ASIAN DEVELOPMENT BANK

TAR:VIE 37654

TECHNICAL ASSISTANCE
(Financed by the Poverty Reduction Cooperation Fund)

TO THE

SOCIALIST REPUBLIC OF VIET NAM

FOR

SUPPORT FOR PRO-POOR HEALTH POLICIES

April 2004

CURRENCY EQUIVALENTS
(as of 15 April 2004)

Currency Unit	–	dong (D)
D1.00	=	$.0000636
$1.00	=	D15,727

ABBREVIATIONS

ADB	–	Asian Development Bank
MOH	–	Ministry of Health
TA	–	technical assistance

TA CLASSIFICATION

Poverty Classification	Core poverty intervention
Sector	Health
Subsector	Health financing
Thematic	Inclusive social development

NOTES

(i) The fiscal year (FY) of the Government and its agencies ends on 31 December.
(ii) In this report, "$" refers to US dollars.

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I. INTRODUCTION

1. The country strategy and program of the Asian Development Bank (ADB) for Viet Nam identifies improving the quality of human resources, removing inequities in access to healthcare, and reducing poverty as the key challenges for the country. During the Country Strategy and Programming Mission in 2003, the Government requested an advisory technical assistance (TA) for strengthening its pro-poor health policies.[1] A fact-finding mission visited Viet Nam from 2 to 6 February 2004 and reached an understanding with the Government on the objectives, scope, cost estimates, terms of reference, and implementation arrangements for the TA.[2] The Mission held consultations with the concerned Government ministries, and various multilateral and bilateral organizations. The TA is included in the country pipeline for 2004. A logical framework for the TA is in Appendix 1.

II. ISSUES

2. Despite the substantial progress during the past 10 years, poverty reduction is still a major challenge for policymakers in Viet Nam. Poor health and expenditure on health care are important causes of poverty in the country. High healthcare costs result in indebtedness and the loss of productive assets for many families. In addition, many chronic health conditions restrict physical and mental activity, raising the effective dependency burden in Vietnamese households affected by poor health and disability. Premature death from illness, accidents, and injuries disadvantages many households. Households headed by females without another adult present are particularly disadvantaged. Not surprisingly, inequities in the use of health services have been increasing in recent years.[3]

3. Limited public resources have forced the Government to rely increasingly on household out-of-pocket financing, especially for curative care. High out-of-pocket costs have hampered poor households' abilities to obtain needed healthcare. Several households have had to cope with catastrophic healthcare costs. Such costs are an important cause of poverty. In addition, associated disabilities negatively affect household income and assets.

4. Viet Nam's Comprehensive Poverty Reduction and Growth Strategy (CPRGS) recognizes that it is not enough to make healthcare physically accessible to all segments of the population. Out-of-pocket costs and other barriers—for example, travel costs and the opportunity cost of time—often prevent the poor from using available health services. The Prime Minister's Decision 139[4] to establish province-level health care funds for the poor is an important step to reduce direct costs as an obstacle to healthcare use by the poor. However, reductions in direct costs alone may not suffice to eliminate existing differentials in healthcare use. Furthermore, Decision 139 covers only the poor people, leaving a vast numbers of near poor households still exposed to the risk of catastrophic healthcare expenditure.

5. The Government faces a two-pronged challenge of effectively implementing Decision 139 and ensuring that the intended benefits reach the intended groups. At the same time, it needs to continue to further refine its health financing policies to provide coverage to the remaining population, especially households just above the poverty line.

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[1] The concept paper for the technical assistance was approved by Management in February 2004.
[2] The TA first appeared in *ADB Business Opportunities* (Internet edition) on 3 September 2003.
[3] Bhushan, I., E. Bloom, N. Thang, N. Huu. 2001. *Human Capital of the Poor in Viet Nam*. Manila: ADB.
[4] The Prime Minister's Decision No. 139/2002/QD-TTg, "Health Care for the Poor" (15 October 2002).

