



Draft Design and Monitoring Framework

Project Number: 40019
October 2008

VIE: Health Care in the South Central Coast Region Project

A design and monitoring framework is an active document, progressively updated and revised as necessary, particularly following any changes in project design and implementation. In accordance with ADB's public communications policy (2005), it is disclosed before appraisal of the project or program. This draft framework may change during processing of the project or program, and the revised version will be disclosed as an appendix to the report and recommendation of the President.

Asian Development Bank

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Targets/Indicators	Data Sources/Reporting Mechanisms	Assumptions and Risks
<p>Impact Improved health status of the population, in particular the poor, women and children, and ethnic minorities in the south central coast region</p>	<p>Between 2009 and 2013:</p> <ul style="list-style-type: none"> • Infant mortality rate reduced by 15% overall and 30% among ethnic minorities (from 19 to 16 overall and from 42 to 29 in poor ethnic minorities per 1,000 live births). • Annual maternal deaths reduced from 245 to 208 overall and from 62 to 43 in ethnic minority women. 	<ul style="list-style-type: none"> • Health statistics profile 2002–2006 • Provincial health surveys 2009, 2013 • Annual report of vital statistics • Monitoring of vital events in ethnic minority communes 	<p>Assumption</p> <ul style="list-style-type: none"> • Health services are appropriate to the needs of the poor and of high quality. <p>Risk</p> <ul style="list-style-type: none"> • Escalating cost of living and direct and indirect cost of health services restrain the poor from using the health services.
<p>Outcome More comprehensive, well-managed, and better-used provincial health systems in the eight provinces, with a focus on health care for the poor, women and children, and ethnic minorities</p>	<p>Between 2009 and 2013:</p> <ul style="list-style-type: none"> • Use of health services by the population in general increased by 15%, and by the poor, women, and ethnic minorities increased by 30%. • Poor pregnant women delivering in health facilities increased from 42% to 48%. • Hospital case fatality rate reduced by 10% for all income groups. • Use of health insurance fund by ethnic minorities increased by 25%. 	<ul style="list-style-type: none"> • Provincial health services and hospital statistics • Provincial and hospital health services surveys 	<p>Assumptions</p> <ul style="list-style-type: none"> • The provinces give priority to health care for the poor, women and children, and ethnic groups. • Investments result in better quality of health services. • Strong demand for services from the poor, in particular ethnic women. <p>Risk</p> <ul style="list-style-type: none"> • Financial support for rural health services declines.
<p>Outputs Output 1: Improved Health Facilities</p> <p>1.1 New and upgraded health facilities and equipment</p> <p>1.2 Improved water, sanitation, and waste management</p>	<p>By 2012:</p> <ul style="list-style-type: none"> • 8 new and 18 upgraded health facilities • District hospitals with capacity for emergency obstetric care increased by 2 per province. • All new and upgraded facilities meet MOH service standards for water, sanitation, and waste management. 	<ul style="list-style-type: none"> • Engineer's report • Hospital statistics • Engineer's report 	<p>Assumptions</p> <ul style="list-style-type: none"> • Provincial Governments provide counterpart funds. • Investments are appropriate to the needs. <p>Risks</p> <ul style="list-style-type: none"> • Price increases due to delays in consulting services and contracting • Technical feasibility of waste management • Purchase of inappropriate equipment
<p>Output 2: Strengthened Provincial HRD</p> <p>2.1 Improved provincial human resource planning and management</p> <p>2.2 Improved provincial training capacity</p>	<p>By 2009:</p> <ul style="list-style-type: none"> • Provincial HRD plans approved, especially the training of women and ethnic minorities • 88 master and 415 core trainers applying skills-based training 	<ul style="list-style-type: none"> • Provincial HRD plan 	<p>Assumptions</p> <ul style="list-style-type: none"> • Provinces have an interest in, and capacity to prepare HRD plans. • Sufficient number of master trainers can be identified. • Trainers adopt skills-based training approach.

