



# Technical Assistance Report

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Project Number: 40019  
October 2006

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

## CURRENCY EQUIVALENTS

(as of 9 October 2006)

|               |   |             |
|---------------|---|-------------|
| Currency Unit | – | dong (D)    |
| D1.00         | = | \$0.0000623 |
| \$1.00        | = | D16,054     |

## ABBREVIATIONS

|     |   |                             |
|-----|---|-----------------------------|
| ADB | – | Asian Development Bank      |
| CHS | – | commune health stations     |
| HRD | – | human resources development |
| MOH | – | Ministry of Health          |
| TA  | – | technical assistance        |

## TECHNICAL ASSISTANCE CLASSIFICATION

|                                 |   |  |
|---------------------------------|---|--|
| <b>Targeting Classification</b> | – | Targeted intervention  |
| <b>Sector</b>                   | – | Health, nutrition, and social protection                         |
| <b>Subsector</b>                | – | Health systems   |
| <b>Themes</b>                   | – | Inclusive social development, governance, gender and development |
| <b>Subtheme</b>                 | – | Gender equity in capabilities                                    |

## NOTE

In this report, "\$" refers to US dollars.

|                         |  |
|-------------------------|--|
| <b>Vice President</b>   | C. Lawrence Greenwood, Jr., Operations Group 2 |
| <b>Director General</b> | R. Nag, Southeast Asia Department (SERD)       |
| <b>Director</b>         | S. Lateef, Social Sectors Division, SERD       |
| <b>Team leader</b>      | V. de Wit, Principal Health Specialist, SERD   |

## I. INTRODUCTION

1. The Government of Viet Nam (the Government) is planning to upgrade the country's public health sector through regional projects based on the sector's Five-Year Plan (2006–2010).<sup>1</sup> The Ministry of Health (MOH) has asked the Asian Development Bank (ADB) to support the Health Care in the South Central Coast Region Project (the project), while the World Bank is to support a similar project for the north central coast region.<sup>2</sup> In July 2006, ADB fielded the Fact-Finding Mission (the Mission) for a project preparatory technical assistance (TA). The Mission discussed the proposed project with the Government, aid agencies, and provincial stakeholders. The Government and the Mission reached an understanding on the project scope, as well as the TA design and implementation arrangements, as confirmed by MOH on 6 September 2006. The design and monitoring framework for the TA is in Appendix 1.<sup>3</sup>

## II. ISSUES

2. The Government remains strongly committed to providing quality health care for all its citizens. It has been operating an extensive health care network of commune health stations (CHS), polyclinics, district health centers, hospitals, and national programs under MOH. The Government employs a large workforce, and also works with retired health staff and war veterans to help reach rural populations. Since the early 1990s, private practitioners and pharmacies have been expanding rapidly, although hospital services remain largely public.

3. Viet Nam's health indicators are surprisingly good for a country at its level of per capita income. The infant mortality rate reportedly fell from 30 per 1,000 live births in 2002 to 19 per 1,000 in 2005, while the maternal mortality ratio dropped from 130 per 100,000 live births in 2000 to 85 per 100,000 live births in 2005. Having reached some of the Millennium Development Goals for 2015, the Government has formulated the Viet Nam development goals. The country is in an epidemiological transition—the burden of communicable diseases fell to about 25% of the total burden of diseases, from 50% three decades ago. Road accidents, cardiovascular diseases, chronic lung diseases, and other welfare-related diseases are now common causes of morbidity and mortality. However, reaching Viet Nam's development goals for health requires addressing the high residual burden of communicable diseases and reproductive health problems in lagging communities, including in ethnic minority communities. Child malnutrition, which is related to poverty, care, and common infections, remains high at 27%. HIV has continued to spread, and 0.5% of the adult population is infected. Viet Nam also has had avian influenza outbreaks in birds, and is preparing for a human epidemic.

4. Changing demography and behavior, urbanization, and other developments are increasing the demand for hospital services, while poor rural communities lack basic health services.<sup>4</sup> The political leadership, while appreciating the gains in the sector, has noted (i) a lack of adaptation to changing disease patterns and to the market economy; (ii) poor quality of services; and (iii) problems in meeting the needs of the poor and those living in remote, mountainous, and minority areas.<sup>5</sup> The difficulty in addressing this double burden of disease is attributed to a failure to match demand side and supply side elements in a health system that has been “stagnant in reforms” and requires adaptation to the socialist market economy.

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<sup>1</sup> Ministry of Health. 2006. *Five Year Plan 2006–2010, June 2006*. Hanoi.