6. The success of Decision 139 depends critically on the government's ability to institutionalize a system of close monitoring, supervision, and evaluation of implementation and impact of the policy. The Government needs to constantly monitor the coverage of the funds in terms of the characteristics of households and individuals reached. Monitoring will also be important to assess the quality and adequacy of services being provided to the beneficiaries. The impact of the policy initiative on health care service use and out-of-pocket expenditure by poor households will also need to be assessed. The TA will support the Ministry of Health (MOH) by strengthening its capacity to manage and monitor the implementation of Decision 139 at the central and local (provincial and district) levels. It will also support the development of a plan for monitoring the impact of Decision 139.

7. Further refining the health financing policies—to more effectively cover the poor and expand the support to near-poor populations—will require a deeper understanding of the linkage between poverty and health, determinants of health care use, and the barriers faced by the poor —particularly ethnic minorities and women—in seeking health care. Policy research is also needed to better understand how cost influences the health care seeking behavior, especially by poor people and ethnic minorities living in rural and remote areas. These insights can help determine policy changes for increasing healthcare use by the poor and expanding health insurance coverage among the large, presently uncovered, rural population. This analysis can provide the basis for modifying Decision 139 to improve its focus and effectiveness. It will also help suggest appropriate modifications of the health insurance policies to achieve the stated goal of universal coverage by 2010.[5] The TA will finance necessary policy research to support government efforts for increasing use of cost-effective healthcare by the poor and other vulnerable groups while simultaneously reducing their financial burden.

8. The TA builds directly on two previous ADB health sector projects, Human Capital of the Poor in Viet Nam: Policy Options, and Making Health Care More Affordable for the Poor: Health Financing in Viet Nam.[6] The TA will also support two other ongoing health sector projects, the Rural Health Project and the Health Care in the Central Highlands Project.[7] The TA will complement health sector work of several other aid agencies, including the expansion of rural health insurance coverage. The TA outputs will directly support the objectives of ADB's country strategy and program for Viet Nam and the CPRGS, which identify reducing out-of-pocket expenditure on health care as a challenge for poverty reduction. The TA is also in line with ADB's Health Sector Policy.

III. THE TECHNICAL ASSISTANCE

A. Purpose and Output

9. The purpose of the TA is to support the pro-poor health sector policies in Viet Nam by (i) strengthening the capacity of MOH in effectively implementing Decision 139; and (ii) attaining

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[5] Both the socioeconomic plan adopted by the Ninth Party Congress and the 10-year plan for the health sector approved by the Prime Minister call for expanding health financing options to gradually extend basic health care coverage to the entire population by 2010.

[6] ADB. 2000. *Technical Assistance to the Socialist Republic of Viet Nam for Human Capital of the Poor in Viet Nam: Policy Options.* Manila and ADB. 2002. *Technical Assistance to the Socialist Republic of Viet Nam for Making Health Care More Affordable for the Poor: Health Financing in Viet Nam.* Manila.

[7] 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 and ADB. 2003. *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.* Manila.

deeper understanding of the determinants of health service utilization, health care costs faced, and health insurance enrollments by the poor and disadvantaged. In particular, the TA will strengthen the monitoring and evaluation system for Decision 139 and support training for officials responsible for implementing the decision at the central and state levels. In addition, the TA will support policy research on the following issues:

(i) Health and poverty in Viet Nam,
(ii) Barriers to health care utilization by the poor,
(iii) Determinants of health care costs, and
(iv) Demand for health insurance among rural population.

B. Methodology and Key Activities

10. The TA will have two components: (i) capacity building for implementing Decision 139, and (ii) policy research to improve the poverty focus of health financing.