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<p>2.3 Improved quality and availability of staff</p> <p>2.4 HRD provincial studies are used in policy formulation.</p>	<p>By 2010:</p> <ul style="list-style-type: none"> • Every CHS has at least one trained female staff member. <p>By 2012:</p> <ul style="list-style-type: none"> • Number of qualified female ethnic minority health care professionals increased by 50%. • HRD studies (10), including at least two focusing on gender and ethnic minority issues, are shared and discussed by MOH. 	<ul style="list-style-type: none"> • Provincial HRD plan • Provincial HRD plan • Assessment by experts 	<ul style="list-style-type: none"> • Female staff willing to work in CHS for low pay. • Staff training results in more competent staff. • Female ethnic minority candidates qualify for scholarships (if necessary, with bridging). • Study proposals are of satisfactory quality. <p>Risk</p> <ul style="list-style-type: none"> • Further disparities between public and private wage levels
<p>Output 3: Improved Access to Health Care for the Poor</p> <p>3.1 Better village health care in remote communes</p> <p>3.2 Health and nutrition promoted in ethnic minority communes.</p> <p>3.3 Reduced barriers to health care funds for the poor</p>	<p>By 2013:</p> <ul style="list-style-type: none"> • At least 95% of 423 poor communes have at least one female skilled staff. • At least 80% of trained VHWs provide standard package of reproductive health care. • At least half of women of 100 ethnic minority communes participated in health and nutrition promotion campaigns. • Ethnic minorities that know how to use insurance card increased by 50%. 	<ul style="list-style-type: none"> • Health services survey (for village level) • Health services survey (for village level) • Household survey 	<p>Assumptions</p> <ul style="list-style-type: none"> • Communes have active health committees. • Suitable candidates can be identified as female or male VHWs and have time and resources to work as such. • VHWs are competent. • Health and nutrition promotion campaign is effective. <p>Risk</p> <ul style="list-style-type: none"> • Other impediments prevent the poor from access the funds.
<p>Output 4: Strengthened Provincial Health Systems</p> <p>4.1 Strengthened provincial health systems management</p> <p>4.2 Strengthened hospital management</p> <p>4.3 Better health management information systems</p> <p>4.4 Effective project management support</p>	<p>By 2010:</p> <ul style="list-style-type: none"> • Provinces prepare quality provincial health plans and budgets based on agreed standard criteria. <p>By 2012:</p> <ul style="list-style-type: none"> • Health system and hospital managers comprise at least 25% females and have been trained in planning and management. • Half of district hospitals have computerized health management information systems. <p>From 2009 onwards: Project procurement and financing management meet ADB standards.</p>	<ul style="list-style-type: none"> • Provincial health plans and budgets • HRD plan and training assessment • Hospital reports • Quarterly report 	<p>Assumptions</p> <ul style="list-style-type: none"> • Provincial health officers and hospital managers apply management skills. • MOH strongly supports improved provincial and hospital management. • Managers have access to web information resources. <p>Risks</p> <ul style="list-style-type: none"> • Financial incentives for investment in expensive medical technology. • Limited capacity to maintain computerized systems.