<sup>2</sup> ADB. 2006. *Viet Nam: Country Strategy and Program 2007–2010*. Manila (for Asian Development Fund \$60 million).

<sup>3</sup> The TA first appeared in *ADB Business Opportunities* on 19 May 2006.

<sup>4</sup> Ministry of Planning and Investment. 2006. *The Five-Year Socio-Economic Development Plan (2006–2010)*. Hanoi.

<sup>5</sup> Politbureau. 2005. Resolution 46. Hanoi (February).

5. MOH's 2006–2010 plan calls for making access and use of health services more equitable and effective to protect and promote people's health. The plan also aims to improve the quality of health care at all levels, with special attention to the poor, women, children, handicapped, minority groups, and those living in remote and disadvantaged areas.<sup>6</sup> Further, the plan seeks to (i) reduce malnutrition and mortality in children, (ii) reduce maternal mortality, (iii) control communicable diseases, (iv) prevent and control noncommunicable diseases, (v) overcome the consequences caused by accidents and injuries, and (vi) assure food and blood safety. This is to be achieved by consolidating and upgrading the health network from CHS to regional medical centers, modernizing medical equipment, improving the training of health workers, and other measures. The MOH plan adopts a dual approach of upgrading hospital services, while improving services for lagging communities with poor health indicators, including minority communities. However, the plan is a continuation of the current public health sector delivery system, and does not fully address some of the main issues affecting the equity, efficiency, and effectiveness of the health sector.

6. Poor households lack financial access to primary health care, which undermines equity in the sector. After the agricultural reforms of *Doi Moi*, the grassroots network of CHS and extension workers collapsed, reducing access for the poor. In the 1990s, the Government allowed private practice and out-of-pocket payment at public health facilities. This greatly improved the availability of services, but not affordability for the poor. MOH, among others, addressed this issue through the establishment of equity funds for the poor. However, more work is needed to improve and sustain arrangements to increase health benefits for the poor.<sup>7</sup>

7. Another equity issue is the care of poor women and children, many of whom are minorities. Coverage of maternal services is limited and often substandard. This includes some specific problems, such as invasive family planning services. Many poor women deliver without a trained birth attendant, and neonatal mortality remains high. Malnutrition, which is still relatively high among the poor, could be reduced with relatively low-cost interventions, such as maternal education, treatment of common infections, and micronutrients. These types of interventions require the strengthening of community-based health care, outreach, and referral services.

8. The efficiency and effectiveness of health spending in Viet Nam is about average for the region. Viet Nam spends about \$21 per person per year on health, including \$15 from private sources, explaining in part the improvements in health indicators. Most of this is for curative care, with the larger hospitals consuming a major share of the public sector budget. While MOH has increased support for health promotion and prevention recently, much remains to be done in this field to address diseases associated with poverty and welfare.

9. The quality of health care remains a major problem affecting all services, with two important dimensions—staff performance and recurrent funds. Staff lack skills-based training. Current policies do not encourage medical staff to work in remote and disadvantaged areas. Minorities are underrepresented among health staff in health centers serving their communities. Inadequate funds are allocated for recurrent costs, including pay, supplies, services, and maintenance and repair. Staff pay barely covers basic living costs, requiring many to find other work or double as a private practitioner. Incentives for field work are low.

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<sup>6</sup> Ministry of Health. 2006. *Plan for Protection, Care and Promotion of People's Health for 2006–2010*. Hanoi.

<sup>7</sup> Government of Viet Nam. 2002. *Prime Minister's Decision 139: Health Insurance for All*. Hanoi.

10. Viet Nam's efforts to adjust the public health system to changing needs have been modest compared to other countries in the region with similar problems, perhaps because the current system appears to be working fairly well. However, MOH realizes it needs to initiate a process of health system development and reform to continue improving health indicators. In addition to a joint national reform program being developed in consultation with aid agencies, MOH is planning to develop provincial health systems through regional projects. These, along with improving health benefits, will drive demand for, and respond to, reforms.

11. Improving access, quality, and affordability of provincial health services involves a wide range of challenges, including (i) balancing basic care and hospital services; (ii) shifting from curative care to health promotion; (iii) integrating national programs at the provincial level; (iv) addressing human resource problems, including staff skills, and posting competent staff to CHSs; (v) financing hospital services and health care for the poor; and (vi) stimulating and regulating the private sector, particularly regarding the quality of health services and medicines. There are also opportunities for improving public health services through enhanced public involvement and professional associations. Private hospitals could help make new technology available, and reduce the burden of public hospitals. At the same time, strong provincial government commitment, stewardship, autonomy, and responsiveness to public needs are essential to address these opportunities and challenges. Funding agencies could facilitate this development and reform process by supporting national and local governments to conduct sector analysis and capacity building towards an integrated, results-based approach to improved outcome and health systems development.

