production of food and cash crops. The Project supports the Government's goals to achieve its health-related VDG targets by 2015. The Project will support Government efforts to develop a comprehensive and well managed health system that preserves the gains in health status already achieved, extends those gains to the poor and underserved, and is better able to address emerging challenges and changing demands.</p> | | | |
| <p>B. Poverty Analysis Targeting Classification: Targeted intervention</p> | | | |
| <p>As a reflection of Viet Nam's booming economy, poverty levels have dropped from over 58 percent in 1993 to less than 20 percent today. Economic progress has not been uniform, however. Urban areas have benefited more than rural. In 2004, the incidence of poverty was 26.4 percent in rural areas compared to 13.7 percent in urban areas. And, while food poverty has been largely eliminated in urban households (3.3 percent), 8.1 percent of rural households remain food-poor. Ethnic minorities, in particular, have not kept pace with the economic progress experienced by others. In 2002, 69.3 percent of ethnic minorities were still in poverty compared to only 23.1 percent of citizens of Kinh or Chinese origin.</p> <p>For most of Viet Nam's 83 million people, health status has also shown remarkable improvements. But the health status of those who live in rural areas, especially ethnic minorities, has not progressed as rapidly as for urban dwellers. Life expectancy in the more rural and mountainous Northwest, for example, was only 66.6 years (based on 2002 data), compared to a high of 73.9 years in the Southeast (Ho Chi Minh City and its environs). According to the 2002 VNHS figures, while 23 percent of Kinh and Chinese children were underweight for their age, the proportion is higher among ethnic people in the Northern Mountains (34 percent), and very high among minorities in both the South Central Coast and the Central Highlands (45 percent). The degree of malnutrition for these groups is also more severe. One quarter of underweight ethnic minority children in the South Central Coast and Central Highlands suffer from level 2 or level 3 malnutrition. Only one tenth of underweight Viet Nameese children suffer from malnutrition of this severity. MMR are much higher in mountainous and remote areas and among minorities compared to the lowlands. Differences in MMR range from 269/100,000 in the mountainous and midland regions, compared to 81/100,000 in the deltas. Between Kinh and ethnic minorities, 81/100,000 to 316/100,000 respectively. Between rural and urban areas, 145 and 79/100,000 respectively.</p> <p>As extensive as it is, Viet Nam's health system is burdened by an infrastructure that is old, badly deteriorated, and poorly equipped, with inadequate systems for water and waste management and infection control. The facilities and equipment at most district hospitals are old and degraded. Provincial Hospitals are typically overwhelmed with patients, with chronically over-crowded wards and large volumes of outpatients. As a result, except for those few facilities that have been recently renovated, most provincial hospital, like district hospitals, have buildings that are physically degraded and equipment that is largely outdated or in a state of ill repair. Many commune health stations in the mountainous areas cannot provide basic health care services and lack essential equipment and drugs.</p> <p>For the rural poor, access to health care remains problematic. The remoteness of many rural communities and the unavailability of skilled health workers contribute significantly to their poverty and poor health status. But other factors are also important. For one, ethnic minorities tend to seek healthcare services less often, averaging 2.3 outpatient visits per year, compared to 3.5 for Kinh/Chinese. Language and literacy also contribute, especially for minority women, with one in four unable to read. While other factors influence access, the cost of health care is the most significant constraining factor. The predominance of user fees at all levels of the health system, coupled with the cost of drugs and indirect expenses for travel and accompanying family members, can be a devastating financial burden for those surviving at a subsistence level. The introduction of health insurance, especially the Health Care Funds for the Poor (HCFP), are beginning to mitigate these financial burdens.</p> | | | |

C. Participation Process

Is there a stakeholder analysis? Yes No

A stakeholder analysis as part of the project design to identify the key stakeholders, to understand their related roles and interests, and to make a preliminary assessment of capacity for Project implementation. A variety of stakeholders were consulted including the Ministry of Health and other national agencies, provincial and district health officials, managers and staff of hospitals and health centers, village health workers, focus group discussions with target groups. Discussions were held with development partners to ensure synergies and complementarities with their ongoing initiatives in the health sector

Is there a participation strategy? Yes No

Participation is integrated into the overall project design. During project design, MOH carried out initial consultations with different stakeholders, and held a number of regional workshops. The involvement of stakeholders will continue during project implementation.

The project will place a strong emphasis on gender-inclusive community participation, as well as coordination with mass organization working with vulnerable communities. Community consultation and participation— especially among the poor and ethnic minority groups—will be required to help identify special needs and to ensure their accessibility to health care services. Women's participation will be a central to the development, implementation and monitoring of project activities. Community participation will be integrated in the monitoring and evaluation of project activities.

D. Gender and Development**Strategy to maximize impacts on women:**

The Project will especially benefit 2.1 million women in the reproductive age group and 800,000 children under five. A gender strategy has been prepared to highlight the different health needs of women and men in the South Central Coast region. The gender strategy focuses on the provision and utilization of reproductive health care services, with a special emphasis on the needs of ethnic minority women and children. It also helps to ensure that both men and women have equal opportunities to participate in training at all levels.

Key elements of the gender strategy include:

- (i) Provide the necessary facilities and equipment for 100% of province and district hospitals constructed under this project to provide quality care for deliveries and safe, comprehensive obstetric care to meet National Standards and Guidelines.
- (ii) HR development strategies in place to enhance the capacity of female staff in the management of the system. Increased number of professional female personnel in the management of the Provincial Health Service, by 33%.
- (ii) Increased % of trained leaders and staff with comprehensive knowledge of gender responsive planning and management of the implementation of reproductive health care programs.
- (iii) Increased number of female ethnic minority health staff by 15 percent.
- (iv) Capacity building for RH Centers in the preventive system to better monitor and supervise maternal and child health activities at all levels.
- (v) Reduced poor, non-poor gap between pregnant women obtaining pre-natal care.
- (vi) One trained and fully paid VHW in each remote ethnic minority community. At least 75% of VHWs are female. And 100% VHWs are members of the ethnic minority group in the village.
- (vii) Increased number of young women, ethnic minority women and male clients, migrant workers, receiving information on reproductive health and family planning by 10 per cent.
- (viii) Gender action plans in place for each of the provinces. Social development and gender specialist services to be recruited for development and support to initial implementation of the EMDP.
- (ix) Improved HMIS to better meet the health care challenges and needs of women, especially poor women and ethnic minority women.
- (x) Increased use of sex-disaggregated baseline data to support planning. Gender-sensitive Medium Term Health Sector Development Plans and Medium Term Expenditure Plans and Frameworks to identify, target and strengthen expenditures on maternal and child health services and other gender equity considerations.

Implementation Mechanisms

The gender strategy, including its monitoring and evaluation, is fully incorporated into all project components. Implementation arrangements, including estimated costs for activities and civil works of the gender strategy, are in line with arrangements for the rest of the project. Social development and gender specialist services to advice in the development and initial implementation of the gender action plan. A gender-sensitive monitoring and evaluation plan based on the collection of sex-disaggregated baseline data and gender sensitive, community-based participatory approaches, will be developed for the project.

Has an output been prepared? Yes No

E. Social Safeguards and other Social Risks

| Item | Significant/ Not Significant/ None | Strategy to Address Issues | Plan Required |
|---|--|---|---|
| Resettlement | <input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None | Resettlement will be confined to compensation for the acquisition of land, including some land under active cultivation.. | <input type="checkbox"/> Full <input checked="" type="checkbox"/> Short <input type="checkbox"/> None |
| Affordability | <input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None | Issues pertaining to affordability are not expected to arise in the Project. | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Labor | <input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None | Labor is not a potential issue. The Project provides training opportunities for health staff at the national, provincial, and local levels. | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Indigenous Peoples | <input checked="" type="checkbox"/> Significant <input type="checkbox"/> Not significant <input type="checkbox"/> None | Ethnic minorities constitute nearly 500,000 people, around 6% of the total population in the 8 project provinces. The Project integrates ethnic minority considerations in project design. The Project will improve access to quality health services for nearly 500,000 ethnic minority people living in the eight target provinces of the South Central Coast Region, thereby directly or indirectly improving their health status. An ethnic minority development strategy has been prepared to highlight the different health needs of ethnic minority groups, especially those living in the remote mountainous areas of the South Central Coast Region. It has focused interventions to improve the quality of services in the basic health care system, including the village-level, in an effort to address the needs of remote mountainous communities. It has a strong gender focus with targeted interventions to address the needs of ethnic minority women and children. It also emphasises the training of health care providers in RH services and helps to ensure that both ethnic minority men and women have increased opportunities to participate in training at all levels. The design also includes focused interventions to improve IEC, such that it is targeted to ethnic minority needs, culturally appropriate and sustained. An Ethnic Minority Development Plan has been prepared for the project. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Other Risks and/or Vulnerabilities | <input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None | The Project is not expected to have an adverse effect on the environment. A summary initial environmental examination has been prepared for the Project, which outlines steps for improving current health care waste management practices. The Project will finance waste management systems to enable the delivery of the basic package of PHC. Improving health care waste management systems is a Project sub-component. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |

ETHNIC MINORITY DEVELOPMENT PLAN

A. Introduction

1. The Health Care in the South Central Coast Region Project will improve access to quality health services for nearly 9 million people (about 4.6 million women and 4.4 million men) and around 500,000 ethnic minority people living in the eight target provinces of the South Central Coast Region, thereby directly or indirectly improving their health status. An ethnic minority development plan has been prepared to highlight the specific health needs of ethnic minority groups, especially those living in the remote mountainous areas of the South Central Coast Region. It has focused interventions to improve the quality of services in the basic health care system, including at the village-level. It has a strong gender focus with targeted interventions to address the needs of ethnic minority women and children. It also helps to ensure that both ethnic minority men and women have increased opportunities to participate in training at all levels. The design includes interventions to improve IEC, such that it is targeted to ethnic minority needs, culturally appropriate and sustained. The strategy is based on a situational analysis and assessment that was prepared for the project, and is designed in accordance with Asian Development Bank (ADB) policy.

B. Background

2. While there are pockets of poor Kinh in every part of the country, nevertheless, the significant rate at which poverty has been reduced and human development enhanced in Viet Nam, compared to how little this overall trend has affected most minority populations, has resulted in the real problem of ongoing poverty being largely, if not entirely, an ethnic minority question.

Table 1: Breakdown of ethnic groups for the eight project provinces

| Province | Ethnic Groups | % of population | Province | Ethnic Groups | % of population |
|------------|---------------|-----------------|------------|---------------|-----------------|
| Da Nang | Kinh | 99.87 | Phu Yen | Kinh | 94.48 |
| | Ka tu | 0.13 | | Ê đê | 2.08 |
| Quang Nam | Kinh | 93.13 | Khanh Hoa | Ba na | 0.43 |
| | Cơ tu | 2.83 | | Chăm hơ roi | 2.06 |
| | Ca dong | 1.73 | | Tày | 0.18 |
| | Bhnoong | 1.01 | | Kinh | 95.5 |
| | Xơ đăng | 0.5 | | Rắc lầy | 3.17 |
| Quang Ngai | Kinh | 88.21 | Ninh Thuan | Hoa | 0.58 |
| | Xơ đăng | 1.15 | | Cờ ho | 0.32 |
| | Hrê | 8.7 | | Ê đê | 0.25 |
| | Cor | 1.87 | | Kinh | 78 |
| | Khác | 0.07 | | Chăm | 12 |
| Binh Dinh | Kinh | 97.98 | Binh Thuan | Raglai | 9 |
| | Ba na | 1.04 | | Kinh | 93 |
| | Hrê | 0.52 | | Chăm | 2.8 |
| | Chăm | 0.3 | | Raglai | 1.2 |
| | Hoa | 0.06 | | Hoa | 1.1 |
| | | | | K'ho | 0.8 |

3. More than 90 percent of ethnic minorities in the SCC lived in poverty in 2004, compared to only 15 percent of Kinh and Chinese. Some 72 percent of minorities in the SCC were considered to be “food poor” in 2004, compared to a few percent among Kinh (Swinkels and Turk, 2006).

4. Viet Nam has long had a strong official policy on ethnic minorities. Articles 36 and 39 of the constitution mandate preferential treatment for minorities in terms of education and health respectively. The government has a stated commitment for improving the health care of the ethnic minority population. Directive No. 6 of 22/1/2002 of the Central Executive Committee emphasises the priority of health care in mountainous and remote areas for people of ethnic minorities. Ethnic minorities, some 10 million people, or 13 percent of the population, are mostly supposed to be provided free health care; this is particularly explicit regarding the minorities of the Central Highlands and six Northern Mountain provinces (WHO 2003: 32). There is also policy discussions about expanding the coverage of the Health Care for the Poor program to include the near-poor in ethnic minority communities.

C. Burden of Disease

5. MMR rates are much higher in mountainous and remote areas and among minorities compared to the lowlands. Differences in MMR range from 269/100,000 in the mountainous and midland regions, compared to 81/100,000 in the deltas. Between Kinh and ethnic minorities, 81/100,000 to 316/100,000 respectively. Between rural and urban areas, 145 and 79/100,000 respectively.⁶⁴

6. According to the 2002 VNHS figures, while 23 percent of Kinh and Chinese children were underweight for their age, the proportion is higher among ethnic people in the Northern Mountains (34 percent), and very high among minorities in both the South Central Coast and the Central Highlands (45 percent). The degree of malnutrition for these groups is also more severe. One quarter of underweight ethnic minority children in the South Central Coast and Central Highlands suffer from level 2 or level 3 malnutrition. Only one tenth of underweight Viet Nameese children suffer from malnutrition of this severity. (NGO Resource Centre).

D. Public Health Sector

1. Quality of Care

7. Antenatal care is highest in the Red River Delta (98%) and Southeast (91%), but also in the poor Kinh North Central region (90%), and slightly lower in the South Central coast and Mekong (around 84-85%). However, Table 2 data below for Quang Nam province indicates that it is much lower in the remote ethnic minority communities.

Table 2: Quang Nam Province: Reproductive Health Care in 2006

| Service type | Mountainous areas | Delta | Province |
|--|-------------------|-------|----------|
| Percentage of women receiving three pre-natal checkups | 47.39 | 95.81 | 90.55 |
| Postnatal care after one-week delivery | 58.91 | 95.31 | 90.66 |

⁶⁴ Ministry of Health, *Viet Nam Health Report 2006*, pp 14.

| | | | |
|---|------|-------|-------|
| Deliveries at health facilities with Obstetrics nurse | 49.5 | 99.39 | 93.13 |
|---|------|-------|-------|

Source: Reproductive Health Care Centre, Quang Nam, 2006

8. The UNFPA assessment of three district hospitals in Ninh Thuan, Thuan Bac, Ninh Son and Bac Ai, where a large proportion of the Raglai ethnic minority live, found that:

- All three district hospitals were missing many essential equipment and drugs to meet maternal and neonatal health care needs.
- Ninh Son and Bac Ai hospitals have insufficient resources to manage postpartum hemorrhage and to address a related emergency. They have no capability to transfuse blood or to perform life saving surgical operations.
- All hospitals have difficulty finding enough staff to cover emergencies at the CHS.
- Ambulances are sometimes unavailable as they are used to transport senior health officials. All the vehicles have very little emergency equipment inside.
- At all three hospitals the health providers do not have the skills and knowledge to adequately manage obstetrics complications, to resuscitate a newborn or provide postnatal care.

9. VHWs play a key role in facilitating community involvement in health programs since they live in the same village, share the same culture and language and are often the first point of contact for health care services. While the government has a policy commitment to strengthening the VHW network, reports and studies indicate that this network is untrained and under-resourced, especially in the remote mountainous areas.

2. Access to services

10. While geography is a factor that limits the access of both poor and non-poor to health services, the primary impediment to access is financial. For example, rich people living in the delta areas have access rates to health services that are six-times higher than poor people living in mountainous areas.⁶⁵

11. The VHLSS 2004 shows that there has been an increase in the proportion of the population covered by either free healthcare cards or health insurance. The increase has been more dramatic for ethnic minorities than for Kinh people and has been particularly striking in the North East, the North West, the central coastal regions and the central highlands. In several regions, more than 70 percent of ethnic minorities possess either health insurance or a healthcare card. However, there are also numerous reports in all of the provinces, of ethnic minority people having no health cards to show upon arrival at health care facilities.

