附　属　資　料

① ミニッツ
② 保健省組織図
③ 保健医療長期指針（1996～2000）
④ 食品衛生関連
⑤ 看護関連
⑥ 感染症対策関連
⑦ 都市保健関連

① ミニッツ

MINUTES OF DISCUSSIONS
BETWEEN
THE JAPANESE BASIC STUDY MISSION
ON MEDICAL COOPERATION
AND
THE AUTHORITIES CONCERNED OF
THE GOVERNMENT OF THE SOCIALIST REPUBLIC OF VIETNAM
ON MEDICAL COOPERATION

The Japanese Basic Study Mission on Medical Cooperation (hereinafter referred to as "the Mission") organised by the Japan International Cooperation Agency (hereinafter referred as "JICA") and headed by Dr. Akira Hashizume visited the Socialist Republic of Vietnam (hereinafter referred to as "Vietnam") from 15 August to 28 August 1999, for the purpose of collecting the necessary data to draft the Japanese medical cooperation in various fields in Vietnam.

During its stay in Hanoi, the Mission exchanged views and had a series of discussions with the authorities concerned of the Government of Vietnam (hereinafter referred to as "GOV") including the Ministry of Planning and Investment (hereinafter referred to as "MPI"), the Ministry of Health (hereinafter referred to as "MOH") and its functional departments (Department of International Cooperation, Department of MCH/FP, Department of Preventive Medicine, Department of Therapy and Department of Food Administration) and other institutions under the Ministry of Health (National Institute of Hygiene and Epidemiology, POLIOVAC, Bach Mai Hospital, Nam Dinh Higher Secondary Medical School and others).

As a result of the discussion, both sides agreed to recommend to their respective governments the matters referred to in the document attached herewith.

Hanoi, August 20, 1999

Dr. Akira Hashizume
Leader
Basic Study Mission
Japan

Dr. Trinh Bang Hop
Director General
Department of International Cooperation
Ministry of Health
S.R. Vietnam

(1) Food Hygiene

The Mission was briefed, by the Department of Food Administration which was newly established in MOH in February 1999 for the purpose of urgently improving food hygiene and safety conditions in view of promoting the people's health and welfare, on current situation of food hygiene and safety conditions and on their control measures conducted by the GOV.

And the Mission recognised prioritized needs for technical cooperation proposed by the MOH to develop a new system regarding the food hygiene and safety control measures.

Both the MOH and the Mission agreed that it would be appropriate that a Japanese expert will be dispatched in short and/or long term for a preliminary action of the cooperation.

(2) Nursing Management

The Mission visited MOH, Bach Mai Hospital, Dong Da Hospital and Nam Dinh Higher Secondary Medical School and had discussions with people concerned. The Mission confirmed as follows;

Nursing plays one of the key roles in successful implementation of hospital management. Therefore, the human resource development in the filed of nursing is urgently required.

Both parties agreed that technical cooperation in the field of nursing management would be further strengthened based on the nursing management cooperation to be carried out as a part of Bach Mai Hospital Project to be implemented from the year 2000.

The Grant Aid request of Nam Dinh Higher Medical Secondary School submitted by the GOV.

The Mission suggested that despatching a short-term Japanese expert might be possible for further consideration.

(3) Reproductive Health

Currently, the JICA is carrying out the Reproductive Health Project in Nghe An Province (hereinafter referred to as the "Project"). The Project has been implemented with the joint collaboration with JICA and the People's Committee of Nghe An Province for three year period from June 1,1997 to May 31, 2000.

The Mission visited MPI, MOH, UNICEF and UNFPA and exchanged views and opinions with people concerned.

Both parties and multilateral organisations the Mission visited recognised that the JICA Reproductive Health Project in Nghe An Province is one of the successful projects in Vietnam in the field of population and reproductive health.

The several activities of the Project specifically appreciated by GOV as very effective are; technical transfers by the Japanese experts, training and capacity building of people of Nghe An Province, counterpart training in Japan and supply of equipment.