12. ADB currently supports provincial health system development through two projects,<sup>8</sup> while the World Bank supports similar projects in the northern mountains and Mekong regions. Both banks have been asked to support the central region, which has received less investment in health infrastructure and health care for the poor. MOH favors such a regional approach, and has asked ADB and World Bank to coordinate these projects. MOH has prepared a concept paper for the proposed project to guide the TA. Cast within MOH's strategic framework, the proposal involves an investment of the equivalent of \$80 million for the south central coast region to improve the health of the people, especially the poor, women, minorities, and other disadvantaged groups. The proposal covers four areas: (i) provincial health services, (ii) human resources development, (iii) health care for the poor, and (iv) provincial health system management. MOH (Planning and Finance Department) will be the Executing Agency. As envisaged, the proposed project will be implemented over 5 years. Given the governance and financing issues, such a regional project could be designed as a sector development program, and support national policy reforms and recurrent cost implications, provided that national arrangements and conditions can be put in place.

13. ADB-funded health projects are generally satisfactory. The projects typically start slowly due to initial capacity constraints in project management and at the provincial level, and sometimes unclear Government regulations. While MOH has built substantial capacity in project management, including financial management, it lacks experience in program lending. MOH's capacity in improving health care for the poor also needs attention. Equity funds require regular adjustment to follow new directives or address implementation issues, and their impact and sustainability are unknown.

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<sup>8</sup> ADB. 2004. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for the Health Care in the Central Highlands Project*. Manila; and ADB. 2000. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Socialist Republic of Viet Nam for the Rural Health Project*. Manila.

### III. THE TECHNICAL ASSISTANCE

#### A. Impact and Outcome

14. The TA is to help prepare a regional project that will improve the health status of the targeted population, particularly the poor, women, children, and other vulnerable groups. The project will strengthen provincial health systems in seven provinces and one city in the south central coast region.<sup>9</sup> The TA will produce a project design that has strong local ownership, is acceptable to all stakeholders, and is linked to national policy actions. Provincial governments will improve their understanding of health issues and priorities, while provincial health teams will develop stronger capacity for health sector planning and budgeting. An initial poverty and social analysis is in Appendix 2.

#### B. Methodology and Key Activities

15. The TA will (i) analyze the provincial health system, and related governance and financing aspects; (ii) assess and initially strengthen provincial health staff capacity in planning and budgeting, financial management, and monitoring; (iii) conduct a participatory planning process to identify priorities for policy reform, capacity building, and investment; and (iv) prepare a project proposal, Government pre-feasibility and feasibility reports, and implementation plan for possible assistance of ADB and other agencies.

16. In the first month, the TA team (staff and consultants) will review sector performance, national policies and plans, and previous experience. It also will consult with ministries and partners in Hanoi, provincial officials and staff, and potential beneficiaries. These inputs will be used to identify the main issues and plan further analysis of policies, the provincial health system, governance, and financing aspects. They also will be used to conduct stakeholder consultations over the following 2 months. After a midterm review of the analysis, consultants and counterparts will conduct a 2-month participatory planning process to prepare a draft project proposal, which will be finalized with Government and ADB inputs over the next month.

17. During the analysis, the TA team will analyze (i) the needs, services, issues, policies, and plans of provincial health systems; (ii) management and financing practices; (iii) provincial 5-year plans and medium-term expenditure frameworks; (iv) situation and development needs of hospital services based on spatial distribution, demand for services, resources, and hospital financing and management; (v) health care and equity funds for the poor; (vi) human resources development, including shortfalls, standards, quality of training, and resources; and (vii) financing modalities. The team also will visit other regional projects, and help develop provincial health sector plans in coordination with the World Bank and other agencies.

18. To help ensure synergies across regions, the team—with the support of MOH, ADB, and other development agencies—will organize two workshops in the central region to review two aspects of provincial health system development: (i) urbanization, welfare diseases, and private health sector development; and (ii) strategic options to improve equity, efficiency, and effectiveness of public health services. The team also will provide orientation of local leaders

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<sup>9</sup> Danang City and the provinces of Quang Nam, Quang Ngai, Binh Dinh, Phu Yen, Khanh Hoa, Ninh Thuan, and Binh Thuan. These have a total population of 8.67 million (2004).

and training of provincial staff in results-based provincial health system development, program financing, financial management, planning and budgeting, and monitoring and evaluation.