12. Despite the high rate of coverage, ethnic minorities seek healthcare less than Kinh people. In 2004, according to the VHLSS, ethnic minority people who have sought treatment have made on average 2.3 out-patient visits. Kinh people who have sought treatment have made on average 3.5 visits. Associated costs, such as transport, food and lodging costs incurred when accessing health services, are also barriers limiting poor peoples access to health.

⁶⁵ Ministry of Health, *Viet Nam Health Report 2006*, Medical Publishing House, 2007, pp X

13. According to WHO (2003), there is limited availability of well-qualified health staff who speak the local languages and have knowledge of local customs, and ethnic minority women in particular remain underrepresented among health staff in minority regions.

E. Project Benefits

14. Ethnic minority considerations have been integrated into project design. The project will result in the following benefits for ethnic minority communities in the project sites, thereby directly or indirectly improving their health status:

- (i) Decreased infant mortality and neonatal mortality by 10 percent
- (ii) Decreased maternal mortality by 10 percent
- (iii) Increased awareness about their health care entitlements and the availability of health care services.

15. Component One

- (i) The necessary equipment and drugs provided for CHS servicing marginalized ethnic minority communities to provide quality care for deliveries and basic essential obstetric care.

16. Component Two

- (i) Health providers will be trained to recognize local knowledge and understand health-seeking behaviors of ethnic minorities.
- (ii) HR development strategies in place to increase the number of qualified ethnic minority healthcare professionals.
- (iii) Focused interventions will ensure proportionate ethnic minority representation in training courses for skills development. These include necessary measures to cater to ethnic minority staff who may not be proficient in the Kinh language, thereby maximizing their opportunities to participate in training activities.

17. Component Three

- (i) Increased enrollments of ethnic minorities in Health Care Funds for the Poor and improved utilization of the card through enhancing awareness of their health care entitlements.
- (ii) One trained and fully paid VHW in each remote ethnic minority community.
- (iii) Effective, community-based, referral systems in place linking poor and ethnic minority communities with the commune and district health facilities.
- (iv) IEC plans in place, which address the major health issues of particular relevance to marginalized ethnic minority groups. Public health education materials and BCC materials translated in to the relevant ethnic minority languages where appropriate.

18. Component Four

- (i) Improve HMIS to better meet the health care challenges and needs of marginalized ethnic minority groups.
- (ii) All provincial and district plans to incorporate programs and activities to meet health care needs of marginalized ethnic minority groups.
- (iii) Ethnic minority development plans in place for each of the provinces.
- (iv) Medium Term Health Sector Development Plans and Medium Term Expenditure Plans to integrate ethnic minority considerations.

F. Implementation Mechanisms

19. The ethnic minority development plan, including its monitoring and evaluation, is fully incorporated into all project components. Implementation arrangements, including estimated costs for activities and civil works of the gender strategy, are in line with arrangements for the rest of the project

(i) Social development specialist services to advice in the development and initial implementation of the EMDP.

(ii) A senior representative/s at the PMU level (national and provincial) to be the ethnic minority focal point/s for the project.

(iii) Ethnic minority communities, women, village-heads, involved in project development, implementation and monitoring and evaluation.

(iv) A monitoring and evaluation plan in place, based on the collection of data disaggregated by ethnicity and sex.

(v) Partnerships with international and local NGOs, as well as the academic sector, in monitoring and evaluation of project activities.

GENDER STRATEGY

A. Introduction

1. The Health Care in the South Central Coast Region Project will improve access to quality health services for nearly 9 million people -- about 4.6 million women and 4.4 million men -- living in the eight target provinces of the South Central Coast Region, thereby directly or indirectly improving their health status. The Project will especially benefit 2.1 million women in the reproductive age group, nearly 500,000 people from ethnic minorities, 1.7 million poor people, and 800,000 children under five. A gender strategy has been prepared to highlight the different health needs of women and men in the South Central Coast region of Viet Nam. The gender strategy focuses on the provision and utilization of reproductive health care services, with a special emphasis on the needs of ethnic minority women and children. It also helps to ensure that both men and women have equal opportunities to participate in training at all levels. The gender strategy is based on a situational analysis and assessment that was prepared for the project, and is designed in accordance with the Asian Development Bank (ADB) policy on gender and development.

B. Background

2. In the East Asia region, Viet Nam stands out for its success in closing gender gaps in the last 20 years. It ranks 80th (out of 136 countries) on the Gender Development Index (GDI). Studies highlight four issues that require additional attention to keep on track: (i) Ethnic minority women and girls lag behind ethnic minority men and Kinh and Chinese women in accessing health and education services and economic opportunities (ii) There is persistent gender stereotyping in textbooks, which perpetuates gender inequalities (iii) Greater recognition is needed regarding the increasingly important role played by women in the agriculture sector (iv) Progress in increasing the number of women in decision making has been slow and inconsistent. Issues (i) and (iv) have particular relevance for this project.

3. The key policy document relating to gender in Viet Nam is the National Strategy for the Advancement of Women to 2010 and associated 5-year Plan of Action for the Advancement of Women. It contains five objectives in the priority areas of employment, education, health, participation and leadership, and strengthening the machinery for the advancement of women. Resolution No. 42/NQ/TW promulgated in 11/2004 states that particular attention should be paid in HR planning pertaining to management positions for women, youth and ethnic minorities, who have achieved distinctive records in their performance.⁶⁶

C. Burden of Disease

4. The UNFPA estimates the MMR at 130 per 100,000 live births (2005). The government admits to significant disparities between regions: "Differences in MMR exist between regions (with rates of 269/100,000 in mountainous and midland regions compared to 81/100,000 in the deltas) between Kinh ethnic majority and ethnic minorities (81 and 316/100,000) between rural and urban areas (145 and 79/100,000)." The following factors have been identified as contributing maternal mortality: (i) Delay in the decision to seek health care (ii) Delay in transferring the pregnant woman to the appropriate referral facilities (iii) Delay in providing

⁶⁶ The National Committee for the Advancement of Women in Viet Nam website. <http://www.ubphunu-ncfaw.gov.vn>

essential treatment (iv) lack of well trained health workers (iv) Lack of drugs and necessary equipment.⁶⁷

Table 1: Maternal Mortality rates in comparison to prevalence of five obstetrics complications by region, 2005.

| Regions | Number of cases | Number of deaths | % Deaths per cases |
|---------------------|-----------------|------------------|--------------------|
| National | 3270 | 93 | 2.8 |
| Red River Delta | 527 | 11 | 2.1 |
| Northeast | 327 | 16 | 4.9 |
| Northwest | 146 | 14 | 9.6 |
| North Central Coast | 338 | 11 | 3.3 |
| South Central Coast | 337 | 9 | 2.7 |
| Central Highlands | 274 | 10 | 3.6 |
| Southwest | 604 | 9 | 1.5 |
| Mekong Delta | 639 | 13 | 2.0 |

Source: Health Statistics Yearbook, 2005

5. In the SCC region for example, the number of deaths per cases would be higher amongst marginalized ethnic minority groups. Gynecological infections and obstetrics complications continue to be prevalent. In Ba To district, Quang Ngai where the main ethnic group is Hrê, according to hospital staff, nearly 80% of all women examined had some type of gynecological disease.

6. The South Central Coast has an infant and child mortality rate lower than the national average, only 13 per 1000, according to the CPFC/PFHP survey of 2002, though the Health Statistics Yearbook 2005 puts it around 18 per 1000, the national average. However, the rates are uneven amongst the provinces: Phu Yen, for example, has a notably higher rate of around 30 per 1000. There are also differences between the mountainous districts and the delta. The Reproductive Health Centre in Quang Nam notes as a concern an increase in infant mortality rates in Quang Nam province: 9.41 (2004), to 8.75 (2005) and 9.95 in 2006.⁶⁸

D. Gender and the Public Health Sector

1. Quality of RH Care

7. Health facilities at all three-levels still need more investment, especially medical instruments and essential drugs on RH care.⁶⁹ The UNFPA assessment of three district hospitals in Ninh Thuan province, Thuan Bac, Ninh Son and Bac Ai, where a large proportion of the Raglai ethnic minority live, found that:

- All three district hospitals were missing essential equipment and drugs to meet maternal and neonatal health care needs, when compared with the lists of the MoH.
- Ninh Son and Bac Ai hospitals have insufficient resources to manage postpartum hemorrhage and to address a related emergency. They have no capability to transfuse blood or to perform life saving surgical operations.
- All hospitals have difficulty finding enough staff to cover emergencies at the CHS.
- Ambulances are sometimes unavailable as they are used to transport senior health officials. All the vehicles have very little emergency equipment inside.

⁶⁷ Ministry of Health, *Viet Nam Health Report, 2006*, pp 14.

⁶⁸ Source: Reproductive Health Centre, Quang Nam, Review Report on Reproductive Health Care in 2006 and Orientation for 2007.

⁶⁹ UNFPA, Ministry of Health Project, End-line Survey Report, *Actual Situation of the Provision and Utilization of RH Care Services in Quang Nam Province, 2006*. pp 9.

- At all three hospitals the health providers do not have the skills and knowledge to adequately manage obstetrics complications, to resuscitate a newborn or provide postnatal care.

2. Gender Division of Labor and Leadership

8. While the proportion of female staff is high, in Quang Ngai for instance there are nearly 62% female staff in the provincial health service, they tend to be predominantly concentrated in the more poorly paid, lower-levels of the system: mid-wives, nurses, cleaners, administration staff, laboratory technicians.

Table 2: Percentage of CHS attaining National Standards having complete set of instruments for essential RH care services in Quang Nam Province

| Set of instruments | % in 2005 |
|---------------------------------------|-----------|
| 1. Set for delivery | 76.7 |
| 2. Set for checking of the cervix | 36.7 |
| 3. Set for neonatal resuscitation | 16.7 |
| Set for insertion and removal of IUDs | 83.3 |
| Set for Gyn. examination | 70.00 |

Source: UNFPA, Ministry of Health Project, End-line Survey Report, *Actual Situation of the Provision and Utilization of RH Care Services in Quang Nam Province*, 2006, pp7, Table 1.

Table 3: Quality of maternal and neonatal care at district hospitals, Ninh Thuan Province

| Type of service | Indicators | Thuan Bac | Ninh Son | Bac Ai |
|------------------------------------|--|-----------|----------|--------|
| Knowledge and skills | ANC contents (9 steps) | X | V | V |
| | Partograph | X | X | V |
| | Active Management of 3 rd stage | X | X | X |
| | Management of severe eclampsia | X | X | X |
| | Newborn resuscitation | X | X | X |
| | Newborn temperature control | X | X | X |
| Maintenance of equipment and drugs | PNC Contents (mother and baby) | X | X | X |
| | Sets in working order | X | X | X |
| Records | Regular supply | X | X | X |
| | Sufficient information | X | X | v |
| Supervision mechanisms | Accurate information | X | X | X |
| | Province to district | X | X | X |
| Universal precautions | District to Commune | V | V | V |
| | Safe disposal of sharp medical waste | X | V | V |
| | Sterilisation of instruments | X | V | X |
| | Hand washing and gloves | X | X | X |

Source: UNFPA/PATH, Rapid Maternal and Neonatal Health Care Needs Assessment in UNFPA Supported Provinces of Viet Nam, November 2006, pp 96

v = available at district hospital;

X = not available at district hospital

9. The directors of the Provincial Health Services in Da Nang, Quang Nam, Quang Ngai, Bing Dinh, Phu Yen and Khan Hoa are all males. At the district level indications are there are higher numbers of female staff in leadership positions.

E. Project Benefits

10. The Project will fully mainstreams gender concerns into its design to ensure that women share proportionately in project benefits. The project will result in the following benefits for women and children:

- (i) Decreased infant mortality and neonatal mortality.
 - (ii) Decreased maternal mortality.
 - (iii) Decreased number of obstetrics complication rates.
 - (iv) Strengthened capacity in managing and implementing programs and policies on reproductive health and family planning.
11. Component One
- (i) Provide the necessary facilities and equipment for 100% of province and district hospitals constructed under this project to provide quality care for deliveries and safe, comprehensive obstetric care to meet National Standards and Guidelines.⁷⁰
12. Component Two
- (i) HR development strategies in place to enhance the capacity of female staff in the management of the system. Increased number of professional female personnel in the management of the Provincial Health Service, by 33%.
 - (ii) Increased % of trained leaders and staff with comprehensive knowledge of gender responsive planning and management of the implementation of reproductive health care programs.
 - (iii) Increased number of female ethnic minority health staff by 10 percent.
 - (iv) Health providers trained so that they can perform comprehensive, essential obstetrics care, in line with National Standards and Guidelines. Training at all levels in RH counseling to meet National Standards and Guidelines. All training activities to include at least 50% female participants.
 - (v) Capacity building for RH Centres in the preventive system to better monitor and supervise maternal and child health activities at all levels.
13. Component Three
- (i) Reduced poor, non-poor gap between pregnant women obtaining pre-natal care.
 - (ii) One trained and fully paid VHW in each remote ethnic minority community. At least 75% of VHWs are female. And 100% VHWs are members of the ethnic minority group in the village.
 - (iii) Increased number of young women, ethnic minority women and male clients, migrant workers, receiving information on reproductive health and family planning by 10 per cent.
 - (iv) Increased proportion of service delivery points providing youth-friendly and culturally appropriate reproductive health counseling services in keeping with National Standards and Guidelines.
14. Component Four
- (i) Gender action plans in place for each of the provinces. Social development and gender specialist services to be recruited for development and support to initial implementation of the gender plans.
 - (ii) Improved HMIS to better meet the health care challenges and needs of women, especially poor women and ethnic minority women.
 - (iii) Increased use of sex-disaggregated baseline data to support planning. Gender-sensitive Medium Term Health Sector Development Plans and Medium Term Expenditure Plans and Frameworks to identify, target and strengthen expenditures on maternal and child health services and other gender equity considerations.

⁷⁰ Ministry of Health, National Standards and Guidelines for Reproductive Health Care Services, 2003.

F. Implementation Mechanisms

15. The gender strategy, including its monitoring and evaluation, is fully incorporated into all project components. Implementation arrangements, including estimated costs for activities and civil works of the gender strategy, are in line with arrangements for the rest of the project.

(i) Social development and gender specialist services to advise in the development and initial implementation of the gender action plan. The social development specialists to also be responsible for training and building capacity of the provincial health officials.

(ii) A senior representative at the PMU level (national and provincial) to be the gender focal point for the project. PIUs to include Viet Nam Women's Union representatives.

(iii) A gender-sensitive monitoring and evaluation plan based on the collection of sex-disaggregated baseline data and gender sensitive, community-based participatory approaches, will be developed for the project.