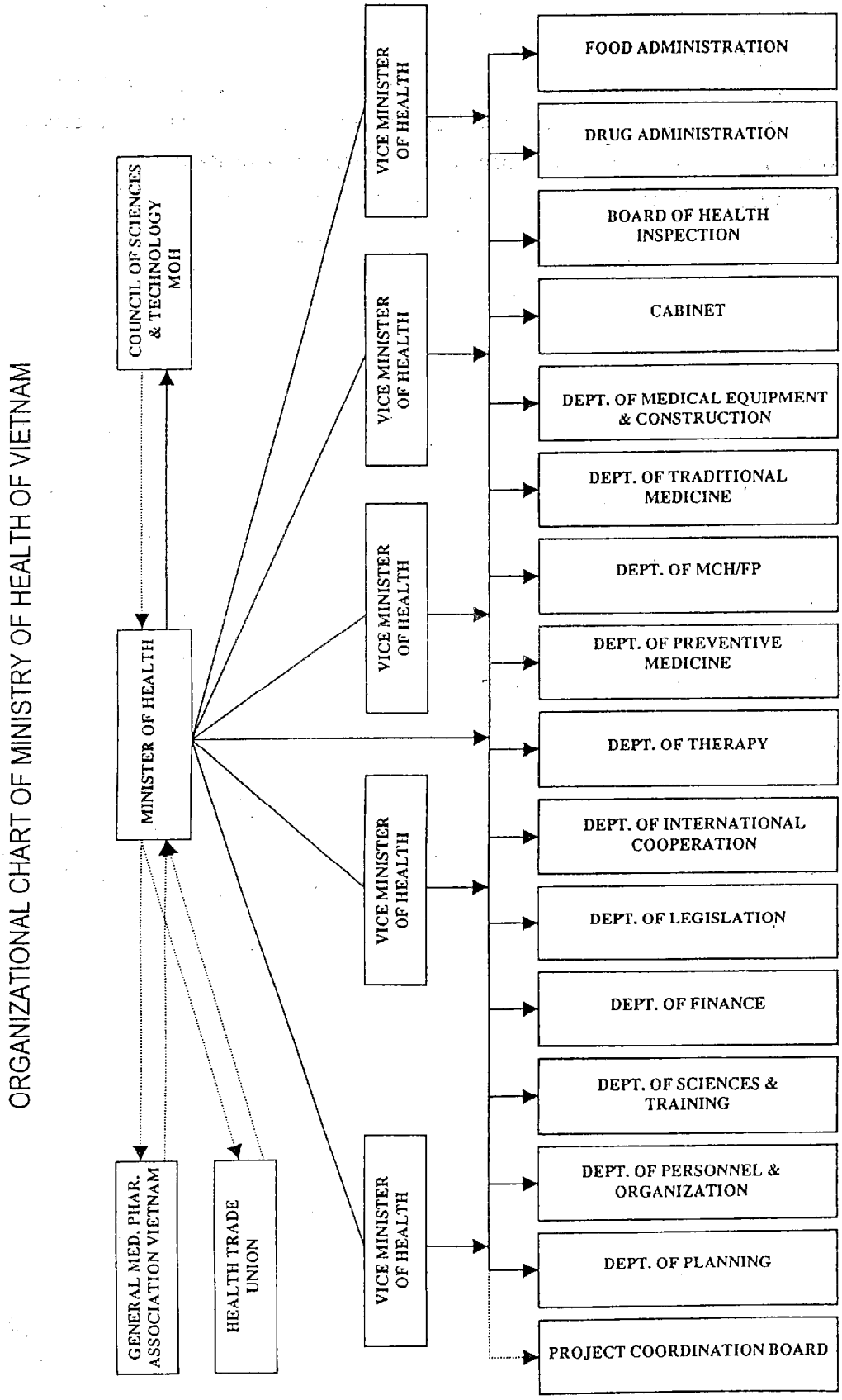
Based on the recognition mentioned above, both parties confirmed that further promotion of the Project activities in Nghe An Province is necessary to maximise the impact of the Project. Therefore, both parties agreed that the next phase of the Project should be developed as soon as possible.