### **C. Cost and Financing**

19. The TA is estimated to cost the equivalent of \$600,000. ADB will finance \$450,000 on a grant basis through ADB's TA funding program. The Government will provide the equivalent of \$150,000 through in-kind contributions for counterpart staff, workshops, and facilities. The cost estimates and financing plan are in Appendix 3. The Government has been informed that approval of the TA does not commit ADB to financing any ensuing project.

### **D. Implementation Arrangements**

20. MOH will be the Executing Agency for the TA. The ADB project steering committee in MOH, chaired by a deputy minister of health, will meet to review and guide TA work after inception, completion of the analysis, and completion of the draft final report. The Planning and Finance Department of MOH will be responsible for TA implementation. MOH will appoint a part-time project director and a full-time deputy project director for the TA. The deputy director and the team leader jointly will lead a regional TA team representing the seven provinces and one city, departments, and consultants. The director of the Planning and Finance Department will provide overall leadership, and arrange monthly meetings to guide and coordinate TA activities. In each province, the provincial health officer will head a provincial team, including representatives of the provincial government, MOH, civil society, and consultants, to guide the planning process.

21. ADB will support 17 person-months of international consulting services (person-months are in parentheses), including a team leader and public health management expert (5), a health economist (4), a health care quality improvement expert (4), and a sociologist (4). ADB also will support 22 person-months of national consulting services, including a public health expert and deputy team leader (10), a financial management expert (4), a community development expert (4), and a health infrastructure expert (4). ADB will engage the consultants individually in accordance with ADB's *Guidelines on the Use of Consultants*. International and national consultants will work together with counterparts to perform the services. The indicative outline terms of reference for consultants are in Appendix 4. MOH will procure equipment under the TA in accordance with ADB's *Procurement Guidelines*. MOH will retain the equipment on completion of the TA.

22. The deputy project director and team leader will submit an inception report to MOH and ADB within 1 month of TA implementation. A sector analysis will be submitted at midterm, along with a project concept and draft project framework. The draft final report will be submitted after 5 months, and a final report and implementation memorandum after 6 months. The TA, which will become effective around 1 November 2006, will be completed within 1 year.

## **IV. THE PRESIDENT'S DECISION**

23. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$450,000 on a grant basis to the Government of Viet Nam for preparing the Health Care in the South Central Coast Region Project, and hereby reports this action to the Board.

## INDICATIVE DESIGN AND MONITORING FRAMEWORK

| Design Summary   | Performance Targets/Indicators  | Data Sources/Reporting Mechanisms                              | Assumptions and Risks  |
|--|---|--|--|
| <p><b>Impacts</b></p> <p>Improved health in the target population:</p> <ol style="list-style-type: none"> <li>1. Reduce infant and maternal mortality, and reduce malnutrition, particularly among the poor and minorities in the seven targeted provinces and one city</li> <li>2. Strengthen provincial health systems in the seven targeted provinces and one city in terms of equity, effectiveness, and efficiency</li> </ol>   | <p>On completion of the ensuing project, health indicators will improve as follows: (i) infant mortality rate from 32 to 23 per 1,000 live births overall, and 44 to 32 per 1,000 live births for poor ethnic minorities in 5 years; (ii) maternal mortality rate from 85 to 60 per 100,000 live births in 5 years; and (iii) child malnutrition rate from 27% to 20% of children below 5 years old in 5 years</p> <p>On completion of the ensuing project, the provincial health system will demonstrate improved impact for the population, proportionally more benefits for the poor, and reduced unit costs of services</p> | <p>Household survey</p> <p>Health services study</p>           | <p><b>Assumption</b></p> <ul style="list-style-type: none"> <li>• Data are available</li> </ul> <p><b>Risks</b></p> <ul style="list-style-type: none"> <li>• Catastrophes</li> <li>• Weak political commitment to pro-poor agenda</li> </ul>   |
| <p><b>Outcomes</b></p> <ol style="list-style-type: none"> <li>1. An agreed project design to improve health in the target population, particularly the poor, women, children, and other vulnerable groups</li> <li>2. Strong local ownership of the project proposal</li> <li>3. Provincial government's improved understanding of health issues and priorities</li> <li>4. Strengthened capacity of provincial health team for health sector planning and budgeting</li> <li>5. Policy recommendations for consideration at the national level for further studies and support</li> </ol> | <ol style="list-style-type: none"> <li>1. Government and ADB accept the proposal</li> <li>2. Provincial governments strongly support the proposal</li> <li>3. Provincial governments fully endorse health issues and priorities</li> <li>4. Provincial health teams have basic planning and budgeting skills</li> <li>5. Ministries accept proposed policy reform agenda</li> </ol>   | <p>TA final report and feedback from MOH and the provinces</p> | <p><b>Assumption</b></p> <ul style="list-style-type: none"> <li>• Proposal is in line with Government policy and expectations</li> </ul> <p><b>Risks</b></p> <ul style="list-style-type: none"> <li>• Provincial governments are more input-oriented than outcome-oriented</li> <li>• High turnover of management staff</li> <li>• National policy dialogue and studies are slow to materialize</li> </ul> |