CONSULTING SERVICES

| Activity | Description | Person months | Total Cost (\$) | Outline TOR |
|----------------------------------|---|---------------|-----------------|---|
| INTERNATIONAL CONSULTANTS | | | | |
| 1 | Architect – hospital design specialist. Asian experience. | 20 | 300,000 | <p>Work with local architects, construction managers, MOH and provincial health authorities to review and update hospital design and construction standards</p> <p>Train and guide work of local architects and construction managers in design and planning for civil works, project management, and supervision</p> |
| 1 | Civil Engineer – hospital engineering design specialist | 4 | 60,000 | <p>Work with architects, construction managers, MOH and provincial health authorities to review and update hospital design, engineering, and construction standards.</p> <p>Train and guide work of local architects, engineers, and construction managers in design and planning for civil works, engineering systems, and preventive maintenance requirements.</p> |
| 1.2 | Medical Equipment Specialist | 12 | 300,000 | <p>Work with MOH and local experts to review and update list of standard medical equipment, especially for district hospitals.</p> <p>Identify newest medical equipment technology with application in Vietnamese environment.</p> <p>Assist local experts to update guidelines and training programs for equipment use and maintenance.</p> |
| 2 | Human Resources Development Specialist/s | 12 | 180,000 | <p>Assist national health authorities in development capacity and readiness for long term HR planning</p> <p>Assist provincial health authorities in developing and implementing annual or biennial HR plans to address key HR issues in target provinces</p> <p>Assist national and provincial health authorities and institutions to improve the quality of training provided by provincial SMS and College</p> <p>Assist national and provincial health authorities and institution to improve the quality and impact of in-service training, with a focus on 8 target provinces</p> |
| 3.1, 3.2 | Public Health Expert -quality of care | 12 | 180,000 | <p>Support national and provincial health authorities to establish standards for treatment at commune and district levels; and to monitor and evaluate the standards through household surveys and patient records</p> <p>Support national and provincial health authorities</p> |

| | | | | |
|---|---|------------|------------------|--|
| | | | | <p>to monitor and evaluate diagnosis and treatment (quality of care) at all health care levels and the referral system at commune, district, and provincial levels for beneficiaries and non-beneficiaries</p> <p>Together with HR specialist and secondary medical schools, support regular needs-based training for commune-level health staff in order to improve quality of care</p> |
| 3.3 | Health Finance – specialist in national health insurance and health equity fund organization and management | 24 | 360,000 | <p>Review provincial processes related to HCFP management, administration, and monitoring</p> <p>Advise PFMBs on improvements in HCFP processes (including information systems)</p> <p>Coordinate household surveys, participatory assessments and special studies related to project interventions and impact of HCFP</p> <p>Advise PFMBs and MOH on policy issues related to HCFP.</p> |
| 4.1, 4.2 | Health Management | 24 | 360,000 | <p>With provincial health department officers, define and assess responsibilities and authorities, organizational structure, and management processes. Help identify opportunities for introducing efficiencies.</p> <p>With managers of provincial and district hospitals, define and assess responsibilities and authorities, organizational structure, and management processes. Help identify opportunities for introducing efficiencies.</p> <p>Assess training needs and develop or adapt skill-based training programs for strengthening managerial capacities.</p> <p>Conduct project management training for provincial and district health managers and for provincial and district project coordinators.</p> <p>Work with national authorities to explore potentials of developing a Masters in Health Services Management. Develop plan of approach.</p> |
| 4.4 | Monitoring and Evaluation expert | 6 | 90,000 | <p>Work with PMU and PPMUs to develop a Project monitoring framework</p> <p>Identify key indicators and sources of data</p> <p>Organize and direct base line surveys</p> <p>Ensure that Project baseline survey data has been collected and a process and indicators for project monitoring and evaluation formulated.</p> |
| Subtotal International Consultants (A) | | 114 | 1,710,000 | |

| NATIONAL CONSULTANTS | | | | |
|-----------------------------|---|-----|---------|---|
| 1 | Architecture and civil works planning specialist | 60 | 180,000 | <p>Coordinate development of upgraded hospital design standards</p> <p>Coordinate development of plans for individual civil works projects</p> <p>Coordinate with construction management to assure conformance with planning documents</p> |
| 1.1 | Construction management specialist 2 persons full time | 120 | 360,000 | <p>Prepare construction bidding documents, in coordination with architect</p> <p>Supervise construction of civil works projects</p> <p>Assure conformance with construction standards</p> |
| 1.2, 4.4 | Equipment and Procurement specialist | 50 | 150,000 | <p>Develop equipment specifications based on provincial requirements and national standards</p> <p>Prepare equipment bidding documents</p> <p>Supervise equipment delivery, installation and inspection</p> |
| 1.3, 2 | Environmental/ Waste Management specialist | 36 | 108,000 | <p>Assist in civil works to incorporate environmental dimensions</p> <p>Develop environmental guidelines for medical waste disposal and supervise development of construction standards</p> <p>Coordinate with construction manager to monitor and supervise construction of waste management systems</p> <p>Coordinate with HR specialist to develop guidelines for training health workers in waste management systems and methodologies</p> <p>Prepare interim and final reports</p> |
| 2 | Human Resources Development specialist | 60 | 180,000 | <p>Assist national and provincial health authorities in developing and implementing human resource plans</p> <p>Support provincial training institutions, Provincial Training Working Groups and District Training Working Groups in activities planned to strengthen the quality, relevance and impact of training in target provinces, including training needs analysis, planning, managing, designing, delivering and evaluating in-service training</p> |
| 3 | Reproductive Health/Maternal and Child Health Expert/ Quality of Care Project Officer | 12 | 36,000 | <p>Assist RH/MCH support to provincial health authorities to monitor and evaluate treatment standards at commune and district levels; and through household surveys and patient records</p> |

| | | | | |
|--------------------|--|-----|---------|--|
| | | | | <p>Assist RH/MCH support to provincial health authorities to identify and design appropriate training resources and materials for doctors, nurses, midwives, including TBAs, technicians, and other clinical health personnel</p> <p>Assist RH/MCH support to provincial training working groups, to develop regular needs-based training for district and commune-level health staff in order to improve quality of care</p> |
| 3 | Social Development specialist | 12 | 36,000 | <p>Provide technical guidance and monitor implementation of ethnic minority development plan, gender strategy, and resettlement plan</p> <p>Develop project indicators and guidelines for implementation of ethnic minority plan and gender strategy</p> <p>Assist Health Finance Experts and contracted NGO in designing and implementing (1) initial participatory assessment related to HCFP, (2) IEC materials and strategies related to HCFP, (3) improved processes for distributing HI cards to beneficiaries, (4) community and beneficiary feedback mechanisms on HCFP, and (5) participatory monitoring of project interventions related to HCFP.</p> |
| 3.3 | Health Finance Expert | 48 | 144,000 | <p>Assist international Health Finance Expert in reviewing provincial processes related to HCFP management, administration, and monitoring</p> <p>Advise PFMBs on improvements in HCFP processes</p> <p>Carry out household surveys, participatory assessments and special studies related to Project interventions and impacts of HCFP</p> <p>Advise PFMBs and MOH on policy issues related to HCFP</p> |
| 3.3, 4.1, 4.2, 4.3 | Management Information Systems specialist 2 full time | 120 | 360,000 | <p>In consultation with Health Finance Experts and PFMBs, design and/or adapt software applications to improve (1) processing of HCFP claims and disbursements, and (2) monitoring of HCFP performance.</p> <p>Design skills-based training in use of HCFP-related software, provide technical support on initial use of software and possible interfaces with other information and health insurance systems.</p> <p>Develop plans for HMIS for provincial health authorities and selected provincial and district hospitals including adapting software applications, hardware, and training</p> <p>Prepare bidding documents for software and hardware</p> <p>Work with HR expert to identify or develop courses for training personnel in MIS and HMIS</p> |

| | | | | |
|--|---------------------------------|------------|------------------|--|
| | | | | Supervise installation of systems and training programs |
| 3.3 | NGO | 48 | 144,000 | In consultation with Health Finance Experts and Social development Experts, assist provincial and local stakeholders in (1) carrying out initial participatory assessments related to HCFP, (2) adapting, testing, and implementing IEC materials and strategies related to HCFP, (3) piloting community and beneficiary feedback mechanisms on HCFP, and (4) participatory monitoring of project interventions related to HCFP. |
| 2, 3, 4 | Short-term National Consultants | 36 | 108,000 | Trainers and technical advisors: - RH specialists - O & G specialists - Hematology lab technician - Equipment preventive maintenance - PHC/ action-oriented training/ VHW networks |
| Subtotal National Consultants (B) | | 602 | 1,806,000 | |
| Subtotal International Consultants (A) | | 114 | 1,710,000 | |
| Total Consulting Services (A+B) | | 716 | 3,516,000 | |
| Note: cost estimates for: International consultants @ \$15,000 per person-month, including travel and per diem National consultants @ \$3,000 per person-month, including travel and per diem for field work Actual costs may vary | | | | |

TECHNICAL ASSISTANCE STRENGTHENING PROVINCIAL HEALTH PLANNING AND BUDGETING

1. The Government gives high priority to the health sector both from the perspective of achieving better health for its people and also for increasing human capital productivity and welfare. Viet Nam's health indicators are better than expected for a country at its level of per capita income, already achieving some of its Viet Nam development goal health targets. The Socio-Economic Development Plan (2006–2010) commits to increasing funding for health care and improving the quality and availability of health services.

2. As per Politburo Resolution (2005), the Government is committed to adjusting the health sector to the changing disease patterns and to the market economy. Driven by strong economic growth, the demand for health services is increasing rapidly and the pattern of disease is changing from predominantly communicable diseases to more non-communicable conditions associated with aging and affluence such as cardio-vascular diseases, cancers and traffic injuries. These types of diseases often require in-patient treatment and expensive medical technology, leading to higher treatment costs and greater financing needs. At the same time, health inequality is increasing with small pockets of vulnerable groups continuing to lack access for affordable, quality care. New and emerging communicable diseases such as severe acute respiratory syndrome (SARS) will need to be managed, and continuing investment is needed to keep traditional communicable diseases under control. These competing demands pose considerable challenges for planning provincial health services, which now rests with provincial governments and lower levels following decentralization.

3. The Ministry of Health's (MOH) 5-year Plan (2006–2010) calls for making access and use of health services more equitable and effective to protect and promote people's health. While the basic network of health services is in place, the health system is inadequately responsive to demand, input driven, hospital focused and lacking in efficiency. For example, in-patient stay is on average longer than in other countries, which is probably related to financial incentives. Similarly, there is a strong tendency to focus investment on civil works and adding in-patient beds, as this increases subsidies. At the same time, provincial plans show less attention for commune level services and staff training, and in general, are not results-oriented. Provincial plans and their budgets including from external aid remain fragmented, decreasing their effectiveness and resulting in high transaction costs. Hence, it is important to strengthen the provincial planning and budgeting process as the basis for improving the performance of the provincial health system and for identifying investment gaps and areas for reform. It is also important that there are strong links between the provinces and national level, so that policy issues can be identified at local level and addressed at national level, and national level has means to strengthen the provincial planning process.

4. One additional reason for wanting to strengthen the provincial planning process is aid coordination. Aid agencies are working towards a national program based approach with a focus on policy dialogue, outcome, and pooled budget support rather than coordination of individual projects. Some pilot efforts for harmonized subsector support are being made in the tuberculosis and safe motherhood programs, as building blocks towards a national sector wide approach for the health sector. It is essential that the provinces develop the capacity for comprehensive planning and budgeting to be able to help plan for, and deliver national reforms and investments.

5. During the project preparatory technical assistance (PPTA) for the Health Care in the South Central Coast Region Project, an initial effort was made to strengthen provincial 5-year

health plans and medium term expenditure frameworks (MTEFs) for eight provinces to provide a more strategic basis for provincial investments and reforms and make plans more results-based.⁷¹ The MTEF was based on provincial health accounts for each province. The draft plans and MTEFs are to guide the annual plans, which are the key investment planning instrument used by MOH. The 5-year plans and MTEF would serve multiple purposes, such as increasing transparency, identifying health system priorities, facilitating expenditure planning and fund raising, improving coordination between levels, and strengthening monitoring and evaluation. It would also facilitate standardization and rationalization within and between provincial health systems. These initial plans and MTEF are highly valued by the MOH as well as the provinces, and considered as building blocks towards national sector wide management. The MOH has recently highlighted the importance of the national MTEF for the health sector at the Health Partnership Group Meeting. Even so, while the plans are illuminating as to the priorities in the provinces, the plans show some weaknesses, as mentioned in para. 3 above, and provincial capacity for planning and budgeting will need to be improved further.

6. The MOH has requested Asian Development Bank (ADB) to consider a TA 'piggy-backed' to the Project for strengthening provincial health planning and budgeting capacity. MOH proposed to develop guidelines and format for comprehensive, results-based provincial 5-year plans and MTEF, piloting and capacity building of the provinces; and in addition, provincial health accounts, to describe all sources and uses of funds being proposed to help prepare plans and MTEF. The capacity of provinces will be strengthened to make plans and MTEF that are essentially comprehensive, pro-poor, outcome focused and sustainable. In coordination with the Health Partnership Group, the provincial health system development plan and MTEF developed under the PPTA and other efforts will be used to develop a model for national application.

C. Impact and Outcome

7. The proposed TA is to foster improved health status and patient satisfaction at provincial level across the country through a more equitable, effective and sustainable provincial health system country-wide.

D. Methodology and Key Activities

8. The output of the TA will be (i) guidelines and format for comprehensive, results-based provincial 5-year plans and MTEF; (ii) development of actual comprehensive results-based provincial health system development plans and MTEFs for the four pilot provinces; and (iii) capacity building for four regions. In addition, collaboration with other key donors will ensure harmonized products for piloting and subsequent implementation. A pilot will be conducted in one province of each of the regions in which ADB is currently working. Relevant health staff involved in planning in pilot provinces will attend workshops to progress the development and piloting of the guidelines, format and MTEF. They will also undertake capacity development activities to ensure they have required the understanding and skills.

9. The piloted guidelines and format for the plans and MTEF will be revised based on the pilot results and from the collaboration with other donors. Training programs will be conducted for the remaining provinces in the four regions so that they gain the skills and knowledge to develop comprehensive plans and MTEF for their province. Consultations will be held with other donors and MOH to encourage implementation across the country but actual implementation is outside of the scope of this TA.

⁷¹ The European Community is also supporting several provinces in planning and budgeting.

10. A key assumption is that other key donors in the health sector are willing to collaborate and adopt a harmonized provincial health system plan and MTEF. Another key assumption is that individual provincial departments of health are willing to adopt this approach and that their staff are willing and able to be trained to use the approach.

E. Cost and Financing

11. The total TA amount will be \$800,000 million equivalent. A development partner will be requested to finance \$650,000 on a grant basis and the Government will contribute the balance of \$150,000.

F. Implementation Arrangements

12. The Executing Agency for the TA will be the MOH. The Department for Planning and Finance of MOH is responsible for implementation with the support of relevant provincial project management units. The project steering committee will provide oversight and the health partnership group will have an advisory role. A suitable MOH senior staff from the Department of Planning and Finance will be appointed as project director (part-time) and deputy project director (part-time), supported by a project coordinator/translator, an accountant, and an administrative assistant. ADB will engage qualified individual consultants to implement the TA. There will be two international experts and two experienced national experts: (i) team leader and project development specialist (international, 8 person-months, intermittent); and (ii) health economist (international, 8 person-months, intermittent); (iii) deputy team leader and public health specialist (national, 12 person-months, full-time); and (iv) financial management specialist (national, 12 person-months, full-time). The consultants will be engaged by ADB in accordance with its *Guidelines on the Use of Consultants*.

13. The TA will be implemented over an estimated 12-month period commencing 01 April 2008 and ending 31 March 2009. The deputy project director and team leader will submit an inception report to MOH and ADB within 1 month of TA inception. This report will include an implementation plan. Within 3 months, a report will be submitted detailing the proposed project plan for piloting, including the proposed guidelines and format for the plans and MTEF. A progress report detailing the results of the pilots will be submitted after 7 months. The proposed plan for the training program will be submitted after 8 months. The draft final report will be submitted after 11 months with the final report after 12 months.