MOH suggested that JICA would consider the possibility to share the experience accumulated through implementation of the Project with other needed areas in the future.

(4) The Measles Vaccine Production

The Mission conducted a series of discussions among people concerned including representatives of MOH, WHO, National Institute of Hygiene and Epidemiology, POLIOVAC Centre and UNICEF. It was confirmed that the GOV has strong interest in local production of Measles vaccine. It was mentioned that the further consideration on technical cooperation might be made after the examination of the technical report to be prepared by a WHO mission, which is planning to visit Vietnam in September 1999.

② 保健省組織図


ORGANIZATIONAL CHART OF MINISTRY OF HEALTH OF VIETNAM
COUNCIL OF SCIENCES & TECHNOLOGY MOH
MINISTER OF HEALTH
GENERAL MED. PHAR. ASSOCIATION VIETNAM
HEALTH TRADE UNION
VICE MINISTER OF HEALTH
VICE MINISTER OF HEALTH
VICE MINISTER OF HEALTH
VICE MINISTER OF HEALTH
VICE MINISTER OF HEALTH
FOOD ADMINISTRATION
DRUG ADMINISTRATION
BOARD OF HEALTH INSPECTION
CABINET
DEPT. OF MEDICAL EQUIPMENT & CONSTRUCTION
DEPT. OF TRADITIONAL MEDICINE
DEPT. OF MCH/FP
DEPT. OF PREVENTIVE MEDICINE
DEPT. OF THERAPY
DEPT. OF INTERNATIONAL COOPERATION
DEPT. OF LEGISLATION
DEPT. OF FINANCE
DEPT. OF SCIENCES & TRAINING
DEPT. OF PERSONNEL & ORGANIZATION
DEPT. OF PLANNING
PROJECT COORDINATION BOARD

③ 保健医療長期指針（1996～2000）

SOCIALIST REPUBLIC OF VIETNAM
MINISTRY OF HEALTH
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STRATEGIC ORIENTATION FOR PEOPLE'S HEALTH CARE AND PROTECTION IN THE PERIOD OF 1996 - 2000 AND VIETNAM'S NATIONAL DRUG POLICY

Hanoi - 1996

Table of Contents

	Page
Government Resolution No 37/CP:	3
Strategic Orientation for People's Health Care and Protection from now to the years 2000 and 2020	4
Vietnam's National Drug Policy	21
Strategy for people's health care and protection from now to the year 2000 (*Presentation of Prof. Do Nguyen Phuong, Minister of Health at the Government Cabinet Meeting in April, 1996*)	28

THE GOVERNMENT
No. 37/CP

SOCIALIST REPUBLIC OF VIETNAM
Independence-Freedom-Happiness

Hanoi, 20 June, 1996

GOVERNMENT RESOLUTION

on strategic orientation for people's health care and protection in the period of 1996-2000 and Vietnam's National Drug Policy

At the meeting session on April 23, 1996 the Government has listened to the report on the situation of people's health and the health service in recent period. Following a discussion a resolution was adopted on strategic orientation for people's health care and protection for the period of 1996-2000. The Government also discussed and decided the drug policy of Vietnam.

Health care and protection is the responsibility of every individual, family, authority of all levels, mass organizations and social organizations.

The Government requests that all Ministries, Government Offices, People's Committee at all levels should well implement the guiding lines and measures for people's health care and protection mentioned in the two following attached documents:

1. Strategic Orientation on People's Health Care and Protection from Now to the Year 2000 and 2020.

2. Vietnam's National Drug Policy.

The Ministry of Health is responsible for formulation of concrete plan providing guidance for implementation and supervising and speeding up the implementation of this resolution by other sectors.