1. Component 1: Capacity Building

11. Component 1 will support the implementation of Decision 139, especially its monitoring and evaluation. The TA will support the further development, pretesting, and installation of the monitoring and reporting software for Decision 139 that was initiated under the ADB financed TA No. 3877-VIE, Making Health Care More Affordable for the Poor: Health Financing in Viet Nam. The TA will finance training of provincial and district officials in the use of the software as well as in other areas. The TA will also assist MOH to develop the methodology and a plan for assessing the impact of Decision 139 on healthcare use and household out-of-pocket spending. The TA will complement the activities planned under Loan 2076-VIE: Health Care in the Central Highlands Project. The monitoring and evaluation methodology developed under the TA will be used in the project to assess the impact of Decision 139 in achieving its objectives in the central highlands using project resources. The methodology could also be used by MOH using its own resources to assess the impact of Decision 139 in other parts of the country.

2. Component 2: Policy Research

12. Component 2 will entail four policy research studies.

(i) **Health and poverty.** This study will focus on relationships between health status (disability and morbidity), and labor supply and productivity and household wealth and indebtedness. There is broad understanding and appreciation in Viet Nam of the role that high healthcare costs play in generating poverty. Several studies[8] have been prepared on the "health poverty trap." However, less is understood about the role that poor health and disability plays in adversely affecting households' ability to earn income. Solid evidence on this relationship is lacking worldwide, reflecting in part the relative dearth of attention to adult health issues. The study will fill this important gap. The study will also explore the gender dimensions of the relationships between health and poverty.

[8] Dahlgren, Goran. 2000. Issues of Equity and Effectiveness in Efficient Equity-Oriented Health Care Policies: An Introduction. In *Efficient, Equity-Oriented Strategies for Health: International Perspectives—Focus on Viet Nam* edited by P. Hung, I. Minas, Y. Liu, G. Dahlgren, and W. Hsio. Melbourne: University of Melbourne.

(ii) **Barriers to healthcare use.** This study will identify the barriers to healthcare use by the poor and other vulnerable groups. In particular, the study will assess the role played by indirect costs, such as travel costs and the opportunity cost of time. This is potentially very important because the available data suggest that significant differentials in healthcare use exist between the poor and the non-poor, independent of health insurance coverage. Knowledge of factors that affect use is critical for formulating appropriate strategies to provide effective access to health care for the poor.

(iii) **Factors affecting the cost of healthcare to households.** This study will examine how out-of-pocket costs and the opportunity costs of time vary according to the type of provider used, provider fee levels, local drug costs, health insurance coverage, eligibility for fee exemptions, and other relevant factors. Several household surveys have collected data on the cost of healthcare to households at various types of public and private health facilities. In addition to the obvious roles played by the type and seriousness of an illness or injury, the type of provider consulted, and the quantity of care obtained, the direct cost of healthcare to households may be affected by a number of additional factors, including health insurance coverage of various kinds, patient eligibility for fee exemptions and fee reductions, the degree of competition among providers, public and private, local prices of drugs, and quality of care. The indirect cost of healthcare (i.e., travel costs, opportunity cost of patient time) is affected by distance, access to and cost of transportation, and wage rates. The study will aim to quantify the determinants of health care costs.

(iv) **The demand for health insurance.** This study will identify the factors that influence the demand for health insurance in Viet Nam. The factors are likely to include cost and expected benefits, access to and quality of healthcare, and knowledge of health insurance. The study findings will be useful for policies to expand the health insurance coverage, in particular the voluntary health insurance.

13. The four studies will be based on existing survey data (for example, the 1997–1998 Vietnam Living Standards Survey, 2002 Demographic and Health Survey, and the 2001–2002 Vietnam National Health Survey). Quantitative analysis will be supplemented by findings from a participatory rapid assessment to be conducted through a nongovernment organization. Research design for the assessment will cover issues related to all four studies. Suggested outlines of the studies are in Appendix 2. The main findings and recommendations of these studies will be summarized in a final report and presented in a workshop organized by MOH. The workshop will include representatives of relevant departments in MOH; interested international agencies; Viet Nam Social Insurance and other Government agencies involved in formulating health financing policy (for example, the ministries of planning and investment, and finance); representatives of mass movement organizations; and nongovernment organizations involved in the health sector.