E. Design and Monitoring Framework

| Design Summary | Performance Targets/Indicators | Data Sources/Reporting Mechanisms | Assumptions and Risks |
|---|--|---|--|
| <p>Impact Improved health status and patient satisfaction in targeted provinces; and more equitable, effective, and sustainable provincial health system in targeted provinces</p> | <ul style="list-style-type: none"> Improvement in key health indicators Improvement in key health system performance indicators such as use of services and patient satisfaction | <ul style="list-style-type: none"> MOH service statistics Health surveys Health services surveys | <p>Assumption</p> <ul style="list-style-type: none"> Improved provincial health system contributes to improved health status |

| Design Summary | Performance Targets/Indicators | Data Sources/Reporting Mechanisms | Assumptions and Risks |
|---|--|--|---|
| <p>Outcome Strengthened provincial planning and budgeting capacity</p> | <ul style="list-style-type: none"> • Pilot provinces develop a quality comprehensive, results-based, pro-poor provincial health plan and budget • At least three persons at provincial level understand the core features of the plan and budget • Provincial committee supports the plan | <ul style="list-style-type: none"> • Provincial plans and budget • Review reports by MOH, provinces, partners, experts • Pre-and post tests | <p>Assumptions</p> <ul style="list-style-type: none"> • Improved planning process leads to better service delivery • Other donors support this planning approach and MTEF in the provinces in which they are working <p>Risks</p> <ul style="list-style-type: none"> • Insufficient budget to implement agreed plans • Implementation constraints |
| <p>Outputs Guideline and format for preparing results-based provincial health system development plan and mid-term expenditure framework</p> | <ul style="list-style-type: none"> • Pilot provinces use standard plan and MTEF to undertake their planning | <ul style="list-style-type: none"> • Pilot provinces health system development plans and MTEF | <p>Assumptions</p> <ul style="list-style-type: none"> • Planning approach is adopted • Design is harmonized with other donors <p>Risk</p> <ul style="list-style-type: none"> • Provinces unwilling or unable to adopt planning approach |
| <p>Activities with Milestones</p> <ol style="list-style-type: none"> 1. Review the provincial health plan and the MTEF under the PPTA, and any other examples; and prepare an inception report, month 1. 2. Consult provinces and partners, and revise provincial health system development plan and MTEF prepared, months 2–3. 3. Prepare provincial plans and MTEF using the new instrument in four pilot provinces and train at least three provincial health staff, months 4–6. 4. With MOH and partners, review and revise province pilots, months 7–8. 5. Conduct training in remaining provinces in the four regions, months 9–12. 6. Consult MOH and partners on national implementation and prepare the final report, months 11–12. | | | <p>Inputs</p> <ul style="list-style-type: none"> • ADB: TA management • Government: \$150,000 • Development partner: \$650,000 • EC collaboration • Consultants reports • Workshops, seminars and meetings |

ADB = Asian Development Bank, EC = European Commission, MOH = Ministry of Health, MTEF = medium term expenditure framework, PPTA = project preparatory technical assistance, TA = technical assistance.

F. Cost Estimates and Financing Plan (\$'000)

| Item | Total Cost |
|---|---------------|
| A. Sponsor^a (tbc) | |
| 1. Consultants | |
| a. Remuneration and Per Diem | |
| i. International Consultants | 324.00 |
| ii. National Consultants | 84.00 |
| b. International and Local Travel | 46.00 |
| 2. Training, Seminars, and Conferences | |
| a. Training Program | 20.00 |
| b. Systems development | 40.00 |
| 3. Workshops | |
| a. Workshops | 40.00 |
| b. Systems development | 20.00 |
| 4. Miscellaneous Administration and Support Costs | 20.00 |
| 5. Contingencies | 56.00 |
| Subtotal (A) | 650.00 |
| B. Government | |
| 1. Office Accommodation and Transport | 50.00 |
| 2. Remuneration and Per Diem of Counterpart Staff | 50.00 |
| 3. Others | 50.00 |
| Subtotal (B) | 150.00 |
| Total | 800.00 |

^aAdministered by the Asian Development Bank.

G. OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. International Consultants

1. Team Leader and Project Development Specialist (8 person-months)

1. The team leader and project development specialist will have at least 10 years of experience, including 5 years in Asia; and experience in sector reforms preferably health, and as team leader of projects. The expert will be responsible for overall coordination, implementation, and report preparation of the TA. In coordination with the counterpart of the MOH, the national public health specialist and deputy team leader, the expert will:

- (i) Report to the project director, MOH, and ADB.
- (ii) Manage TA administration and implementation.
- (iii) Guide the consultants, ensure that the TA is implemented according to the terms of reference of the consultants and any subsequent instructions or guidance from MOH and ADB, and be responsible for the collective work of the consultants.

- (iv) Ensure regular liaison with MOH, other ministries, provincial health departments, development partners, and civil society; and coordinate a participatory planning process, including consultations, task forces, field visits, and workshops, to obtain the necessary inputs for project design and ensure government ownership of the Project.
- (v) Prepare a detailed proposal for improving the provincial health system development plan and mid-term expenditure framework and capacity building requirements.
- (vi) Provide training on public health planning and budgeting.
- (vii) Identify and address any legal or social issues arising from the proposed guidelines and format of the plans or MTEFs.
- (viii) Take responsibility for preparing and ensuring on-time submission of formal written reports, including inception report at 1 month, proposed project plan for piloting including the proposed revised guidelines and format for the plans and MTEF at 2 months, a report detailing the results of the pilots at 7 months, proposed plan for the training program at 8 months, draft final report at 11 months and final report at 12 months

2. Health Economist (8 person-months)

2. The health economist will have a health economics background with at least 5 years of experience in this field. The expert will be responsible for examining ways to improve health care financing and spending in the provinces, improving the affordability of care for the poor, producing the medium-term expenditure plans, the ADB financing modality, and undertaking the financial and economic analysis of the Project. The consultant will:

- (i) Report to the team leader, and work as a member of the team and task force.
- (ii) Train the provincial health teams on financial analysis of the health sector.
- (iii) With assistance of the national financial management expert, review sources and uses of funds in the health sector, the fiscal situation of the provinces, and inter- and intra-provincial allocation mechanisms; review and assess policies, plans, and arrangements for financing health services; compare options for improving health care financing and spending; and help prepare a subcomponent for strengthening provincial health financing and spending.
- (iv) Oversee the preparation of the provincial health development plans and MTEFs.
- (v) Guide the national financial management expert in preparing cost estimates and adjustment costs.

B. National Consultants

1. Deputy Team Leader and Public Health Expert (12 person-months)

3. The deputy team leader and public health expert will have at least 10 years of public health experience, including 5 years in project planning. The expert will:

- (i) Report to the team leader, and work as a member of the team and task force.
- (ii) Assist the team leader and project development specialist in managing TA implementation.
- (iii) Arrange and implement liaison with MOH, other ministries, provincial health departments, development partners, and civil society.
- (iv) Assist with the preparation of the provincial health development plans and MTEFs, with guidance of the health economist.

2. Financial Management Expert (12 person-months)

4. The financial management expert will have a degree in business administration or accounting, and at least 5 years experience in the health sector. The expert will be responsible for helping the health economist prepare the medium-term expenditure plan for each province, the cost estimates, and the plan for improving financial management. The expert will:

- (i) Report to the team leader, and work as a member of the team and task force.
- (ii) Train the provincial health staff on financial management.
- (iii) Review the financial management capacity of the provincial health system, based on the *Guidelines for the Financial Governance and Management of Investment Projects*, and propose a project component to strengthen it.
- (iv) Prepare the health system development plans and the medium-term expenditure plan, as well as the annual plan and budget for the first year, with guidance of the health economist.

INDICATIVE LIST OF TRAINING ACTIVITIES

August 30

| Training Course | Number Of Courses | Duration | Participants in each course | Objective/ Outputs | Location | Unit Cost | Person Months (estimate) | |
|--|---|------------------------------|-----------------------------|--|---|--|--------------------------|-------|
| Component 1: Upgrading Hospitals | | | | | | | | |
| 1 | Waste management | 66 courses | 5 days | 25 persons (5 managers and 50 staff from each of 30 hospitals being constructed under Project) | 1650 hospital staff with an understanding of segregation, handling & collection, storage and disposal of waste, including incineration and transport issues | Hospital sites in Province and Districts | \$ 125 / person / course | 412.5 |
| 2 | Infection control | 60 courses | 5 days | 25 persons (20 doctors, 20 nurses, 10 technicians from each of 30 hospitals being constructed under Project) | 1500 hospital staff with increased skills in safe hygiene for health workers, including universal precautions | Hospital sites in Province and Districts | \$ 125 / person / course | 375 |
| 3 | Equipment maintenance | 60 courses | 1 – 5 days | 25 persons (5 doctors, 5 nurses, 7 technicians from each of 89 hospitals in target provinces) | 1500 hospital staff with increased skills in operating equipment, cleaning it, and routine maintenance | Hospitals in Province and Districts | \$ 125 / person / course | 375 |
| 4 | Study tour on hospital facilities & equipment | 1 | 10 days | 5 persons (selected PDOH or Hospital managers and PMU / PPMU officers) | 5 persons with increased understanding of best practice in hospital facilities and equipment | Other countries in the Region | \$4,000 | 2.5 |
| Component 2: Human Resource Development | | | | | | | | |
| 1 | Training on HRMIS | 8 / year Project Years 1 - 5 | 5 days | 10 persons (staff with HR responsibilities in provincial DOH and selected hospitals) | 80 persons trained / retrained to collect, enter, analyze and report HR data consistent with MOH & Gov. | Province s (on-the-job training) | \$125 / person / course | 100 |

| Training Course | Number Of Courses | Duration | Participants in each course | Objective/ Outputs | Location | Unit Cost | Person Months (estimate) | |
|-----------------|--|---|-----------------------------|---|--|-------------------------------------|---------------------------|-------|
| 2 | Masters in Nursing (including prep course) | 16 total Project Years 2 - 4 | 2 years | 1 person (2 senior nurse or midwife from each SMS or College without this qualification) | Up to 16 teachers trained to provide leadership to improve quality of training of nursing & midwifery requirements | University in Viet Nam | \$3,500 / person / course | 192 |
| 3 | Short-course training attachment to University in Viet Nam | 16 / year Project Years 2 - 4 | 2 month | 1 persons (teachers from SMS and College in 8 provinces) | 64 teachers with experience in modern teaching content and methods | Universities in Viet Nam | \$1,600 / person / course | 128 |
| 4 | Orienta-tion course on advisory support | 1 Project Year 1 | 5 days | 30 persons (staff from Universities that will take responsibility for supporting SMS & College) | 30 teachers trained to provide quality support to SMS and Colleges | Ha Noi | \$320/ person / course | 7.5 |
| 5 | Skills training for teachers | 8 / year Project Years 2 - 5 | 1 month | 10 persons (staff from SMS and College) | 320 teachers trained to provide better quality of education | SMS / College (on the job training) | \$400 / person / course | 320 |
| 6 | Training of Master Trainers | 3 Project Year 1 | 5 days x 2 times | 29 persons (senior trainers from hospitals, SMS, Prev. Med. Centers, RH Centers etc) | 85 provincial & district staff trained to provide leadership in training | Selected provinces | \$265/ person / course | 42.5 |
| 7 | Training of District Trainers | 17 / year Project Years 1 & 3 | 5 days x 2 times | 25 persons (staff with training and supervisory responsibilities) | 415 district staff trained to provide SBT in-service training | Provinces | \$265 / person / course | 207.5 |
| 8 | Training of district staff | 13 Year 2 27 Year 3 40 Year 4 - 5 | 2 weeks | 25 staff from district level, selected based on Training Needs Assessment | 3018 district staff trained or retrained to provide improved quality of health care in target provinces | Districts or Provinces | \$265 / person / course | 1509 |

| | Training Course | Number Of Courses | Duration | Participants in each course | Objective/ Outputs | Location | Unit Cost | Person Months (estimate) |
|----|--|--|-----------------|--|--|--------------------------------------|--|---------------------------------|
| 9 | Training of Commune Health Station staff | 18 Year 2 27 Year 3 46 Year 4-5 | 2 weeks | 25 staff from CHS, selected based on Training Needs Assessment | 3435 CHS staff trained or retrained to provide improved quality of health care in target provinces | Districts | \$250 / person / course | 1718 |
| 10 | Training in supportive supervision | 8 Year 2 8 Year 4 | 2 weeks | 25 supervisors (staff from Prov DOH, and selected pilot districts) | 200 supervisors trained and retrained in integrated supervision for quality improvement | Provinces | \$265 / person / course | 200 |
| 11 | Preparatory course for ethnic minority candidates | 32 Year 1 64 Year 2 128 Year 3 - 5 | 1 years | 1 person (nominated by community of remote mountainous Communes in target provinces) | 480 ethnic minority students with skills needed to join in Pre-service training to become health workers) | Provincial Ethnic Minority Schools | \$300 / person / course (Tuition free, scholarship for living costs) | 5760 |
| 12 | Pre-service training | 32 Year 1 64 Year 2 128 Year 3 - 5 | 2 – 3 years | 1 person (nominated by community of remote mountainous Communes in target provinces) | 480 new staff trained to secondary or college level to staff CHS in mountainous areas of target provinces) | Province SMS or College in Da Nang | \$1800 / person / course (Govt pays tuition - (scholarship for living costs) | 14400 |
| 13 | Upgrading training | 40 Year 1 80 Year 2 - 4 | 2 years | 1 person (staff from Province, District or Commune level selected based on priority needs) | 280 staff with upgraded qualifications and skills to provide improved quality of health care | Colleges or Universities in Viet Nam | \$ 3500 / person / course | 6720 |
| 14 | Masters or Specialty 1 st Degree Training | 8 Year 1 24 Year 2 - 4 | 2 years | 1 person (staff from Province, District or Commune level selected based on priority needs) | 80 staff with advanced qualifications and skills to provide improved quality of health care | Universities in Viet Nam | \$3500 / person / course | 1920 |

| | Training Course | Number Of Courses | Duration | Participants in each course | Objective/ Outputs | Location | Unit Cost | Person Months (estimate) |
|--|--|---------------------------|-----------------|---|---|--------------------------------|--------------------------|---------------------------------|
| 15 | Study tour on human resource development | 1 | 10 days | 5 persons (selected PDOH officers and PMU / PPMU officers) | 5 persons with increased understanding of best practice in human resource development | Other countries in the Region | \$4,000 | 2.5 |
| Component 3: Access to Quality Health Care for the Poor | | | | | | | | |
| 1 | Training of new Village Health Workers | 5 / Yr Project Years 2-5 | 3 months | 25 persons selected by their community to become VHW | 504 new VHW to provide basic health services to villages | CHS or District | \$ 750 / person / course | 1512 |
| 2 | Refresher training of Village Health Workers | 13 / Yr Project Years 2-5 | 1 month | 25 VHW from target provinces | 1332 VHW retrained to provide improved quality of basic health services to villages | CHS or District | \$250 / person / course | 1332 |
| 3 | Community-based health promotion, community mobilization | 33 | 5 days | 25 district & commune level HP / CM facilitators (10 from each target District) | 830 staff trained to provide improved health promotion and community mobilization | District | \$ 110 / person / course | 207 |
| 4 | Study tour community based health promotion and community mobilization | 2 | 2 weeks | 8 persons (2 supervisors with HP / CM responsibilities from each target province) | 16 persons with increased understanding and awareness of successful HP / CM strategies used in Viet Nam | Selected provinces in Viet Nam | \$? / person / course | 8 |
| 5 | Ethnic minority language training | 17 | 2 weeks | 25 persons (staff from 425 CHS in remote ethnic minority areas) | 425 staff with increased capacity to communicate effectively with ethnic minority patients / clients | Province | \$ 265 / person / course | 212 |
| 15 | Study tour increasing access to health care for the poor | 1 | 10 days | 5 persons (selected PDOH officers and PMU / PPMU officers) | 5 persons with increased understanding of best practice in provision of health care to | Other countries in the Region | \$4,000 | 2.5 |

| Training Course | Number Of Courses | Duration | Participants in each course | Objective/ Outputs | Location | Unit Cost | Person Months (estimate) | |
|--|--|--|-----------------------------------|---|--|--|---------------------------|------|
| the poor | | | | | | | | |
| Component 4: Strengthening Provincial Health Systems Management | | | | | | | | |
| 1 | Foundation Course to prepare for Masters | 2 / year in Project years 2 - 4 | 6 months | 32 persons (hospital managers from each target province) | 192 managers with capacity to enroll and participate successfully in Masters training | Regional training institution or Province | \$1800 | 1152 |
| 2 | Masters in Hospital Management | 1 in Project Years 3-4 1 in Project Years 4-5 | 2 years | 32 persons (8 hospital managers from each target province) | 64 managers with increased capacity to effectively manage health services | Viet Nam Uni. in collaboration with international Uni. | \$ 10000 | 1536 |
| 3 | Management & leadership | 2 | 8 weeks (part-time over 8 months) | 25 persons (6 health officers from DOH in each target province) | 48 managers with increased skills in leadership, team building, decision making, communication, project management, monitoring & supervision | Province | \$ 1200 / person / course | 96 |
| 4 | Financial management | 2 | 2 weeks | 25 persons (6 health officers with financial responsibilities from DOH in each target province) | 48 managers with increased skills in budgeting, cost finding and pricing policy | Province | \$ 265 / person / course | 24 |
| 5 | Management Information Systems | 2 | 2 weeks (part time over 2 months) | 25 persons (6 health officers from DOH in each target province) | 48 managers with increased skills in use and application of MIS in health service management | Province | \$ 265 / person / course | 24 |
| 6 | Management & leadership | 8 | 8 weeks (part-time over 8 months) | 25 persons (2 hospital managers from each of 89 hospitals in target provinces) | 182 hospital managers with increased skills in leadership, team building, decision making, communication, project management, | Province | \$ 1200/ person / course | 364 |