The Vietnam Fatherland Front and other mass organizations within the Front are request to collaborate with the sector and concerning government offices to mobilize people in the whole country to actively respond to and participate in hygiene and prophylaxis activities, people's health care and protection, contribute to the successful implementation of the set objectives in the strategic orientation for eventual improvement of people's quality of life, thus accelerating the process of socio-economic development of our country.

On behalf of the Government
The Prime Minister

(Signed)

VO VAN KIET

STRATEGIC ORIENTATION FOR PEOPLE'S HEALTH CARE AND PROTECTION FROM NOW TO THE YEARS 2000 AND 2020

Part 1

Assessment of people's health care and protection in the period of renovation, particularly since the end of the VII Congress of the Communist Party of Vietnam

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I. FUNDAMENTAL ACHIEVEMENTS

Over the past years, the close guidance given by the Party and State to health care and protection has been reflected by the resolutions of the VI and VII Party resolutions, in particular the 4th meeting of the 7th Plenum of the Party Central Committee which passed a resolution on "Urgent problems in the people's health care and protection". Also, the National Assembly has promulgated the Law on Protection of the People's Health. The Government has issued a number of instructions and decisions to institutionalize the party 's guiding lines. Much efforts have been made by the health services in organizing the implementation of the Party and State lines and policies and therefore, important achievements have been obtained in the field of health care and protection for the people.

1. Consolidation of the basic health network:

The introduction of the contractual system into the network of agricultural cooperatives in accordance with the 10th Plenum of the Party Central Committee has created an adverse impact on the network of commune health centers, leading to the partial or complete interruption of

activities of many commune health centers due to the lack of resources. Facing with this situation, some localities have been actively looking for measures to consolidate the basic health network. In particular, after the promulgation of the resolution of the 4th Plenum of the Party Central Committee and the Prime Minister Decision 58/TTg, the network of commune health centers was further consolidated in terms of organization, staff, facilities and equipment. Also, the content of health-related activities were changed anew and more senior health workers were seconded to work at and help improve the performance of commune health centers . About 1,800 medical doctors are working at commune health centers. Within the years 1994-1995, over 700 commune health centers were built anew and both the professionalism and managerial capacity of communal and district health workers have been improved. *The consolidation of basic health network has facilitated the speeding up of the implementation of the Party and State policy on people's health care and protection as well as primary health care at each and every household and hamlet.*

2. The health services has actively coordinated with all levels of authority and mass organizations in involving people in IEC activities in the campaigns for hygiene and prophylaxis as well as in the good implementation of programmes for prevention of diseases and epidemics, epidemic surveillance. The National Health Programs have also obtained good results. Thanks to this, the cases and deaths due to in epidemic infectious diseases have been gradually controlled and reduced. The promotion of hygiene and prophylaxis has resulted in the control of a number of diseases and a marked reduction of vaccine preventable diseases covered by the Expanded Programme on Immunization (EPI)

With support and guidance given by all levels of the party, authorities and mass organizations in co-ordination with the health services, the EPI, started in 1986 has been able to maintain a coverage rate of 85% for many successive years. Good results have also been obtained in malaria control with a marked decrease in both morbidity and mortality rates, non-outbreak of major epidemic. Goiter, TB, Leprosy and other health programmes have also met the set targets.

Good results have also been obtained in the prevention and control of non-infectious diseases common in developed countries such as cardio-vascular diseases and hypertension, cancer, mental diseases, drug abuse, arthritis, injuries due to traffic accidents, and such issues as health

care for the elderly, overcoming the consequences left by the war on health, prevention and control of common diseases by age group, population group and type of labour/occupation.

3. Initial changes for the better in examination and treatment:

The health sector has readjusted hospital management by launching an emulation movement within the sector to consolidate the daily routine of all hospitals, improve the quality of examination and treatment, particularly the health providers' responsibility and behaviour. Health insurance and the partial collection of hospital fees have supplemented the funds for examination and treatment. In recent years, the State and localities have invested in upgrading health facilities, giving them not only better appearance but more equipment as well as (re)training for staff. As a result, hospital staff can now provide early detection and complete cure of some diseases which they could not in the past due to the lack of resources. The re-organization of the curative health network has resulted in diversifying the forms of health care providers and mobilizing the participation of people of all strata in [providing/receiving] health services in accordance with the ordinance on private medical and pharmaceutical practice.