C. Cost and Financing

14. The total cost of the TA is estimated at $640,000 equivalent, of which $500,000 equivalent will be financed by ADB, covering the entire foreign exchange component of $230,000 and the local currency cost of $270,000 equivalent. The TA will be financed by ADB on a grant basis by the Poverty Reduction Cooperation Fund. ADB will finance consulting

services, production of reports, workshops, studies, and some administrative support services. The Government's contribution to the TA, estimated at $140,000 equivalent, will be in kind and will include the provision of counterpart staff; office accommodation; office support; translation services; and the support for organizing seminars, workshops, and meetings. The detailed cost estimates and proposed financing arrangements are in Appendix 3.

D. Implementation Arrangements

15. MOH will be the Executing Agency. The Health Policy Unit under the Department of Planning and Finance of MOH will be directly responsible for the day-to-day implementation of the TA. The TA will be implemented in close coordination with Component 3 of 2076-VIE: Health Care in the Central Highlands Project.[9] A team comprising one international consultant and team leader (12 person-months) and six domestic consultants (68 person-months) will be recruited on individual basis to provide specialist services. Outline terms of reference of the consultants are in Appendix 4. The services of the consultants will be engaged by ADB in accordance with its *Guidelines on the Use of Consultants* and other arrangements satisfactory to ADB for the engagement of domestic consultants. An international consultant (with a sociology background) engaged under the Health Care in the Central Highlands Project financed by Swedish Government will also support the TA implementation.

16. The steering committee for 2076-VIE: Health Care in the Central Highlands Project, chaired by a vice minister of MOH, will provide overall guidance to the TA and ensure coordination with ministries and agencies concerned. The TA team will present the progress of the study to the steering committee at regular intervals and seek its feedback and guidance.

17. The TA will be implemented over 2 years, starting in July 2004 and finishing in June 2006. The TA team leader will submit a draft inception report to ADB and MOH within 1 month from the commencement of the TA. The inception report will describe the study design, sources of data, and time schedule of each output. An interim report will be submitted after 1 year, and a final report by May 2006.

IV. THE PRESIDENT'S DECISION

18. The President, acting under the authority delegated by the Board, has approved ADB administering technical assistance not exceeding the equivalent of $500,000 to the Government of Viet Nam to be financed on a grant basis by the Poverty Reduction Cooperation Fund, for Support for Pro-Poor Health Policies, and hereby reports this action to the Board.

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[9] ADB. 2003. *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.* Manila.

TECHNICAL ASSISTANCE FRAMEWORK

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks
1. Sector/Area Goal Improve the health status of people, especially the poor and disadvantaged, and weaken the linkage between poverty and poor health.	Close health status gap based on ethnicity and income in line with the 10 year socio-economic plan.	Ministry of Health (MOH), health service statistics.	Economic growth and political stability will continue.
2. Objective/Purpose • Build capacity at the national and provincial levels to effectively implement Decision 139.	• Proportion of poor people covered through health cards reaches 100% by 2005. • Private out-of-pocket expenditure on health by the poor reduces by 50% by 2005.	• National Health Survey 2001. • Follow up household surveys.	• Government will continue to allocate sufficient resources for the Health Care Fund for the Poor.
• Improve the poverty focus of Government health policies through a deeper understanding of the determinants of health care use—especially by the poor—health care costs, health insurance enrollment, and targeting of government subsidies.	• Effective health financing policies and strategies for improving the access of the poor identified, and implementation guidelines for Decision 139 finalized.	• Feedback from MOH and other partners. • Review missions.	• Poverty reduction and provision of primary health care, especially in poor rural areas, continue to be a Government priority.
3. Outputs **Component 1: Capacity Building** (i) Monitoring system for implementation of Decision 139.	• Monitoring system in place, and use and targeting of the Fund efficiently monitored.	• Feedback from MOH and other partners.	• None.
(ii) Trained fund managers.	• All provinces have trained staff to manage the Fund.	• Feedback from MOH and other partners.	• None.
Component 2: Policy Research (i) Final study report, containing the findings from the following five studies: (a) health and poverty, (b) barriers to health care utilization, (c) factors affecting the cost of healthcare to households, and (d) demand for health insurance.	• Four publications in national and international refereed journals, acceptable to all partners.	• Feedback from MOH and other partners.	• Data from the 2001 National Health Survey will be readily available and cost survey supported by the Government of Sweden will not be delayed.