| Training Course | Number Of Courses | Duration | Participants in each course | Objective/ Outputs | Location | Unit Cost | Person Months (estimate) | |
|-----------------|--|----------|-----------------------------------|--|---|-------------------------------|--------------------------|-----|
| | | | | monitoring & supervision | | | | |
| 7 | Financial management | 8 | 2 weeks | 25 persons (2 hospital managers with financial responsibilities from each of 89 hospitals in target provinces) | 182 hospital managers with increased skills in budgeting, cost finding and pricing policy | Province | \$ 265 / person / course | 364 |
| 8 | Quality management | 8 | 2 weeks | 25 persons (2 hospital managers from each of 89 hospitals in target provinces) | 182 hospital managers with increased skills in quality management in hospital services | Province | \$ 265 / person / course | 91 |
| 9 | Hospital Management Information Systems for Managers | 8 | 2 weeks (part time over 2 months) | 25 persons (2 hospital managers from each of 89 hospitals in target provinces) | 182 hospital managers with increased skills in use and application of HMIS in hospital management | Province | \$ 265 / person / course | 91 |
| 10 | Hospital Management Information Systems operations | 32 | 5 days | 25 persons (8 clerical and technical workers from each of 89 hospitals in target provinces) | 712 clerical staff with increased skills in HMIS operations including data entry and report preparation | Province | \$ 125 / person / course | 178 |
| 11 | Research methods using existing data | 2 | 2 weeks (2 sessions of 1 week) | 24 (6 managers from each target province) | 48 managers with skills in analysis and reporting of data for use in quality improvement of health services | Province | \$265 / person / course | 24 |
| 15 | Study tour on health systems management | 1 | 10 days | 5 persons (selected PDOH officers and PMU / PPMU officers) | 5 persons with increased understanding of best practice in health systems management | Other countries in the Region | \$4,000 | 2.5 |

| | Training Course | Number Of Courses | Duration | Participants in each course | Objective/ Outputs | Location | Unit Cost | Person Months (estimate) |
|---------------------------|---|--------------------------|-----------------|---|---|-----------------|--------------------------|---------------------------------|
| Project Management | | | | | | | | |
| 1 | Procurement | 1 | 2 weeks | 22 persons (6 PMU staff and 2 PPMU staff from each target province) | 22 persons with increased skills in ADB procurement process | Ha Noi | \$ 485 / person / course | 11 |
| 2 | Monitoring for results | 1 | 2 weeks | 22 persons (6 PMU staff and 2 PPMU staff from each target province) | 22 persons with increased skills in using performance indicators, monitoring inputs, outputs and outcomes, and evaluation | Ha Noi | \$ 485 / person / course | 11 |
| 3 | International procurement, financial management, and project implementation | 1 | 2 weeks | 20 persons (MOH officers and PMU / PPMU staff) | 20 persons with increased skills in international procurement of equipment, civil works and disbursement procedures, | Ha Noi | \$1000 | 10 |

CIVIL WORKS AND EQUIPMENT

August 15, 2007

| Priority | Name of Facility | Description | Site and Resettlement | Civil Works (USD) | Safe Water & Waste (USD) | Equipment (USD) |
|--|---|--|--|--------------------------------------|--------------------------|------------------|
| DA NANG CITY: | | | | | | |
| 01 | Hoa Vang District Hospital | New construction & Equipment | X 7 vacant storage units owned by RX company | 1,920,000 | 168,000 | 1,870,000 |
| Total Da Nang: | | | | 1,920,000 | 168,000 | 1,870,000 |
| Component One Allocation: \$ 4,353,000 | | | | Total Comp. One: \$ 3,958,000 | | |
| QUANG NAM PROVINCE: | | | | | | |
| 01 | Bac Tra My District Hospital | Upgrading and Expansion & Equipment | | 1,208,000 | 168,000 | 623,000 |
| 02 | Quang Nam Provincial Hospital | Equipment only | | | | 623,000 |
| 03 | Quang Nam Regional Hospital | Upgrading and Expansion & Equipment | | 3,645,000 | 246,000 | 623,000 |
| 05 | Tay Giang District Hospital | | | | | 312,000 |
| 06 | Nam Tra My District Hospital | | | | | 312,000 |
| Total Quang Nam: | | | | 4,853,000 | 414,000 | 2,493,000 |
| Component One Allocation: \$ 7,905,000 | | | | Total Comp. One: \$ 7,760,000 | | |
| QUANG NGAI PROVINCE | | | | | | |
| 01 | Ba To District Hospital | New Construction (replacement) & Equipment | X | 654,000 | 168,000 | 125,000 |
| 02 | Son Tay District Hospital | Upgrading & Expansion & Equipment | Old Site + Acquire adjacent agricultural land | 546,000 | 168,000 | 125,000 |
| 03 | Tay Tra District Hospital | New Construction & Equipment | | 820,000 | 137,000 | 125,000 |
| 04 | Tra Bong District Hospital | New Construction (replacement) & Equipment | | 1,038,000 | 137,000 | 125,000 |
| 05 | Quang Ngai Provincial Hospital | Equipment for new building | | | | 1,246,000 |
| 06 | HIV/AIDS Preventive Health Center | | | 278,000 | | 374,000 |
| 07 | Drug Quality Control Preventive Health Center | | | 278,000 | | 93,000 |
| 08 | 9 District Hospitals | Equipment | | | | 623,000 |
| Total Quang Ngai: | | | | 3,614,000 | 610,000 | 2,836,000 |
| Component One Allocation: 7,124,000 | | | | Total Comp. One: \$ 7,061,000 | | |

| BINH DINH PROVINCE: | | | | | | |
|--|--|-----------------------------------|---|--------------------------------------|----------------|------------------|
| 01 | Binh Dinh Provincial Hospital | Upgrading & Equipment | | 2,592,000 | 137,000 | 1,870,000 |
| 02 | Phu Cat District Hospital | Upgrading & Equipment | | 249,000 | 125,000 | 125,000 |
| 03 | Phu My District Hospital | Upgrading & Equipment | | 723,000 | 168,000 | 125,000 |
| 04 | An Lao District Hospital | Upgrading & Equipment | | 62,000 | | 62,000 |
| 05 | Van Canh District Hospital | Upgrading & Equipment | | 62,000 | | 62,000 |
| 06 | Vinh Thanh District Hospital | Upgrading & Equipment | | 62,000 | | 62,000 |
| 07 | Tuberculosis Regional Hospital | Upgrading | | 62,000 | | |
| 08 | Regional Mental Hospital | Upgrading | | 62,000 | | |
| 09 | Bang Son District Hospital | Equipment | | | | 249,000 |
| 10 | Quy Nhon City District Hospital | Equipment | | | | 125,000 |
| 11 | Tuy Phuoc District Hospital | Equipment | | | | 125,000 |
| 12 | An Nhon District Hospital | Equipment | | | | 125,000 |
| 13 | Hoai Nhon District Hospital | Equipment | | | | 93,000 |
| 14 | Hoai An District Hospital | Equipment | | | | 93,000 |
| 15 | Tay Son District Hospital | Equipment | | | | 312,000 |
| Total Binh Dinh: | | | | 3,874,000 | 430,000 | 3,428,000 |
| Component One Allocation: \$ 7,752,000 | | | | Total Comp. One: \$ 7,733,000 | | |
| PHU YEN PROVINCE: | | | | | | |
| 01 | Tuy An Regional Hospital | New Construction & Equipment | X 2 houses (vacant) | 2,843,000 | 168,000 | 810,000 |
| 02 | Tuy Hoa District Hospital | Upgrading & Expansion & Equipment | Old Site + Acquire adjacent agricultural land (5,120 m2) | 1,280,000 | 168,000 | 224,000 |
| Total Phu Yen: | | | | 4,123,000 | 336,000 | 1,034,000 |
| Component One Allocation: \$ 5,055,000 | | | | Total Comp. One: \$ 5,493,000 | | |
| KHANH HOA PROVINCE: | | | | | | |
| 02 | Ninh Diem District Hospital | New Construction & Equipment | X | 990,000 | 137,000 | 374,000 |
| 03 | Van Ninh District Hospital | Upgrading & Expansion | | 1,261,000 | 168,000 | |
| 04 | Dien Khanh District Hospital | Upgrading & Expansion | Old Site + Acquire adjacent agricultural land | 1,417,000 | 75,000 | |

| | | | | | | |
|--|------------------------------------|------------------------------|-------------------------------|--------------------------------------|-------------------------------------|------------------------|
| | | | (2 ha) | | | |
| Total Khanh Hoa: | | | | 3,668,000 | 380,000 | 374,000 |
| Component One Allocation: \$ 5,521,000 | | | | Total Comp. One: \$ 4,422,000 | | |
| NINH THUAN PROVINCE: | | | | | | |
| 01 | Thuan Bac District Hospital | New Construction & Equipment | X Agricultural land | 997,000 | 168,000 | 1,246,000 |
| 02 | Ninh Hai District Hospital | New Construction & Equipment | X Agricultural land | 997,000 | 168,000 | 1,246,000 |
| Total Ninh Thuan: | | | | 1,994,000 | 336,000 | 2,492,000 |
| Component One Allocation: \$ 4,449,000 | | | | Total Comp. One: \$ 4,822,000 | | |
| BINH THUAN PROVINCE: | | | | | | |
| 01 | Binh Tuanh Provincial | Equipment only | | | | 1,863,000 |
| 02 | Bac Binh District | Upgrading & Expansion | | 3,310,000 | 247,000 | 405,000 |
| Total Binh Thuan: | | | | 3,310,000 | 247,000 | 2,268,000 |
| Component One Allocation: \$ 5,842,000 | | | | Total Comp. One: \$ 5,825,000 | | |
| SUMMARY | | | | | | |
| | | Number of Facilities | Site and Resettle-ment | Civil Works (USD) | Safe Water & Waste (USD) | Equipment (USD) |
| | Civil Works: | | | | | |
| | District Hospitals | 18 | 8 | 17,596,000 | 2,370,000 | |
| | Regional or Other Hospitals | 6 | 1 | 7,168,000 | 414,000 | |
| | Commune Health Station | 0 | | | | |
| | Provincial Hospitals | 1 | | 2,592,000 | 137,000 | |
| | Total: | 25 | | 27,356,000 | 2,921,000 | |
| | Equipment: | | | | | |
| | District Hospitals | 36 | | | | 9,916,000 |
| | Regional or Other Hospitals | 4 | | | | 1,900,000 |
| | Provincial Hospitals | 4 | | | | 5,602,000 |
| | Total: | 44 | | | | 17,418,000 |
| | | | | 27,356,000 | 2,921,000 | 17,418,000 |
| Total Component One Allocation: USD 48,000,000 | | | | \$ 47,695,000 | | |

INDICATIVE LIST OF MAJOR EQUIPMENT

Medical Equipment Standards for District Hospitals

| | | | |
|----------|---|----------|--|
| 1 | Polyclinic and General Treatment | 41 | Ultrasonic Nebulizer |
| 1 | Electric suction pump | 42 | Neuromuscular stimulator |
| 2 | Oxygen concentrator | 43 | Exercise bicycle |
| 3 | Nebulizer | 44 | Infrared lamp for therapy |
| 4 | Electric low pressure continuous suction pump | 45 | Pulse oxymeter |
| 5 | Portable pulse oxymeter | 46 | Electrocardiograph (ECG) 3 channel |
| 6 | Portable ventilator | 4 | Pediatrics |
| 7 | Oxygen Regulator humidifier | 47 | Infant incubator |
| 8 | Oxygen cylinder + Manometer + Regulator | 48 | Ventlator for children |
| 9 | Examining lamp | 49 | Phototherapy lamp for jaundice |
| 10 | Examination instrument set | 5 | General Surgery – Operating Room |
| 11 | Sphygmomanometer for adult and child | 50 | Electro surgical unit |
| 12 | Head light with mirror | 51 | Bone drill. Electric driven |
| 13 | Weighing scale 120kg with measuring rod | 52 | Mobile operating light 60,000-80,000 lux |
| 14 | Minor operating instrument set | 53 | Ceiling operating light 180,000-200,000 lux with satellite |
| 15 | Endotracheal instrument set | 54 | Anesthesia apparatus with ventilator |
| 16 | X ray film illuminator, 2 film 30x40cm | 55 | Universal operating table |
| 17 | Ultraviolet lamp for sterilization | 56 | Bone cutter, electric type |
| 18 | Resuscitation bag for adult | 57 | Surgical suction pump |
| 19 | Resuscitation bag for child | 58 | Surgical scrub station for two persons |
| 20 | Patient bed | 59 | Air disinfection apparatus |
| 2 | Emergency Intensive Care | 60 | Major operating instrument set |
| 21 | Infusion pump | 61 | Medium operating instrument set |
| 22 | Electric syringe pump | 62 | Venotomy surgery instrument set |
| 23 | Defibrillator | 63 | Uterine surgical instrument set |
| 24 | Ventilator | 64 | Thyroid surgical instrument set |
| 25 | Patient monitor | 65 | Gastrectomy surgical instrument set |
| 26 | Ultraviolet lamp for sterilization, mobile type | 66 | Obstetrical surgical instrument set |
| 27 | Emergency bed | 67 | Gynecology surgical instrument set |
| 28 | Laryngoscope | 68 | Delivery surgical instrument set |
| 29 | Tracheotomy Surgical instrument set | 69 | Vasectomy kit |
| 3 | General Medicine | 70 | Tubectomy kit |
| 30 | Rectofiberscope with light source | 6 | Obstetrics and Gynecology |
| 31 | Bronchofiberscope with light source | 71 | Obstetrical monitor |
| 32 | Gastrofiberscope with light source | 72 | Delivery table |
| 33 | Microwave therapy apparatus | 73 | Baby scale |
| 34 | Acupuncture apparatus | 74 | Doppler foetus apparatus |
| 35 | Laser Acupuncture apparatus | 75 | Menstrual regulation pump |
| 36 | Shortwave therapy apparatus | 76 | IUD insertion set |
| 37 | Laser therapy apparatus | 77 | Gynecological examination table |
| 38 | Electro magnetic therapy apparatus | 78 | Colposcope |
| 39 | Low frequency therapy apparatus | | |
| 40 | Ultrasonic therapy apparatus | | |

Ministry of Health, *Medical Equipment Database*, Department of Medical Equipment and Construction and Vietnam-Sweden Health Cooperation, Medical Publishing House, Hanoi 2006.