|   |   |   |  |
|---|---|---|--|
| <p><b>Outputs</b></p> <ol style="list-style-type: none"> <li>1. Analysis of the provincial health system and related policy, capacity, and financing aspects</li> <li>2. Provincial health management staff trained in planning and budgeting, financial management, and monitoring</li> <li>3. Consensus built through participatory planning to identify priorities for policy reform, capacity building, and investment</li> <li>4. Project proposal, MOH pre-feasibility and feasibility reports, draft project administration memorandum</li> </ol>  | <p>Analysis includes provincial health services, quality of care, care for the poor, management, and health financing</p> <p>All provinces have at least five trained provincial health management staff</p> <p>In each province, provincial stakeholders have reached consensus about health sector priorities</p> <p>Project proposal is of high quality and pro-poor, and addresses governance and financing issues, including (i) policy action and adjustment costs, (ii) gender strategy and action plan, (iii) ethnic minority development plan, and (iv) environmental assessment</p> | <p>Midterm report</p> <p>TA progress report</p> <p>TA progress report</p> <p>Project proposal</p> | <p><b>Assumptions</b></p> <ul style="list-style-type: none"> <li>• Sufficient data are available</li> <li>• Provinces fully cooperate in data collection</li> <li>• Provincial health management team has basic planning and budgeting skills</li> <li>• Differences of views can be negotiated</li> </ul> <p><b>Risk</b></p> <ul style="list-style-type: none"> <li>• Limited time and funds to carry out the assignments, while initiating the TA also takes time</li> </ul> |
| <p><b>Activities with Milestones for the TA</b></p> <ol style="list-style-type: none"> <li>1. MOH establishes a project team for the TA, and informs the steering committee.</li> <li>2. Team leader and deputy director conduct initial national and provincial consultations, and prepare a detailed inception report, submitted in the first month of the TA.</li> <li>3. In the first and second months of the TA, consultants provide training for provincial health teams and staff in planning and budgeting, financial management, program support, and other topics.</li> <li>4. Experts conduct meetings, workshops, field visits, and other activities to identify priorities for reform, capacity building, and services development in the targeted provinces in the first and second months of the TA.</li> <li>5. Provincial health teams and experts analyze subsectors to update progress, and identify issues and opportunities for provincial health system development. A sector analysis will be submitted after the second and third months of the TA.</li> <li>6. Provincial teams update strategic plans for the sector, including policy reforms, capacity building, and PHC service delivery in the northern provinces in the fourth month of the TA.</li> <li>7. Project team prepares a project outline for reform, capacity building, PHC service delivery, aid coordination, and project management in the fourth month of the TA.</li> </ol> |   |   | <p><b>Inputs</b></p> <ul style="list-style-type: none"> <li>• ADB funding: \$450,000</li> <li>• Government funding: \$150,000</li> </ul>   |

|  |  |
|--|--|
| <p>8. Team confirms the project scope, cost estimates and financing, and implementation arrangements; and completes the draft final report in the fifth month of the TA. The team also prepares the implementation memorandum and pre-feasibility study.</p> <p>9. Deputy director, team leader, and financial expert incorporate comments and finalize the project proposal and implementation memorandum in the sixth month of the TA.</p> |  |
|--|--|

ADB = Asian Development Bank, MOH = Ministry of Health, PHC = primary health care, TA = technical assistance.