Design Summary	Performance Indicators/Targets	Monitoring Mechanisms	Assumptions and Risks
(ii) Dissemination of study findings.	• Changes in policies, guidelines, and project designs incorporating the findings of the study.	• Feedback from MOH and other partners.	• Effective coordination between related ministries and departments at the national and provincial levels will be achieved.
4. Activities **Component 1: Capacity Building** (i) Monitoring software. (ii) Monitoring plan for impact assessment. (iii) Training. **Component 2: Policy Research** (i) Data analysis and report writing for the following studies: (a) poverty and health, (b) barriers to health care utilization, (c) factors affecting the cost of healthcare to households, and (d) demand for health insurance. (ii) Dissemination workshops.			• Suitable consultants will be available. • MOH can effectively coordinate the study.
5. Inputs Resources Funds and consulting inputs Consulting Services • International (12 person months) • Domestic (68 person months) Participatory Rapid Assessment • $20,000 Training • $40,000			

PROPOSED OUTLINES OF ALL STUDIES

A. Health and Poverty

EXECUTIVE SUMMARY
- Main Findings
- Main Recommendations

I. INTRODUCTION
- A. Objective and Scope of the Study
- B. Relevant Background Features of the Health Sector and the Economy
- C. Review of Relevant Studies from Viet Nam and Elsewhere
- D. Methodology (use annex[es] to describe the theory and specification of empirical models estimated)

II. DESCRIPTION OF THE DATA SET(S) USED
- A. Description of the Survey, the Sample, and Relevant Parts of the Questionnaire
- B. Selected Descriptive Tables Describing Key Variables Used in the Analysis

III. ESTIMATION RESULTS
- A. Health (Disability and Morbidity), Labor Supply, and Productivity
- B. Health (Disability and Morbidity) and Household Wealth and/or Indebtedness

IV. DISCUSSION
- A. Impact of Health on Household Income and Wealth (including discussion of significant differences by income, gender and ethnicity)
- B. Impact of Health on the Incidence and Intensity of Poverty

V. CONCLUSIONS AND RECOMMENDATIONS

VI. APPENDIX. (theoretical and empirical models of the effect of health [disability and morbidity] on labor supply and productivity and household wealth and/or indebtedness)

B. Barriers to Healthcare Utilization

EXECUTIVE SUMMARY
- Main Findings
- Main Recommendations

I. INTRODUCTION
- A. Objective and Scope of the Study
- B. Relevant Background Features of the Health Sector
- C. Review of Relevant Previous Studies from Viet Nam and Elsewhere
- D. Methodology (use annex[es] to describe the theory and model specification in detail)

II. DESCRIPTION OF THE DATA SET(S) USED
   A. Description of the Survey, the Sample, and Relevant Parts of the Questionnaire
   B. Selected Descriptive Tables Describing Key Variables Used in the Analysis

III. ESTIMATION RESULTS

IV. DISCUSSION (including discussion of significant differences by income, gender, and ethnicity)
   A. Role of Direct Costs
   B. Role of Indirect Costs
   C. Role of Other Factors

V. CONCLUSIONS AND RECOMMENDATIONS

VI. APPENDIX. (theoretical and empirical model of healthcare utilization [demand])

C. Factors Affecting the Cost of Healthcare to Households

EXECUTIVE SUMMARY
- Main Findings
- Main Recommendations

I. INTRODUCTION
   A. Objective and Scope of the Study
   B. Relevant Background Features of the Health Sector
   C. Review of Relevant Previous Studies from Viet Nam and Elsewhere
   D. Methodology (use annex[es] to describe the theory and model specification in detail)