| | | | |
|----------|---|----------|---|
| 7 | E.N.T. Stomatology, Maxillo faces, and Ophthalmology | 121 | Blood gas analyzer |
| 79 | Audiometer | 122 | Electrolyte analyzer |
| 80 | E.N.T. treatment unit and chair | 123 | Automatic biochemistry analyzer |
| 81 | E.N.T. examination – treatment instrument set | 124 | Semi automatic biochemistry analyzer |
| 82 | Oesophageal foreign body removal instrument set | 125 | Automatic urin analyzer 10 parameter |
| 83 | Tracheotomy diagnostic set hand type | 126 | Binocular microscope |
| 84 | Ear and Nose diagnostic set hand type | 127 | Stereo microscope |
| 85 | Surgical instrument set for tonsil removing | 128 | Fluorescent microscope |
| 86 | Dental chair unit | 129 | Spectrophotometer |
| 87 | Dental scaler | 130 | Photometer |
| 88 | Curing light lamp | 131 | pH meter |
| 89 | Dental drill (hand type) | 132 | Electrophoresis apparatus |
| 90 | Dental extraction forceps for adult | 133 | Denisiometer |
| 91 | Dental extraction forceps for children | 134 | CO ² Incibator |
| 92 | Dental treatment instrument set | 135 | Bacteria culture cabinet |
| 93 | E.N.T. and eye examination instrument set | 136 | Technical balance 0.1 gr |
| 94 | Sight tester | 137 | Analytical balance 0.1 mg |
| 95 | Ophthalmoscope hand type | 138 | Roberval balance 1.0 gr |
| 96 | Tonometer hand type | 139 | Magnetic stirrer |
| 97 | Visual acuity chart | 140 | Electric shaker |
| 98 | Color blindness vision test chart | 141 | Shaker-Vortex mixer |
| 99 | Ophthalmic examining instrument set | 142 | Electric shaker-rotator |
| 100 | Ophthalmic examining lamp, hammer type | 143 | Auto-Pipette different sizes (P10, P20, P200, P1000) ul |
| 101 | Skiascope set | 144 | Diluting apparatus |
| 102 | Retinoscope | 145 | Osmometer |
| 103 | Trial box with pinhole and frame | 146 | Incubator |
| 104 | Chalazion instrument set | 147 | Water bi-Distilling apparatus |
| 105 | Enucleation instrument set | 148 | Water Distilling apparatus 10 l/h |
| 106 | Extracapsular cataract extraction set | 149 | Water bath |
| 107 | Eye lid surgical instrument set | 150 | Oil bath |
| 108 | Electric oven 250 ^o C 50L | 151 | Medical refrigerator |
| 109 | Flash Autoclave type 20L | 152 | Ultrasonic instrument cleaner 20 litres |
| 8 | Laboratory | 153 | Autoclave 50 litres |
| 110 | Biological safety cabinet | 9 | Diagnostic Imaging |
| 111 | Multi-function centrifuge | 154 | Mobile X-ray Apparatus |
| 112 | Hematology centrifuge for test-tube | 155 | X-ray radiographic system 300mA |
| 113 | Hematology centrifuge, 24 capillaries | 156 | B/W Ultrasound Scanner – portable |
| 114 | Blood coagulation apparatus | 157 | B/W Ultrasound Scanner |
| 115 | Hb meter | 158 | Automatic X-ray film processing machine |
| 116 | Automatic blood cell analyzer 18 parameters | 159 | Red lamp for dark room |
| 117 | Colony counter | 160 | Lead apron |
| 118 | Blood bag mixer and scale | 161 | X-ray film dryer |
| 119 | Platelet agitator | 162 | X-ray film Cassette with intensifying screen, different sizes |
| 120 | Blood storage refrigerator | 163 | Film processor tank |

| | | | |
|-----------|---|-----------|--|
| 10 | Pathology | 13 | General Equipment for Various Departments |
| 164 | Microtome | 186 | Electric oven 250°C 150 L |
| 165 | Mortuary refrigerator | 187 | Disinfectant instrument – boiling type |
| 166 | Microscope with camera | 188 | Wheel stretcher |
| 167 | Paraffin dispenser | 189 | Medicament carriage |
| 168 | Paraffin oven | 190 | Syringe destruction apparatus |
| 169 | Slide warmer | 191 | Medicament cabinet |
| 170 | Dryer for rack of slides | 192 | Oxygen cylinder trolley |
| 171 | Microtome knife sharpener | 193 | Laundry trolley |
| 11 | Infection Control | 194 | Instrument carriage |
| 172 | Sealing apparatus for plastic bags | 195 | Weighing scale 120 kg |
| 173 | Autoclave 250 litres | 196 | Patient wheel chair |
| 174 | Washing machine 30 kg | 197 | Bedside cabinet |
| 175 | Ultrasonic instrument cleaner 40 litres | 14 | General Equipment and Standby |
| 176 | Electric oven 250°C 250 L | 198 | Waste hand material incinerator |
| 177 | Autoclave 20 litres | 199 | Standby generator |
| 178 | Autoclave 75 litres | 200 | Ambulance |
| 12 | Pharmacy | | |
| 179 | Water Distilling apparatus 20 l/h | | |
| 180 | Analytical balance 300 gr / 0.1 mg | | |
| 181 | Digital scale 500 gr | | |
| 182 | Digital scale 4000 gr | | |
| 183 | Digital scale 8000 gr | | |
| 184 | Refractometer | | |
| 185 | Whirl and mixer | | |
| | | | |

NON-MEDICAL EQUIPMENT AND MATERIALS

| Component | Description | Number | Unit Cost | Total Cost |
|------------|---|---|-----------|------------|
| 1.3 | Waste Management | | | |
| | Waste containers - contaminated | | | |
| | Waste containers - sharps | | | |
| | Plastic bags – color coded | | | |
| | Waste collection/holding bins | | | |
| | | | | |
| 2.2 | Strengthening Training Capacity | | | |
| | Vehicles: for transport of trainers to training sites | | | |
| | Computer: for teaching modules | | | |
| | Software: Teaching Modules | | | |
| | Software: PowerPoint | | | |
| | Overhead Projector - portable | | | |
| | Overhead projector – bench top | | | |
| | Video player | | | |
| | Camera – SLR | | | |
| | Television | | | |
| | Video camera | | | |
| | Slide projector | | | |
| | OHP Screen | | | |
| | Photocopier | | | |
| | Felt board | | | |
| | Demonstration models: | | | |
| | Midwifery model | | | |
| | Delivery mechanism model | | | |
| | Post partum placental model | | | |
| | Female pelvic model | | | |
| | Newborn asphyxiation, resuscitation model | | | |
| | Fetus inside uterus | | | |
| | Gynecological exam model | | | |
| | CPR rehabilitation | | | |
| | Emergency resuscitation (computerized) | | | |
| | Power stabilizer | | | |
| | Computer/Theater Projector | | | |
| | Laptop computer | | | |
| | Printed materials: Instructor and Student materials | | | |
| | Flip-charts, paper pads, marker pens | | | |
| | Teaching Supplies | | | |
| | | | | |
| 3.2 | Poor and Ethnic Minority Communities | | | |
| | Drug kits | | | |
| | Bicycles: for local out-reach activities | | | |
| | Motor bikes | | | |
| | IEC Materials | | | |
| | | | | |
| 3.4 | Health Care Funds for the Poor | | | |
| | Software for HCFP beneficiary database: Computerize DoLISA lists of Decision 139 beneficiaries, reduce errors, speed process of issuing HI cards, and facilitate replacement of lost and defective cards | 1 common template 8 provincial systems | | |
| | Software for HCFP claims processing: Standardize and streamline systems for | 1 common template | | |

| | | | | |
|------------|--|---|--|--|
| | processing HCFP claims and disbursements | 8 provincial systems | | |
| | Software for HCFP monitoring: Establish supplemental information system for DOH to regularly collect data on HCFP performance (building on system being piloted in HICH Project) | 1 common template 8 provincial systems | | |
| | Computers: DOH (Finance Department) to run HCFP monitoring system and access HCFP data base and claims processing systems | 8 | | |
| | Computers: DoLISA (HCFP Department) to Manage HCFP beneficiary data base | 8 | | |
| | Computers: PSS (HCFP Department) to run HCFP claims processing system | 8 | | |
| | Computers: Provincial Hospitals to run HCFP claims processing system | 8 | | |
| | Computers: District Hospitals to run HCFP claims processing system | 32 | | |
| | | | | |
| 4.3 | Health Management Information Systems | | | |
| | Software: Hospital systems software adapted from systems designed under UNFPA project in Viet Nam | | | |
| | Computers: for management access and various clerical input stations. | | | |
| | | | | |
| 4.4 | Project Management Unit | | | |
| | Office furniture | | | |
| | Software | | | |
| | Computers | | | |
| | Printers | | | |
| | Copy machines | | | |
| | Vehicle | 1 | | |
| | | | | |
| 4.4 | Provincial Project Management Units | | | |
| | Office furniture | | | |
| | Software | | | |
| | Computers | | | |
| | Printers | | | |
| | Copy machines | | | |
| | Vehicles | 8 | | |
| | | | | |

FINANCIAL MANAGEMENT ASSESSMENT

A. Organization

1. The Project Executing Agency, the Ministry of Health, has implemented many large projects for multiple donors, including 5 projects with ADB over a period of 11 years. The Project Management Unit (PMU) of the Department of Planning and Finance will be responsible for financial management of the health system development project. It is currently doing the same for many other projects and has gained substantial experience in financial management while functioning as the Project Management Office for the ADB Rural Health Project. The EA is reporting to the Vice Minister and the Minister of Health. This structure is considered appropriate for the Project which has a major emphasis on procurement of civil works and equipment.

3. The financial unit will be staffed with former staff of the PMU of the Rural Health Project including a Project Director, a Deputy Director, and 2 full time accountants. The existing account staff of the PHM of the RHP are trained and experienced. For the new project, staff will be carried over from the PMU of the RHP. Staff turnover is low. Provincial PMU staff will be trained by the PMU for 2 weeks prior to project implementation. .

5. The provincial plans are based on five year plan and medium-term expenditure frameworks and reflect the priorities and commitment of the provinces. Detailed annual plans and budgets are prepared for all activities and approved by the province, MOH and ADB, and monitored and compared on quarterly basis. Approval for budget variations is requested in advance. All assets purchased under the project are registered with a code number. Physical inventories are checked regularly. A system of weighted physical progress monitoring will be put in place but this is not only linked to financial data as non-financial matters are also included. The financial management system will be completely computerized and training will be provided to support this.

B. Accounting

4. A specific project accounting system has been developed for ADB projects with appropriate chart of accounts, and which is accepted by the Department of Accounting, of the Ministry of Finance. A procedure manual for financial management is available for the PMU and will be updated for the new project. Transactions are prepared by PMU and approved by PMU for minor transactions and through concerned authorities within MOH for major transactions, as per Decree 131. Cost allocations to the various funding sources have been done accurately and in accordance with established agreements. The general ledger and subsidiary ledgers are regularly reconciled and in balance. All accounting and supporting documents are retained on a permanent basis in a defined system that allows authorized users easy access. The various accounts functions are appropriately segregated.

2. In terms of fund flow arrangements, MOH opens an imprest account at a commercial bank, to be operated in accordance with ADB procedures and replenished by ADB using SOE. The initial deposit in the imprest account is \$4 million. Part of this imprest will be used to open an SGIA with an initial advance of \$250,000 in each of the 8 provinces. Project funds from the Government are directly paid by the National treasury. The fund flow arrangement is in figure 1. These arrangements have worked satisfactorily in previous projects. The only major problem in fund flow has been the time it takes to process WAs. It takes about two months from the

preparation of the WA to the replenishment of the imprest account, which may result in cash flow problems.

6. Invoice-processing procedures are done correctly. Before payment, FU is provided with (i) invoice, (ii) purchase order and (iii) delivery slip approved by procurement unit, and FU checks appropriateness of the purchase and accuracy of calculation. The PMU maintains an adequate, up-to-date cashbook, recording receipts and payments. Controls exist for the collection, timely deposit and recording of receipts at each collection location. Bank and cash reconciled on a monthly basis.

C. Internal Control and Audit

7. Financial statements are prepared on an annual and quarterly basis in accordance with, respectively, international and project-specific standards. Internal audit is done by the Department of Inspection in MOH has limited capacity. The accounting firm recruited under the PMU is carrying out internal audits by staff other than the accountants. Audit reports prepared by the firm are submitted to the Project Director, with copy to the Provincial Director for provincial expenditures.

8. There is no entity auditor. The State Audit Office of the Prime Minister's Office performs the external audit of project accounts. With the assistance of ADB, SAO is building its capacity towards being able to perform audits in accordance with international auditing standards. Audit is done according to generally accepted auditing standards in Viet Nam but not necessarily international audit standards. Audit is sometimes delayed due to capacity constraints, and the scattered nature of health projects, requiring auditors to visit a sample of provinces to assess the financial management. The ADB standard of a 6 months audit completion period is considered manageable with good cooperation of the SAO. There are no major audit issues. There were some problems with the competency of provincial staff in managing accounts properly. This will be further addressed with additional training and supervision.

D. Conclusion

Viet NAM has improved its performance in financial management and is moving towards international accounting and auditing standards. The EA has been using an accounting system acceptable to the Ministry of Finance for which detailed guidelines are available. To ensure adequate accounting capacity at the onset of the Project, the PMU of the Rural Health Project is expected to continue implementing this Project, the accountants working with previous project will be rehired, and PMU and provincial staff will be provided training. The EA has been implementing 5 ADB projects successfully and its financial management capacity is considered satisfactory.

ECONOMIC AND FINANCIAL SUSTAINABILITY ANALYSIS

A. Project Objectives

The objective of the Project is to improve the health status of the poor, women, children, ethnic minorities, and other vulnerable groups, and strengthen health systems in eight provinces in Viet Nam's South Central Coast Region. The Project has four components: (i) upgrading district and provincial hospitals, (ii) strengthening human resources, (iii) improving access and quality of health care for the poor, and (iv) strengthening health systems management.

B. Project Beneficiaries

As a result of investment in hospitals, health systems and human resources, the Project will improve access to quality health services for 8.8 million people living in the South Central Coast Region, thereby directly or indirectly improving their health status.

The Project will target 2.1 million women in the reproductive age group, 537,000 ethnic minorities, 1.3 million poor people, 1 million children under five, and 870,000 elderly. Health status amongst these groups has been improving across much of Vietnam. For example, infant mortality has halved over the last twenty years. The percentage of low-weight newborns has decreased, 97.8 percent of children are fully immunized and malnutrition among under fives has dropped to 25.2 percent in 2005

Despite country-wide improvements, the health status of those who live in rural areas, especially ethnic minorities, has not progressed as rapidly. Infant mortality in rural areas is twice that observed in urban areas. Differences are greater for ethnic minorities. The numbers of days of lost work due to illness are also higher in rural areas. For example, in 2004, a national average of 16 days were lost for those that were ill across all of Vietnam, whereas 16.4 days were lost in the south central coast region. Average productivity losses were even greater in the north central coast, where an average of 23.5 days were lost per year amongst those experiencing illness (GSO, 2006).

Investments in improved health services and infrastructure are likely to generate considerable national economic benefits. Project interventions have been designed to specifically address vulnerable groups in the south central coast through capacity development, improving access to health facilities, and providing equipment and drugs in areas of priority need. By improving access and quality of care, the productivity losses costs associated with illness will be reduced.

C. Rationale for Investment

The proposal involves an investment of the equivalent of \$80 million, eighty percent being financed from an ADB loan. Current investment in the health system is inadequate. The national medium-term health sector expenditure submission (Ministry of Health, 2005) points out that government budget is deficient to achieve health and development targets. Policy reforms are required to increase health's share of overall public expenditure, appropriate hospital fees need to be determined and health insurance premiums need to be set, so as to increase revenues for health institutions. In conjunction with these reforms, external assistance is required to help meet financing targets for the health sector. The private market undersupplies health information and products due to incomplete information about the benefits of investments in health; economies of information; externalities in some markets and differences between

private and social discount rates, leading to private decisions that do not adequately reflect long-term benefits¹.

D. Cost-Benefit Analysis

The quantitative cost-benefit analysis for the Project follows the methodologies outlined in *ADB's Guidelines for the Economic Analysis of Projects*.² Key assumptions include:

- **Discount rate.** The economic opportunity cost of capital was assumed to be 12%.
- **Projection of Project Benefits and Costs.** The period of analysis covers 20 years and benefits and costs are converted into constant 2007 dollar prices.
- **Economic cost of labor.** The opportunity cost of labor or the shadow wage rate (SWR) for both urban and rural adults was calculated using monthly per capita income data from the Vietnam Living Standards Survey.

E. Economic Costs

Base investment costs are in constant 2007 dollar prices. Taxes and duties account for a small proportion of the project costs. Incremental recurrent costs are calculated for the 20 years following the five-year project implementation period.

F. Economic Benefits

Economic benefits may flow from reduced health care costs, or through gains in labor productivity as a result of decreased incidence and severity of illness. In the case of cost savings, out-of-pocket savings may flow from (i) increased access to health services to reduce transport costs; and (ii) more efficient and rational diagnosis and treatment to reduce cost of treatment. Bloom and Choynowski (2003) found that a considerable percentage of economic benefits from health sector reform projects, such as the introduction of contracting-out, were generated from efficiencies generated in service provision and the consequent cost reduction for those using services.