## INITIAL POVERTY AND SOCIAL ANALYSIS

### A. Links to the Country Poverty Analysis

|   |  |  |  |
|---|--|--|--|
| <b>Is the sector identified as a national priority in country poverty analysis?</b>   | <input checked="" type="checkbox"/> Yes<br><br><input type="checkbox"/> No | <b>Is the sector identified as a national priority in country poverty partnership agreement?</b> | <input checked="" type="checkbox"/> Yes<br><br><input type="checkbox"/> No |
| <p><b>Contribution of the sector or subsector to reduce poverty in Viet Nam:</b></p> <p>The health sector plays a major role in poverty reduction. The high burden of diseases among the poor affects their productivity, the cost of medical care is a major reason for new poverty, poor quality of care leads to income erosion, and the high level of poverty requires government intervention to make services available and affordable.</p> |  |  |  |

### B. Poverty Analysis

**Targeting Classification:** Targeted intervention

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|--|
| <p><b>What type of poverty analysis is needed?</b></p> <p>The project will aim to strengthen the provincial health system to (i) improve the quality of care; (ii) make health care more affordable for the poor; and (iii) make health care more acceptable for women, ethnic minorities, and other vulnerable groups. The technical assistance (TA) will analyze health services performance, quality of care, human resources development, health financing, and management. Further, the TA will propose policy reforms, capacity building, and investments. The purpose is to establish a process of year-by-year upgrading of the provincial health services based on needs and results, rather than inputs, to make services more equitable, efficient, and effective.</p> <p>The poverty analysis will include an assessment of physical, social, and financial access to health services. It also will determine whether health services management is pro-poor and pro-gender, and assess opportunities for women and ethnic minorities, and specific issues for vulnerable groups. Finally, the analysis will assess the potential benefits of reforms and investment for the poor.</p> |
|--|

### C. Participation Process

|   |   |                             |
|---|---|-----------------------------|
| <b>Is there a stakeholder analysis?</b>   | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Is there a participation strategy?</b>   | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| <p>The TA will establish a project team to (i) provide guidance; (ii) train provincial health teams initially on planning and budgeting; (iv) place experts in the provinces to guide provincial health teams through the planning process; (v) conduct field visits, including to existing projects; and (vi) hold cross-regional workshops to synchronize development efforts. As envisaged, the comprehensive provincial plans will lead to provincial sector-wide approaches in the future.</p> |   |                             |

### D. Gender Development

|   |   |
|---|---|
| <p><b>Strategy to maximize impacts on women:</b></p> <p>The TA will develop a gender strategy and plan to emphasize the needs of women, particularly regarding reproductive health and access to health services. It also will examine ways to provide women from minority groups with jobs and social protection. The strategy will incorporate the views of beneficiaries, including women from ethnic minority groups.</p> |   |
| <b>Has an output been prepared?</b>   | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

**E. Social Safeguards and Other Social Risks**

| Item                                      | Significant/<br>Not Significant/<br>None   | Strategy to Address Issues   | Plan Required   |
|---|--|--|---|
| <b>Resettlement</b>                       | <input type="checkbox"/> Significant<br><input checked="" type="checkbox"/> Not significant<br><input type="checkbox"/> None | The project will use Government land. Civil works will upgrade existing services and schools. Consultants will examine if any resettlement issues arise during the TA, and will prepare a resettlement plan if needed. | <input type="checkbox"/> Full<br><input type="checkbox"/> Short<br><input checked="" type="checkbox"/> None |
| <b>Affordability</b>                      | <input type="checkbox"/> Significant<br><input type="checkbox"/> Not significant<br><input checked="" type="checkbox"/> None | One of the aims of the project is to make health services more affordable for the poor.  | <input type="checkbox"/> Yes<br><input checked="" type="checkbox"/> No                                      |
| <b>Labor</b>                              | <input type="checkbox"/> Significant<br><input type="checkbox"/> Not significant<br><input checked="" type="checkbox"/> None | The project aims to create jobs for paramedics, and to train volunteers to increase their income through a small markup on the sale of drugs.  | <input type="checkbox"/> Yes<br><input checked="" type="checkbox"/> No                                      |
| <b>Indigenous Peoples</b>                 | <input checked="" type="checkbox"/> Significant<br><input type="checkbox"/> Not significant<br><input type="checkbox"/> None | The project is targeting ethnic minorities with the purpose of increasing their benefits.  | <input checked="" type="checkbox"/> Yes<br><input type="checkbox"/> No                                      |
| <b>Other Risks and/or Vulnerabilities</b> | <input type="checkbox"/> Significant<br><input type="checkbox"/> Not significant<br><input checked="" type="checkbox"/> None | The TA will examine if any other major risk or vulnerability arises that might need to be addressed in the project design.   | <input type="checkbox"/> Yes<br><input checked="" type="checkbox"/> No                                      |