II. DESCRIPTION OF THE DATA SET(S) USED
   A. Description of the Survey, the Sample, and Relevant Parts of the Questionnaire
   B. Selected Descriptive Tables Describing Key Variables Used in the Analysis

III. ESTIMATION RESULTS

IV. DISCUSSION (including discussion of significant differences by income, gender and ethnicity)
   A. Role of Provider Fees and Local Drug Costs
   B. Effect of Health Insurance and Exemptions
   C. Factors Affecting Indirect Costs

V. CONCLUSIONS AND RECOMMENDATIONS

VI. APPENDIX. (theoretical and empirical model of household healthcare expenditure [including indirect costs])

D. The Demand for Health Insurance

EXECUTIVE SUMMARY
- Main Findings
- Main Recommendations

I. INTRODUCTION
- A. Objective and Scope of the Study
- B. Relevant Background Features of the Health Sector
- C. Review of Previous Relevant Studies from Viet Nam and Elsewhere
- D. Methodology (use annex[es] to describe the theory and model specification in detail)

II. DESCRIPTION OF THE DATA SET(S) USED
- A. Description of the Survey, the Sample, and Relevant Parts of the Questionnaire
- B. Selected Descriptive Tables Describing Key Variables Used in the Analysis

III. ESTIMATION RESULTS

IV. DISCUSSION (including discussion of significant differences by income, gender, and ethnicity)
- A. Role of Cost and Expected Benefits
- B. Role of Access to and Quality of Healthcare
- C. Role of Knowledge and Information about Health Insurance
- D. Other Factors Affecting the Demand for Health Insurance

V. CONCLUSIONS AND RECOMMENDATIONS

VI. APPENDIX. (theoretical and empirical model of the demand for health insurance)

COST ESTIMATES AND FINANCING PLAN
($'000)

Item	Foreign Exchange	Local Currency	Total Cost
A. Poverty Reduction Cooperation Fund Financing			
1. Consultants			
a. Remuneration and Per Diem			
i. International Consultants	180.0	0.0	180.0
ii. Domestic Consultants	0.0	116.0	116.0
b. Travel			
i. International	12.0	0.0	12.0
ii. Local	0.0	15.0	15.0
c. Reports	10.0	0.0	10.0
2. Workshops, Seminars, Training	0.0	40.0	40.0
3. Participatory Research Analysis	0.0	20.0	20.0
4. Miscellaneous Administration and Support Services			
a. Office and Administrative Expenses	0.0	12.0	12.0
b. Facilitation and Use of Local Assistants	0.0	12.0	12.0
c. Communications	3.0	0.0	3.0
d. Computer hardware and software	0.0	15.0	15.0
5. Contingencies	25.0	40.0	65.0
Subtotal (A)	**230.0**	**270.0**	**500.0**
B. Government Financing			
1. Counterpart Staff and Allowances	0.0	72.0	72.0
2. Office Accommodation and Utilities	0.0	32.0	32.0
3. Secretarial and Office Support	0.0	16.0	16.0
4. Translation Services	0.0	8.0	8.0
5. Meeting Rooms	0.0	12.0	12.0
Subtotal (B)	**0.0**	**140.0**	**140.0**
Total	**230.0**	**410.0**	**640.0**

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. Health Financing Expert and Team Leader (international, 12 person-months)

1. The consultancy will be divided into three periods. During the first 4 months, the consultant will do the following:

(i) Review relevant documents and available information about health care financing in Viet Nam, including the final report of Asian Development Bank (ADB) technical assistance (TA) 3877-VIE Making Health Care More Affordable for the Poor: Health Financing in Viet Nam and the Reports of the 2001–2002 Viet Nam National Health Survey, the 2002 Multi-Purpose Household Survey, and the National Health Accounts.