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<p>Activities with Milestones</p> <p>Output 1: Improved Health Facilities (base cost: \$52.9 million)</p> <p>1.1.1 Resettlement by 2009.</p> <p>1.1.2 Revision of hospital design and service standards by 2009.</p> <p>1.1.3 Construction design and bidding by 2011.</p> <p>1.1.4 New construction of 8 health facilities, including 1 regional and 1 district hospital, 1 SMS, and 5 DPMCs; and upgrading of 18 health facilities, including 1 provincial, 4 regional, 11 districts, 1 rehabilitation, and 1 traditional hospital by 2012.</p> <p>1.1.5 Preparing equipment list and bidding by 2011.</p> <p>1.1.6 Procurement of equipment and training for 31 health facilities by 2013.</p> <p>1.2.1 Improving hospital water, sanitation, and waste management systems in 26 targeted health facilities by 2012.</p> <p>1.2.2 Waste management training by 2012.</p> <p>Output 2: Strengthened Provincial Human Resources (base cost: \$6.2 million)</p> <p>2.1.1 Provincial teams conduct workshops and field visits to develop provincial HRD plans annually.</p> <p>2.2.1 Conduct of teacher training for better skills-based training methods at SMSs by annually, with support of external teachers.</p> <p>2.3.1 In-service training for totals of 3,000 district staff and 3,500 CHS staff by 2013.</p> <p>2.3.2 Merit-based scholarships for teachers, nurses, paramedics, doctors, and managers by 2013.</p> <p>2.3.3 Ethnic minority scholarships for preservice training (160), at least 60% to ethnic minorities, 50% to women, by 2013.</p> <p>2.4.1 Field-based HRD studies on topics aimed at improving health care for the poor, women, children, and ethnic minorities, completed by 2012.</p> <p>Output 3: Improved Access to Health Care for the Poor (base cost: \$6.2 million)</p> <p>3.1.1 Design of village health worker training.</p> <p>3.1.2 Training of district and CHS staff.</p> <p>3.1.3 Retraining 6,500 VHWs, 1 female and 1 male, for 423 remote communes, by 2013.</p> <p>3.1.4 New training of 1,600 VHWs for remote communes, where required, by 2012.</p> <p>3.2.1 Design of health and nutrition promotion program by 2009.</p> <p>3.2.2 Community-based health and nutrition promotion using a NGO and targeting 100 ethnic communes, in particular to improve reproductive health, by 2012.</p> <p>3.3.1 Education campaign for 100 ethnic minority communes to better use the health care funds for the poor, by 2011.</p> <p>3.3.2 System development and training for better fund management, by 2011.</p> <p>Output 4: Strengthened Provincial Health Systems (base cost: \$4.3 million)</p> <p>4.1.1 Update provincial health management manual, by 2009.</p> <p>4.1.2 Provincial health manager training, by 2011.</p> <p>4.1.3 Provincial health accounts, in 2009 and 2013.</p> <p>4.2.1 Introduction of new management standards for hospitals, by 2010.</p> <p>4.2.2 Hospital manager training, by 2012.</p> <p>4.3.1 Improving HMIS design by 2009.</p> <p>4.3.2 Training of 800 staff in HMIS, by 2011.</p> <p>4.4.1 Provincial health system gender action plan and ethnic minority development plan are part of the provincial 5-year and annual plans from July 2009 onwards, and their implementation is coordinated and monitored by the provincial health bureaus.</p> <p>4.4.2 Provincial health and health services surveys conducted in 2009 and 2013.</p>			<p>Inputs</p> <p>ADB: \$72 million</p> <ul style="list-style-type: none"> • Civil works: \$21.37 million • Equipment and vehicles: \$17.68 million • Drugs and supplies: \$3.28 million • Staff development: \$8.43 million • Workshops, studies, system development: \$2.31 million • Consulting services: \$3.55 million • Project management: \$2.04 million • Taxes and duties on investment: \$1.46 million • Operations and maintenance: \$2.40 million • Taxes and duties on recurrent costs: \$0.11 million • Contingencies: \$7.44 million • Interest charges on loan during implementation: \$1.93 million <p>Government: \$8 million</p> <ul style="list-style-type: none"> • Resettlement: \$0.86 million • Civil works: \$5.27 million • Taxes and duties on investment: \$0.28 million • Operations and maintenance: \$0.56 million • Taxes and duties on recurrent costs: \$0.03 million • Contingencies: \$1.00 million

ADB = Asian Development Bank, CHS = commune health station, DPMC = district preventive medicine center, HRD = human resource development, MOH = Ministry of Health, PHC = primary health care, SMS = secondary medical school, VHW = village health worker.