**COST ESTIMATES AND FINANCING PLAN**  
(\$'000)

| Item  | Cost         |
|---|--------------|
| <b>A. Asian Development Bank (ADB) Financing<sup>a</sup></b>        |              |
| 1. Consultants  |              |
| a. Remuneration and Per Diem  |              |
| i. International Consultants  | 270.0        |
| ii. National Consultants  | 40.0         |
| b. International and Local Travel                                   | 30.0         |
| c. Reports and Communications                                       | 5.0          |
| 2. Equipment and Furniture <sup>b</sup>                             | 10.0         |
| 3. Workshops and Field Visits                                       | 20.0         |
| 4. Financial Studies  | 20.0         |
| 5. Miscellaneous Administration and Support Costs                   | 10.0         |
| 6. Contingencies  | 45.0         |
| <b>Subtotal (A)</b>   | <b>450.0</b> |
| <b>B. Government Financing</b>                                      |              |
| 1. Office Accommodation and Transport <sup>c</sup>                  | 50.0         |
| 2. Remuneration and Per Diem of Counterpart Staff and Support Staff | 50.0         |
| 3. Others, e.g., Workshop Facilities                                | 50.0         |
| <b>Subtotal (B)</b>   | <b>150.0</b> |
| <b>Total</b>  | <b>600.0</b> |

<sup>a</sup> Financed by ADB's technical assistance funding program.

<sup>b</sup> Includes computers, printer, photocopy machine, and telecommunication equipment.

<sup>c</sup> Ministry of Health will make additional transport available.

Sources: Ministry of Health of Viet Nam and ADB estimates.

## INDICATIVE OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

### A. International Consultants

#### 1. Team Leader and Public Health Management Expert (5 person-months)

1. The team leader and public health management expert will have at least 15 years of public health experience, including 5 years in Asia, in health sector reforms, and as team leader of projects. The expert will be responsible for overall coordination, implementation, and report preparation of the technical assistance (TA). In coordination with the counterpart of the Ministry of Health (MOH), the national public health expert, and deputy team leader, the expert will

- (i) Report to the project director, MOH, and the Asian Development Bank (ADB).
- (ii) Manage TA administration and implementation.
- (iii) Provide training on public health planning and budgeting.
- (iv) 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.
- (v) 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.
- (vi) Prepare a detailed analysis and proposal, examining alternative options, for strengthening provincial planning, management, budgeting, and monitoring, including reform and capacity building requirements.
- (vii) Take responsibility for preparing the feasibility study for submission to MOH and ADB, including (a) inception report (with a summary of sector performance and issues, policies and plans, initial consultations with stakeholders, and TA implementation arrangements); (b) midterm report (sector analysis); (c) project proposal; (d) project administration memorandum; and (e) Government pre-feasibility and feasibility studies.
- (viii) Ensure on-time submission of formal written reports, including the inception report at 1 month, sector analysis and project concept paper with draft project framework at 3 months, draft final report at 5 months, and a final report on completion of the TA at 6 months.

#### 2. Health Economist (4 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 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) Identify health care affordability issues for the poor—options for improving these including fee structures and equity funds—and prepare with the sociologist a detailed analysis and proposal for improving health care financing for the poor.
  - (v) Examine the suitability of a sector development program for ADB assistance; identify capacity building requirements; oversee the preparation of the medium-term expenditure plans and budgets; and, if feasible, prepare the program framework, policy matrix, and poverty impact assessment.
  - (vi) Guide the national financial management expert in preparing cost estimates and adjustment costs.
  - (vii) Conduct an economic and financial analysis of the project using ADB's *Guidelines for the Economic Analysis of Projects*, and ADB's *Economic Analysis of Policy-Based Operations: Key Dimensions*, in case of program lending.

### 3. Health Care Quality Improvement Expert (4 person-months)

3. The health care quality improvement expert will have a nursing, public health, or human resources development (HRD) background with at least 5 years of experience in this field. The expert will be responsible for planning the improvement of quality of care. The expert will

- (i) Report to the team leader, and work as a member of the team and task force.
- (ii) Train the provincial teams on improving quality of care and HRD.
- (iii) Conduct a detailed analysis of quality of care issues, including (a) quality of services at various levels; (b) staff availability, skills, and management; (c) HRD planning and policy issues; and (d) HRD training, recruitment, and remuneration.
- (iv) Identify HRD policy and capacity issues to be addressed at the national level, and prepare a medium-term HRD implementation plan for the provinces.
- (v) Prepare a component examining alternative options for quality improvement.