Adults often have to care for sick children, or they themselves may fall ill and suffer reduced work productivity and foregone income through premature death. The costs associated with decreased labor productivity have received considerable attention in health economics literature, and days lost to illness have been estimated as part of Vietnam living standard surveys (GSO, 2006). As previously mentioned it was found that an average of 16.4 days were lost in the year proceeding the 2004 living standards survey among ill residents of the south central coast region.

The percentage of people suffering an average of 16.4 days illness per year, is estimated to be 25%³ of all residents – generating an average loss of 4.1 days of work per person per year in the region. The value of these days of lost labor are calculated for each of the eight provinces

¹ Knowles, J. (2003) "Health Nutrition and Infectious disease and Economic Growth in Cambodia," Bangkok, 2003.

² Bloom, E. and Choynowski, P. (2003) *Economic Analysis of Health Projects: A Case Study in Cambodia*, ERD Technical Note No. 6, ADB, Manila and P. A. Musgrove (2003) *Health Economics in Development*, November 2003 by World Bank.

³ GSO (2006) found that an average of 10.2% of ill and injured in the south coast had to stay in bed, while 35% of all residents had treatment over the 12 months prior to the survey. An average of 25% is used for the economic analysis as not all those seeking treatment were ill (eg. health checks, family planning) and not all those having time off work were confined to bed.

in the project area using average monthly income data from the living standard survey and an average loss per year of 4.1 days per person. It is evident that the economic costs of lost productivity are highest for Binh Dinh – the province with the greatest population and lowest for Ninh Thuan. The total value of productivity losses are estimated to be \$43 million per year, corresponding with 36 million days of lost labor.

**Table 1: South Central Coast Region
Productivity Cost of Illness, 2004**

| | Population | Days Lost to Illness (millions) | Per Capita Income (\$ day) | Productivity Cost (\$m) |
|------------|------------|---------------------------------|----------------------------|-------------------------|
| SCC Region | 8,762,700 | 36 | 1.19 | 43 |
| Da Nang | 777,100 | 3 | 1.90 | 6 |
| Quang Nam | 1,463,300 | 6 | 0.93 | 6 |
| Quang Ngai | 1,269,100 | 5 | 0.96 | 5 |
| Binh Dinh | 1,556,700 | 6 | 1.19 | 8 |
| Phu Yen | 861,100 | 4 | 1.07 | 4 |
| Khanh Hoa | 1,122,500 | 5 | 1.34 | 6 |
| Ninh Thuan | 562,300 | 2 | 1.11 | 3 |
| Binh Thuan | 1,150,600 | 5 | 1.26 | 6 |

Source: Vietnam Living Standard Survey, 2004 and consultant estimate

Improved access to health services and improved quality of health services will decrease the costs associated with lost labor through numbers of sick days. The numbers of people estimated to benefit from the project are outlined in Table 2 along with the number of gained work days. For the purposes of the economic appraisal it is assumed that 40% of residents in each province will benefit from improved services as investment is limited to a selection of district hospital, or the provincial hospital within each of the eight provinces. The average number of sick days for these beneficiaries is estimated to decrease by 40%.

Table 2: Cost-benefit Analysis and Projection of Beneficiaries

| Year | Beneficiaries | Gained Days | Gross Benefit | Investment Cost | Recurrent Cost | Net Benefit | NPV -2007 |
|-------------|---------------|-------------|---------------|-----------------|----------------|-------------|-----------|
| | Number | Million | US\$m | US\$m | US\$m | US\$m | US\$m |
| 2007 | - | - | - | - | - | - | - |
| 2008 | 1,777,076 | 3.0 | 4.0 | 26.7 | 1.3 | (24.0) | (21.4) |
| 2009 | 3,603,222 | 6.0 | 8.6 | 18.3 | 2.2 | (12.0) | (9.5) |
| 2010 | 3,652,293 | 6.1 | 9.2 | 12.6 | 2.9 | (6.2) | (4.4) |
| 2011 | 3,701,364 | 6.2 | 9.9 | 4.5 | 3.1 | 2.3 | 1.4 |
| 2012 | 3,750,436 | 6.2 | 10.5 | - | 3.1 | 7.4 | 4.2 |
| 2013 | 3,799,507 | 6.3 | 11.2 | - | 3.1 | 8.1 | 4.1 |
| 2014 | 3,848,578 | 6.4 | 11.9 | - | 3.1 | 8.7 | 4.0 |
| 2015 | 3,897,649 | 6.5 | 12.5 | - | 3.1 | 9.4 | 3.8 |
| 2016 | 3,946,720 | 6.6 | 13.2 | - | 3.1 | 10.1 | 3.7 |
| 2017 | 3,995,791 | 6.6 | 14.0 | - | 3.1 | 10.9 | 3.5 |
| 2018 | 4,044,862 | 6.7 | 14.7 | - | 3.1 | 11.6 | 3.3 |
| 2019 | 4,093,933 | 6.8 | 15.4 | - | 3.1 | 12.3 | 3.2 |
| 2020 | 4,143,005 | 6.9 | 16.2 | - | 3.1 | 13.1 | 3.0 |
| 2021 | 4,192,076 | 7.0 | 16.9 | - | 3.1 | 13.8 | 2.8 |

| | | | | | | | |
|-------------|-----------|--------------|--------------|-------------|-------------|--------------|-------------|
| 2022 | 4,241,147 | 7.0 | 17.7 | - | 3.1 | 14.6 | 2.7 |
| 2023 | 4,290,218 | 7.1 | 18.5 | - | 3.1 | 15.4 | 2.5 |
| 2024 | 4,339,289 | 7.2 | 19.3 | - | 3.1 | 16.2 | 2.4 |
| 2025 | 4,388,360 | 7.3 | 20.2 | - | 3.1 | 17.1 | 2.2 |
| 2026 | 4,437,431 | 7.4 | 21.0 | - | 3.1 | 17.9 | 2.1 |
| | | 123.1 | 265.0 | 62.1 | 56.1 | 146.8 | 13.4 |

The number of gained days and value of labor are multiplied together to obtain the gross benefit from the investment. Real wages are increasing in Vietnam. Across the 1990s, Gallup (2004) found the real cost of labor to be increasing by around 10% per year. This increase may not be sustained over the next 20 years and may not have evident in rural areas such as the south coast. Consequently, an average real wage growth rate of 7% per annum is included in the projection.

G. Economic Internal Rate of Return (EIRR)

The Project is estimated to lead to the avoidance of an average of 6.5 million work days per year in the south central coast, valued at nearly \$14 million per year. The EIRR from this impact is estimated to be 16%, and an economic net present value (NPV) of \$13.4 million is calculated.

H. Financial Sustainability Analysis

Provincial expenditure is financed by government at the central and provincial levels, donor institutions that make contributions to the government, user fees and insurance. The provincial budget is the most important of the public sector contributions, as direct central budget is relatively minor. Government allocations for the health sector are largely driven by economic growth and consequent tax revenues. In the case of Vietnam, real GDP growth has averaged over 6 percent over the 2001-2003 period. Coupled with this growth in GDP, public expenditures increased by 9 percent in real terms between 2001 and 2005 (World Bank 2006).

Resources for health sector expenditure are forecast over the 2006-2010 period from government, user fee, insurance, donor and other sources. It is difficult to predict the exact magnitude of these financial streams as they are subject to political and economic factors that are not known with certainty at the moment. Both recurrent and capital MoH and provincial revenues are forecast to increase by varying degrees dictated by MoF ceilings and revenue growth assumptions in MoH (2005). Average annual provincial expenditure is provided in Table 3 for each of the eight provinces. It is evident that Khanh hoa has the highest annual expenditure, while Ninh thuan has the lowest.

Table 3: Project Expenditure During Implementation and Associated Recurrent Costs

| | Implementation | | | Follow-On Requirement | | |
|------------|-------------------------------|---|----------|--------------------------------|-------------------------------------|----------|
| | Provincial Expenditure (\$m)* | Average Annual Project Disbursement (\$m) | % Expend | Provincial Expenditure (\$m)** | Average Recurrent Expenditure (\$m) | % Expend |
| Da Nang | 20.0 | 1.6 | 8.0% | 24.0 | 0.08 | 0.3% |
| Quang nam | 17.6 | 3.0 | 17.2% | 21.2 | 0.15 | 0.7% |
| Quang ngai | 14.7 | 1.9 | 13.0% | 17.1 | 0.10 | 0.6% |
| Binh dinh | 19.5 | 2.9 | 14.8% | 23.6 | 0.14 | 0.6% |

| | | | | | | |
|------------|------|-----|-------|------|------|------|
| Phu yen | 7.7 | 1.8 | 22.9% | 9.2 | 0.09 | 1.0% |
| Khanh hoa | 22.0 | 1.0 | 4.4% | 25.1 | 0.05 | 0.2% |
| Ninh thuan | 7.1 | 1.4 | 20.4% | 8.4 | 0.07 | 0.9% |
| Binh thuan | 11.9 | 1.8 | 14.8% | 14.1 | 0.09 | 0.6% |

* Average annual expenditure across 2006-2010 period, ** 2010

Average annual project disbursement is estimated relative to total provincial expenditure for each province. It is apparent that project expenditure varies from 8% of total annual expenditure in DaNang to 23% of expenditure in Phu Yen

The Project's recurrent costs include operation and maintenance expenditures. These costs only represent a minor percentage of provincial health expenditure in target provinces. Overall these expenditures represent about 0.6% of total expenditure, varying from 0.3% in DaNang to 0.9% in Phu Yen. The national health accounts demonstrate the reliance of provincial health departments on user fees and insurance, particularly for provincial curative activities, while the primary health care system is largely supported by central level state budget allocated to the communes. Although recurrent costs are only a small portion of overall costs, careful health sector planning will be required to ensure financial sustainability, as user fees are not forecast to keep pace with inflation.

I. Conclusions

The economic benefits from investments in health have been shown to be substantial. The private market fails, however, to appropriately investment in health prevention and care activities due to externalities in some markets and differences between private and social discount rates. Economic analysis undertaken in this report suggests that investment in health services and infrastructure in the south central coast will be economically attractive. Although only a small portion of total costs, careful health sector planning will be required to ensure there are sufficient resources to support on-going recurrent costs and ensure financial sustainability.

J. References

Bloom, E. and Choynowski, P. (2003) Economic Analysis of Health Projects: A Case Study in Cambodia, ERD Technical Note No. 6, ADB, Manila and P. A. Musgrove (2003) Health Economics in Development, November 2003 by World Bank.

Gallup, J. (2004) The Wage Labor Market and Inequality in Vietnam in Glewwe, P. et (Ed.) Economic Growth Poverty and Household Welfare in Vietnam, World Bank Regional and Sectoral Studies, World Bank, Washington.

General Statistics Office of Vietnam (2006) Results of the Survey on Household Living Standards 2004, GSO, Hanoi.

Knowles, J. (2003) "Health Nutrition and Infectious disease and Economic Growth in Cambodia," Bangkok, 2003.

Ministry of Health, (2005) 2006-2008 MTEF Submission from the Ministry of Health, 23 December 2005

World Bank (2006) Public Expenditure Review, Hanoi

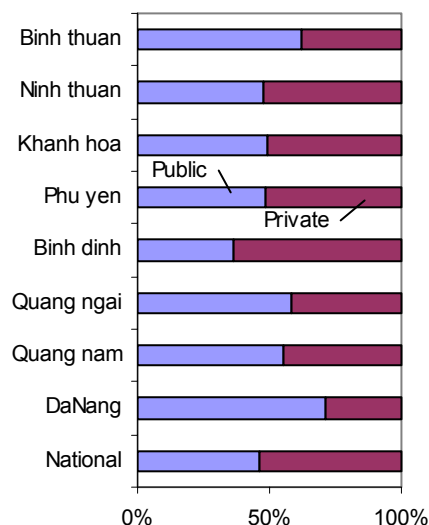
PROVINCIAL HEALTH EXPENDITURE AND MEDIUM TERM PLANNING

Current provincial health expenditures were estimated for 2006 and a medium term projection of available resources for development of provincial health systems respectively were estimated for each of the eight coastal provinces. Expenditure needs associated with each of the province’s medium term plan were calculated. These needs are reviewed in light of available resources and gaps in available financing identified for major cost categories.

A. TOTAL HEALTH EXPENDITURE

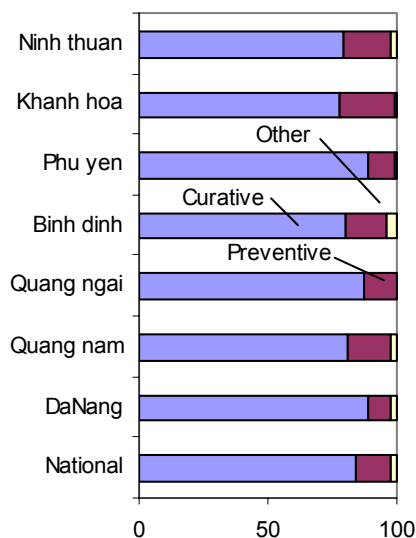
WHO (2007) calculated total health expenditure per person was 504 thousand VND in 2005, with private expenditure¹ accounting for 77% of total expenditure. A significant proportion of private expenditure occurs at public establishments, with out-of-pocket financing supporting most health expenditure.

Figure: Provincial Expenditure by Health Establishment (%), 2006



Source: Provincial Health Accounts (2006)

Figure: Functional Expenditure by Public Health Establishment (%), 2006



Source: Provincial Health Accounts (2006)

National health accounts for years following 2005 are currently being prepared, therefore provincial accounts were generated as part of project preparations. The proportions of health expenditure at public and private establishments are outlined in the adjoining figure. It is evident that for most provinces expenditures are equivalent for public (hospitals and clinics, prevention activities, administrative units, science and training) and private (hospitals, clinics and chemist shops) establishments. This balance reflects the relative composition at the national level. Public establishments have a larger share of expenditures in DaNang, which may reflect the large capacity of provincial hospitals relative to the size of the provincial population.

Most public expenditure is associated with curative activities² at the provincial and district level. Preventive services only comprise a small percentage of overall provincial health

¹ Private expenditure on health is defined as the sum of expenditures from prepaid plans and risk-pooling arrangements (private and private social insurance) schemes, firms, non profit institutions and direct outlays of households. These include payments made to health practitioners and suppliers, household payments to public services, non-profit institutions and nongovernmental organizations (WHO, 2006). Also, <http://www.who.int/nha/country/VNM.xls>

² World Bank (2006) Public Expenditure Review, Hanoi

expenditure. The adjoining figure illustrates the composition of total provincial expenditure.

B. PUBLIC SECTOR EXPENDITURE

Public sector funding sources include government at the central and provincial levels, and donor institutions that make contributions to the government. World Bank (2006) suggest that provincial spending is weakly pro-poor (i.e., more equal than the distribution of GDP per capita but less than proportional to population size). The provincial budget is the most important of the public sector contribution, as direct central budget is relatively minor. The change in provincial budget is provided in the table below for 2000 and 2005. It is evident that the annual change in local budget has been greatest for Binh thuan.

Table: Provincial Budget, 2000 and 2005

| | 2000 | | | 2005 | | | Annual Change % | % above nation |
|------------|------------|---------------------|-------------------|------------|---------------------|-------------------|-----------------|----------------|
| | Pop ('000) | Local Budget (VNDm) | Per Capita (VNDm) | Pop ('000) | Local Budget (VNDm) | Per Capita (VNDm) | | |
| National | 77,679 | 2,321,730 | 29.9 | 83,120 | 5,528,544 | 66.5 | 13.8 | - |
| Da Nang | 700 | 36,573 | 52.2 | 777 | 70,023 | 90.1 | 9.1 | 35 |
| Quang nam | 1,389 | 44,695 | 32.2 | 1,463 | 92,902 | 63.5 | 10.8 | -5 |
| Quang ngai | 1,199 | 40,493 | 33.8 | 1,269 | 73,880 | 58.2 | 8.2 | -12 |
| Binh dinh | 1,482 | 40,880 | 27.6 | 1,557 | 96,190 | 61.8 | 13.5 | -7 |
| Phu yen | 804 | 22,515 | 28.0 | 861 | 53,730 | 62.4 | 13.9 | -6 |
| Khanh hoa | 1,049 | 34,699 | 33.1 | 1,123 | 72,318 | 64.4 | 10.8 | -3 |
| Ninh thuan | 516 | 26,190 | 50.8 | 562 | 37,036 | 65.9 | 4.1 | -1 |
| Binh thuan | 1,066 | 24,212 | 22.7 | 1,151 | 75,190 | 65.3 | 21.1 | -2 |

Source: Health Statistics Yearbook (2000, 2005)

The provincial governments receive their allocated recurrent and investment funds directly from MOF. The planning and budgeting functions for the health sector were devolved to the provincial governments from the central ministries and provinces have flexibility in reallocating budgets between different programs.