(ii) Develop a detailed comprehensive study framework and plan for implementing the entire TA, including a schedule for the four studies, the workshop to present study findings, and the training of provincial and district staff to support the implementation of Decision 139. This will be summarized in an inception report and to be submitted to the Ministry of Health (MOH) and ADB within 1 month from the start of the TA.

(iii) Work with domestic consultants and MOH counterparts (including the MOH Health Care Financing Committee) to develop a detailed design and terms of reference (TOR) for the four studies (including appropriate data sets) and evaluation criteria for the selection within the first month.

(iv) Prepare the study design and detailed TORs for the participatory rapid assessment (PRA).

(v) Help identify researchers for the four studies (as the member of the evaluation committee) and thoroughly brief the researchers on the TORs and expected outcomes.

(vi) Help identify the nongovernment organization to undertake the PRA.

(vii) Work with the domestic consultant for Decision 139 monitoring and MOH counterparts to develop detailed plans for the further development of Decision 139 monitoring and reporting software.

(viii) At the end of the 4 months, submit an interim report summarizing what has been achieved in and future plans, especially for the period when the consultant will be away.

2. During the second 4-month period, the consultant will do the following:

(i) Work with domestic consultants and MOH counterparts to review and finalize the Decision 139 monitoring and reporting software.

(ii) Supervise and support the PRA.

(iii) Together with MOH counterparts, review and support the work of domestic consultants on each of the four studies.

(iv) Work with domestic consultants and MOH counterparts to develop a plan for monitoring the impact of Decision 139 and supervise its implementation in the central highlands under 2076-VIE: Health Care in the Central Highlands Project.

(v) At the end of the second 4-month period, submit an interim report summarizing what has been achieved in and future plans, especially for the period when the consultant will be away.

3. During the last 4 months, the consultant will do the following:

(i) Work with the domestic consultants to finalize their reports for each study, including the integration of PRA findings.

(ii) Work with the selected nongovernment organization to finalize the PRA report.

(iii) Review progress in training provincial and district staff in the use of the Decision. 139 monitoring and reporting software and in other areas to support the implementation of Decision 139.

(iv) Summarize the findings and recommendations of the TA studies in a final report.

(v) Hold workshop(s) to present the findings of the TA studies and to review the TA's final report.

B. Domestic Consultants

1. Monitoring and Evaluation Consultant (24 person-months)

4. This assignment will be done by one or two consultants, depending on the availability. The consultant will do the following:

(i) Work with the team leader and MOH counterparts to identify the routine monitoring and reporting needs for Decision 139.

(ii) Work with the software vendor to further develop the Decision 139 monitoring and reporting software so that it can fully meet monitoring and reporting needs.

(iii) Pretest the software at the central, provincial, and district levels and recommend any changes needed in the software.

(iv) Work with the domestic consultant for training to identify training needs at provincial and district levels for the monitoring and reporting software.

(v) Work with the domestic consultant for training to develop suitable training materials for the monitoring and reporting software.

(vi) Work with the team leader and MOH counterparts to develop a plan for monitoring the impact of Decision 139.

(vii) Support the implementation of the monitoring plan, especially in the central highlands

(viii) Work with the domestic consultant for training to evaluate the effectiveness of the software training in a representative sample of provinces and districts.

(ix) Prepare final report summarizing the capacity development work in monitoring that has been accomplished during the TA and describing the plan for monitoring the impact of Decision 139.

2. Training Consultant (24 person-months)

5. This assignment will be done by one or two consultants, depending on the availability. The consultant will do the following:

(i) Visit a sample of provinces and districts to assess training needs for the effective implementation of Decision 139.

(ii) Work with the domestic consultant for monitoring to assess training needs in connection with the monitoring and reporting software.

(iii) Work with the team leader and MOH counterparts to develop a training plan, including dates and venues for the various training activities.

(iv) Work with the domestic consultant for Decision 139 monitoring to prepare suitable training materials.

(v) Train provincial trainers so that they will be able to train district staff in the use of the Decision 139 monitoring and reporting software and in other areas to support the effective implementation of Decision 139.