### 4. Sociologist (4 person-months)

4. The sociologist will have at least 10 years of experience in Asia, including in Viet Nam. The sociologist will be responsible for the social analysis of the project (poverty, gender, and ethnic minorities), and will help plan the third component of improving health care for the poor. 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 social aspects of health care.
- (iii) Undertake consultations with ministries, health care providers, and other stakeholders on improving access and quality of health services for the poor, women, ethnic minorities, and other vulnerable groups.
- (iv) Prepare a social analysis, a gender action plan, and an ethnic minority development plan based on ADB's *Guidelines for the Social Analysis of Projects*, and ADB's policies on indigenous peoples and gender and development.<sup>10</sup>
- (v) Propose a practical, integrated approach to strengthening poverty and social aspects of health care delivery for all social groups.

<sup>10</sup> ADB. 1998. *Policy on Indigenous Peoples*. Manila; and ADB. 2003. *Gender and Development*. Manila.

- (vi) Prepare with the health economist a detailed analysis and proposal, examining alternative options, to improve health care for the poor.

## **B. National Consultants**

### **1. Deputy Team Leader and Public Health Expert (10 person-months)**

5. The deputy team leader and public health specialist 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 public health management expert in managing TA implementation.
- (iii) Arrange and implement liaison with MOH, other ministries, provincial health departments, development partners, and civil society.
- (iv) Conduct a detailed sector analysis for improving the provincial health management systems; and prepare a detailed proposal for the fourth component of strengthening provincial management.
- (v) Prepare a detailed proposal, examining alternative options, for strengthening provincial health services.
- (vi) Prepare the pre-feasibility study and the feasibility study of MOH.

### **2. Financial Management Expert (4 person-months)**

6. 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) Help examine sources and uses of funds for each province; and prepare the medium-term expenditure plan, as well as the annual plan and budget for the first year, with guidance of the health economist.
- (v) Prepare cost estimates and adjustment costs, including the costs of reforms and recurrent costs for the investments, and design a fund flow and disbursement mechanism for supporting the provincial health system.

### **3. Community Development Expert (4 person-months)**

7. The community development expert will be a sociologist or similar expert with at least 5 years of experience in community development. The expert will help the international sociologist with the social analysis and planning for improving community-based health care. The expert will

- (i) Report to the team leader, and work as a member of the team and task force

- (ii) Consult with beneficiaries on improving access and quality of health services for the poor, women, ethnic minorities, and other vulnerable groups; and prepare a report on their problems, perceptions, and practices.
- (iii) Assist with the social analysis based on ADB's *Guidelines for the Social Analysis of Projects*, ADB's *Policy on Indigenous Peoples* (footnote 1), and other relevant social and gender strategies; and help prepare a social analysis, a gender action plan, and an ethnic minority development plan.
- (iv) Advise the sociologist on options to improve health care delivery for all social groups, and prepare a proposal to improve community-based health care.

**4. Health Infrastructure Expert (4 person-months)**

8. The architect or engineer will have at least 10 years of experience in health facility planning in Asia. The expert will examine the proposed upgrading and new construction of hospitals and health centers. The expert will

- (i) Report to the team leader, and work as a member of the team and task force.
- (ii) Train provincial teams on planning public health facilities.
- (iii) Review provincial plans for civil works, and assess their appropriateness in terms of their location, size, expected use, maintenance, and recurrent financing costs.
- (iv) Prepare a detailed analysis and proposal, examining alternative options, for health infrastructure development that has a sound economic justification.
- (v) Based on ADB's *Involuntary Resettlement Policy*, screen sites of facilities targeted for upgrading for possible involuntary resettlement impacts, including impacts to non-titled people, such as loss of legal structures and incomes; and prepare a resettlement plan, as required.
- (vi) Review Government policies, guidelines, and standards on environmental aspects of health facilities, including the National Environmental Health Action Program; and consult the Ministry of Natural Resources and Environment on proposed national strategies.
- (vii) Conduct environmental screening using the rapid environmental assessment checklist to (a) avoid and minimize environmental interference in site selection, (b) determine required level of environment assessment based on the screening, and (c) conduct rapid environmental assessment.
- (viii) Review current practices and issues on medical waste treatment and other environmental aspects, and design proper mitigation measures as a component of the proposed project for environmentally sound medical waste treatment and disposal. This should include (a) proper source separation for reducing the volume of medical waste; (b) development of appropriate collection and transportation of medical waste; (c) preparation of a concentrated safe treatment facility, if one does not exist; and (d) awareness raising and education of stakeholders, including doctors.