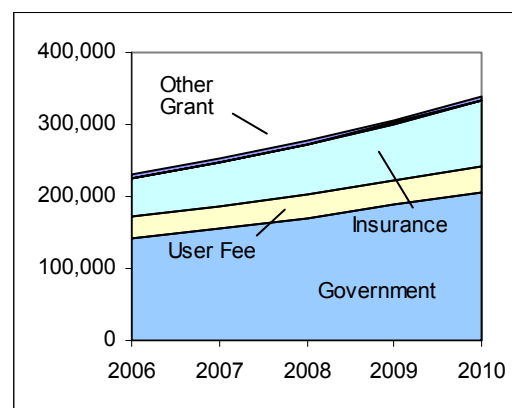
C. Available Resources over 2006-2010 Period

Resources for health sector expenditure are forecast over the 2006-2010 period for government, user fee, insurance, donor and other sources. It is difficult to predict the exact magnitude of these financial streams as they are subject to political and economic factors that are not known with certainty at the moment. Government allocations for the health sector are largely driven by economic growth and consequent tax revenues. In the case of Vietnam, real GDP growth has averaged over 6 percent over the 2001-2003 period³. Coupled with this growth in GDP, public expenditures increased by 9 percent in real terms between 2001 and 2005 and remained relatively stable as a percentage of GDP over this period at an average of 20 percent. This increase in government spending was largely financed by proportional expansion in non-oil and gas tax revenues.

³ World Bank (2006) noted that export development has been a major driver of growth. Exports grew at an average annual rate of 14 percent in value terms over the last 6-7 years. The garments sector had the highest growth rate (45 percent) and equaled crude oil as the most important export for Vietnam in value terms.

Current financial commitments from central and provincial governments, grants, along with user fee and insurance revenues were estimated for 2006 as part of development of 2006 provincial health accounts. The annual change in government and other funds over the 2006-2010 are projected from national MTEF modeling⁴. Health insurance revenues are forecast to increase by the greatest percentage average annual amount. For central and provincial governments, it is assumed that an annual growth rate of 10% will be in evidence for both capital and recurrent financing. Insurance is estimate to increase by an annual growth rate of 15%. A growth rate of 5% is included for user fee financing. Donor and other sources of finance, are assumed to remain constant in nominal terms across the projection period. These growth rates are incorporated with financing source data from 2006 to estimate the available fiscal resource envelope. An example of the fiscal resource envelope for Quang Nam is presented in the adjoining figure. The increased relative value of insurance as a source of finance can be seen.

a. **Figure:
Provincial Fiscal Resource Envelope
(VND million)**



Source: Study Team Projection

D. Expenditure and Financing Implications for Planned Activities

Most of the eight coastal provinces have developed 5-year medium term plans for development of their respective health systems. Main strategies for provincial health service development include strengthening of the curative health services network with a focus on district hospitals and provincial hospital infrastructure, improving human resource capacity, improving preventive medicine services, enhancing organizational structure and improving human resource capacity. Developing drug policies, information technology capacity, traditional medicine and the private sector are also key elements of the provincial medium term strategies

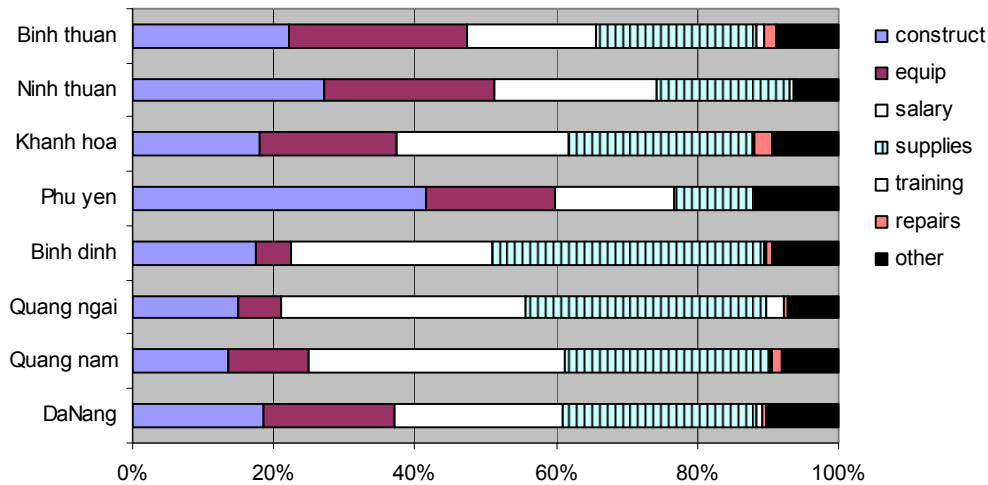
Each of these elements of the plan are described and planned expenditure projected. Expenditure items include civil works, equipment, staff numbers and training. In addition to capital costs, increasing health system capacity entails increased operating and consequent recurrent costs. Non-staff recurrent costs are associated with supplies, administration, maintenance and other items. Each of these cost items is included in a 5-year projection. A health sector inflation factor of 7% (which is 5% core inflation plus 2% for health sector) is also used to account for price inflation over the medium term period. (from MoH MTEF).

Within the curative sector, expenditure forecasts are relatively evenly distributed among district and provincial levels. There is limited commune proposed expenditure, and where detailed, is dominated by a large equipment procurement need. For most provinces civil works comprise about 15-20% of total expenditure need over the medium term, except in the case of Phu Yen, where civil works are estimated to accounts for about 40% of all expenditure needs. The relatively high civil works expenditure need – which is equivalent to that in Binh dinh, Danang and Binh thuan – generates the large share for this cost item. Phu Yen has a much smaller

⁴ Ministry of Health, 2005, 2006-2008 MTEF Submission from the Ministry of Health, 23 December 2005

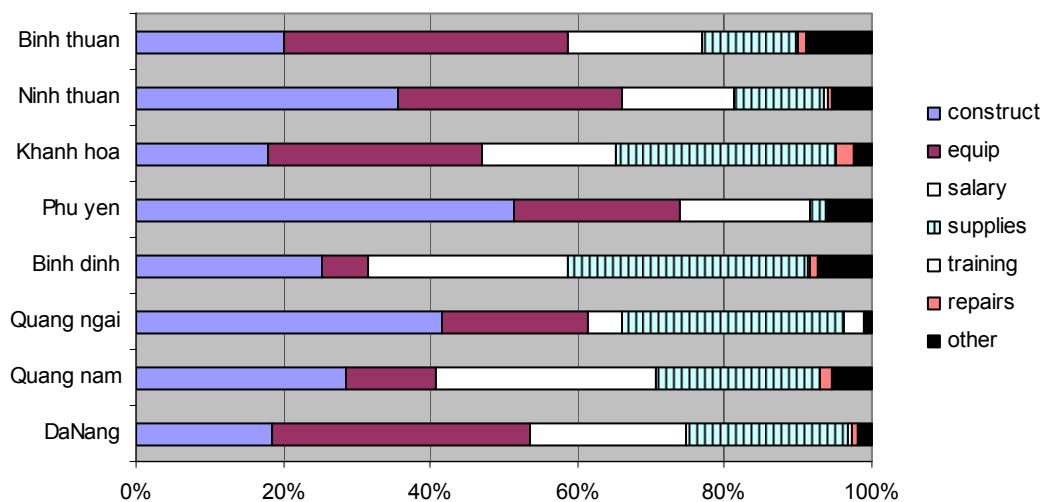
public establishment expenditure budget when compared to these provinces, which in part reflects the lower per person health spending and smaller population of the province.

Figure: Composition of Total Provincial Expenditure, 2006-2010



Some provinces may have only included capital works and equipment expenditure needs in their 5-year plans that could be supported by the ADB loan. Expenditure requirements need to be adjusted in most provinces to capture expenditure needs at the commune level and also for the preventive health system. Available sources of finance from government and non-state sources are combined with 5-year expenditure projections to determine key financing gaps.

Figure: Composition of Provincial Expenditure Gap, 2006-2010



The combination of available resources and proposed expenditures reveals that projected expenditures are likely to exceed available resources over the 2006-2010 period for all provinces. This difference is expressed as a finance gap. The contribution of each cost category to the overall financing gaps is presented in the next figure. It is apparent that gaps exist for all cost items. Civil works, equipment, salary and supplies needs are the most pronounced and have proportionally higher financing needs.

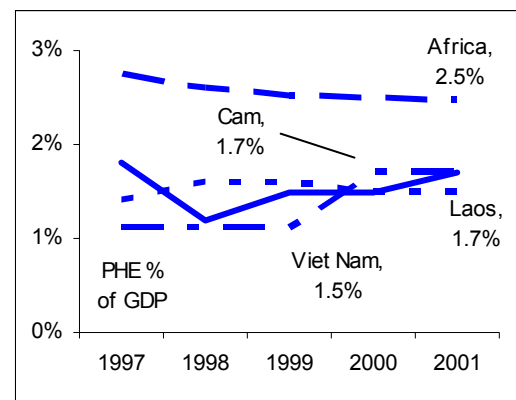
The main message of this provincial MTEF, as that in the national MTEF, is that there is insufficient government budget funding to achieve health and development targets. Government investment in the health sector should be increased. Equally, non-state revenues are not sufficient to finance key expenditures. The MoH MTEF suggests that policies relating to hospital fees and health insurance premiums need to be adjusted to ensure appropriate costing so as to increase revenues for health institutions.

E. Planning Recommendations

There are inadequate resources to support expenditures in the 5-year provincial health plan. State spending on health has grown rapidly in the early 1990s. However, Vietnam's public health spending as a share of GDP is low by international standards at 1.5 percent. This was below the East Asian average and lower than that in Laos, Cambodia and also sub-Saharan Africa.

The national health accounts and provincial data demonstrate the reliance of provincial health departments on user fees and insurance, particularly for provincial curative activities, while the primary health care system is largely supported by central level state budget allocated to the communes. A small amount of central level funding is also allocated to district and provincial construction activities, however, civil works and purchased of fixed assets largely is supported through annual approved provincial budget. Given that government budget is insufficient to achieve the health and development targets, policy reforms are required. These include: setting priorities for health sector investment based on evidence-based interventions, improving efficiency of service delivery, ensuring investments are balanced with incremental financing of recurrent costs, increasing health's share of overall public expenditure to become more in line with international public health financing benchmarks, set appropriate hospital fees, develop policies to authorize the use of non-state budget sources of funds (savings from regular income for investments, bank loans, funds mobilized from individual employees, and equitization), (World Bank 2006) and develop insurance to mobilize resources while simultaneously enhancing access to health care.

**Figure: Public Health Expenditure
as % of GDP**



Source: WHO (2006)

DETAILED COST ESTIMATES

Table 1: Estimated Project Base Cost By Component and Province

| Component/Sub-Component | Da Nang | Quang Nam | Quang Ngai | Binh Dinh | Phu Yen | Khanh Hoa | Ninh Thuan | Binh Thuan | MOH | Total |
|---|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|---------------|
| 1 Improving Provincial Health Services | | | | | | | | | | |
| 1 Hospital Upgrading and Expansion | 4,237 | 6,664 | 6,299 | 6,675 | 4,696 | 4,949 | 4,669 | 5,242 | 720 | 44,151 |
| 2 Hospital Waste Management | 168 | 412 | 606 | 428 | 335 | 378 | 335 | 413 | 276 | 3,550 |
| Subtotal | 4,405 | 7,076 | 6,905 | 7,103 | 5,030 | 5,327 | 5,003 | 5,655 | 996 | 47,502 |
| 2 Human Resource Development | | | | | | | | | | |
| 1 Provincial Human Resource Planning | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 37 | 460 | 754 |
| 2 Strengthening Local Training Capacity | 149 | 206 | 189 | 175 | 168 | 160 | 145 | 167 | 131 | 1,489 |
| 3 Improving Quality of Clinical Health Care | 276 | 537 | 450 | 462 | 330 | 376 | 250 | 374 | 224 | 3,279 |
| 4 Scholarships, Fellowships, and Studies | 160 | 160 | 160 | 160 | 160 | 160 | 160 | 160 | 105 | 1,385 |
| Subtotal | 621 | 940 | 836 | 834 | 695 | 732 | 592 | 738 | 920 | 6,907 |
| 3 Access to Quality Health Care | | | | | | | | | | |
| 1 Improving Quality of Clinical Health Care | 93 | 93 | 93 | 93 | 93 | 93 | 93 | 93 | - | 741 |
| 2 Health Services in Remote Communities | 549 | 981 | 541 | 780 | 337 | 406 | 193 | 404 | 36 | 4,227 |
| 3 Reducing Financial Barriers to Access | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 414 | 491 |
| Subtotal | 651 | 1,083 | 643 | 882 | 439 | 508 | 295 | 506 | 450 | 5,458 |
| 4 Provincial Health Systems Management | | | | | | | | | | |
| 1 Strengthening Provincial Health System Management | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 50 | 360 | 761 |
| 2 Strengthening Management of Provincial and District Hospitals | 54 | 54 | 54 | 54 | 54 | 54 | 54 | 54 | - | 428 |
| 3 Health Management Information System | 86 | 86 | 86 | 86 | 86 | 86 | 86 | 86 | - | 688 |
| 4 Project Management | 143 | 143 | 143 | 143 | 143 | 143 | 143 | 143 | 165 | 1,309 |
| Subtotal | 333 | 333 | 333 | 333 | 333 | 333 | 333 | 333 | 885 | 3,556 |
| TOTAL | 6,010 | 9,432 | 8,717 | 9,151 | 6,496 | 6,901 | 6,223 | 7,231 | 3,251 | 63,413 |

Table 2: Detailed Cost Estimates by Year and Category

| Item | 2008 | 2009 | 2010 | 2011 | 2013 | Total |
|---|-------------|-------------|-------------|------------|------------|-------------|
| A. Investment Costs | | | | | | |
| 1. Civil Works | 8.3 | 13.8 | 5.5 | - | - | 27.6 |
| 2. Equipment and Vehicles | 14.3 | 0.7 | 0.4 | 0.4 | - | 15.7 |
| 3. Drugs and Supplies | 0.3 | 0.3 | 0.3 | 0.3 | 0.3 | 1.3 |
| 4. Staff Development Workshops, Studies, System Development | 1.4 | 1.4 | 1.6 | 1.8 | 1.8 | 8.0 |
| 5. Consulting Services | 0.5 | 0.8 | 0.6 | 0.5 | 0.4 | 2.8 |
| 6. Project Management | 0.7 | 0.5 | 0.5 | 0.4 | 0.4 | 3.7 |
| 7. Operations and Maintenance | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 | 1.2 |
| 8. Operations and Maintenance | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 | 4.1 |
| Subtotal (A) | 26.4 | 18.5 | 9.9 | 4.5 | 3.9 | 63.4 |
| B. Taxes and Duties | 1.8 | 1.2 | 0.7 | 0.3 | 0.3 | 4.2 |
| C. Contingencies | | | | | | |
| 1. Physical Contingencies | 1.5 | 1.4 | 0.6 | - | - | 3.4 |
| 2. Price Contingencies | - | 1.5 | 2.1 | 1.9 | 1.3 | 6.8 |
| Subtotal (C) | 1.5 | 2.9 | 2.7 | 1.9 | 1.3 | 10.2 |
| Total Base Cost | | | | | | |
| D. Financing Charges During Implementation | 0.1 | 0.3 | 0.5 | 0.7 | 0.8 | 2.2 |
| Total (A)+(B)+(C)+(D) | 29.7 | 22.8 | 13.7 | 7.3 | 6.2 | 80.0 |