(vi) Work with the domestic consultant for Decision 139 monitoring to evaluate the effectiveness of the training in a representative sample of provinces and districts.

(vii) Prepare a final report summarizing the capacity development work that has been accomplished during the TA and report the main findings of the evaluation of the training provided under the TA (including the training provided in the use of the monitoring and reporting software).

3. Public Health Researcher 1: Health and Poverty Study (5 person-months)

6. The consultant will do the following:

(i) Review all relevant documents related to the study.

(ii) Review available data sets for possible use in the study.

(iii) Work with the team leader and MOH counterparts to specify empirical models of labor supply and productivity and household income, wealth, and indebtedness that can be used to enhance understanding of the impact of poor health (morbidity and disability) on poverty, especially for women and ethnic minorities.

(iv) Estimate the model parameters and review their policy implications with the team leader and MOH counterparts.

(v) Prepare a report of the study according to the outline presented in Appendix 2 (which may be revised on the basis of discussions with the team leader).

(vi) Present the study's findings in a workshop, and revise the report to incorporate comments received at the workshop and from the team leader, MOH counterparts, and ADB.

(vii) Work closely with the team leader, other domestic consultants, and MOH counterparts to achieve the overall objectives of the TA.

4. Public Health Researcher 2: Barriers to Healthcare Utilization Study (5 person-months)

7. The consultant will do the following:

(i) Review all relevant documents related to the study.

(ii) Review available data sets for possible use in the study.

(iii) Work with the team leader and MOH counterparts to specify empirical models of healthcare use (demand) that can be used to identify the main constraints to increased healthcare use by the poor and other vulnerable groups (for example, women and ethnic minority groups, persons residing in remote areas).

(iv) Estimate the model parameters and review their policy implications with the team leader and MOH counterparts.

(v) Prepare a report of the study according to the outline presented in Appendix 2 (which may be revised on the basis of discussions with the team leader).

(vi) Present the study's findings in a workshop, and revise the report to incorporate comments received at the workshop and from the team leader, MOH counterparts, and ADB.

(vii) Work closely with the team leader, other domestic consultants, and MOH counterparts to achieve the overall objectives of the TA.

5. Public Health Research 3: Factors Affecting the Cost of Healthcare to Households Study (5 person-months)

8. The consultant will do the following:

(i) Review all relevant documents related to the study.

(ii) Review available data sets for possible use in the study.

(iii) Work with the team leader and MOH counterparts to specify empirical models of household healthcare expenditure that can be used to identify the factors associated with the direct and indirect costs of healthcare to households, especially for the disadvantaged populations.

(iv) Estimate the model parameters and review their policy implications with the team leader and MOH counterparts.

(v) Prepare a report of the study according to the outline presented in Appendix 2 (which may be revised on the basis of discussions with the team leader).

(vi) Present the study's findings in a workshop, and revise the report to incorporate comments received at the workshop and from the team leader, MOH counterparts, and ADB.

(vii) Work closely with the team leader, other domestic consultants, and MOH counterparts to achieve the overall objectives of the TA.

6. Public Health Researcher 4: Demand For Health Insurance Study (5 person-months)

9. The consultant will do the following:

(i) Review all relevant documents related to the study.

(ii) Review available data sets for possible use in the study.

(iii) Work with the team leader and MOH counterparts to specify empirical models of the demand for health insurance that can be used to identify the main constraints to the expansion of voluntary health insurance coverage among the largely uncovered rural population, especially ethnic minorities and women.

(iv) Estimate the model parameters and review their policy implications with the team leader and MOH counterparts.

(v) Prepare a report of the study according to the outline presented in Appendix 2 (which may be revised on the basis of discussions with the team leader).

(vi) Present the study's findings in a workshop, and revise the report to incorporate comments received at the workshop and from the team leader, MOH counterparts, and ADB.

(vii) Work closely with the team leader, other domestic consultants, and MOH counterparts to achieve the overall objectives of the TA.