4. The pharmaceutical sector has demonstrated good development by satisfying most of the people's needs for drug and essential medical equipment supply which was impossible in many past years. In 1994, the per capita drug consumption averaged 3.2 USD, a 6 fold increase over the figure during the 1986-1990 period. Thanks to the expansion of the drug distribution network (state, collective and private), pharmaceuticals are nowadays can be found even in mountainous and remote hamlets. The drug market is also re-organized to prevent and eventually eliminate the sale of fake drugs, sub-standard drugs and psychotropic drugs.

5. Promotion and development of traditional medicine

The network of traditional health providers has been consolidated and organized to suit the new management mechanism, which is community oriented to provide primary health care and linked with the programme for socio-economic development and eradication of hunger and poverty. Every year, about a third of all patients at curative health facilities, particularly at the community level receive traditional methods of treatment. The training of traditional practitioners has been strengthened

alongside the expansion of international cooperation in traditional medicine. Some traditional medicine establishments have been upgraded.

The health status of the Vietnamese people has experienced an improvement. While the average life expectancy has been on the increase while malnutrition, mortality rates among children under one year and under five, among expectant mothers, the rate of new-borns of less than 2500 g have been all decreasing. Some of Vietnam's health indicators reach the levels of countries where per capita income is two or three times higher than that of Vietnam.

II. OUTSTANDING PROBLEMS AND CHALLENGES

The health sector must be capable of responding to the increasing health needs, both in quality and quantity, of people of all strata, first and foremost those who rendered meritorious services to the country, the poor, people living in disadvantaged areas or in former resistance zones. To ensure equity in health care for the people and maintain the humanism of the health sector in the context of a market economy is both an urgent task and long-term policy of Vietnam.

Environmental pollution, drug abuse, prostitution and other social evils are creating a negative impact on the people's health and increasing the risk of illness. In the countryside, environmental pollution has been caused by the habit of using untreated manure, chemical insecticides, chemical fertilizers and a lack of proper latrines. In urban centers, pollution has been caused by improper treatment of garbage, industrial wastes and noises. The percentage of people accessible to clean water remains very low. IEC activities for health are only occasionally conducted within the framework of campaigns and have not yet become a popular movement for hygiene and prophylaxis at the community.

The attainment of the set targets is also hamstrung by the fact that the available material basis fall short of demands. Alongside the country's growth the health sector has been developing towards modernization with limited resources. Most of the health facilities in Vietnam were built long ago and their equipment are now old and antiquated, especially at hospitals in the districts and mountainous areas. In recent years, the State has made more yet still modest investments in upgrading health facilities. The State financing for health is limited whilst the health equipment very expensive.

The pharmaceutical service is slow in changing structurally now that the country has been shifting to the socialist-oriented market mechanism. Failing to catch up with the changes, the service is incapable of exercising an effective state management over the drug market which is now becoming more diversified and complex. It is also unable to control the imports of drugs, in particular through smuggling and under the "gift" label. The pharmaceutical industry is scattered and not rationally organized, its equipment and facilities are old, antiquated and not compatible with one another. Research/ study into science and technology and management has not been given due attention to.

The system for organization and training of health personnel is slow in changing to suit the new mechanism. The local health network has been reorganized but there remain problems with the organizational structures of district health centers, commune health centers and/or inter-communal polyclinics, other health centers administered by the provincial health bureau and the management of health facilities in a geographical area.

More health personnel has been trained but the ratio of physician per population remains low. The training of health personnel has not yet been linked with their employment, and therefore, physicians are superfluous in cities and towns but lacking in the countryside. There are only few physicians working in the communes.

A portion of health personnel are irresponsible and lack medical ethics. The behaviour and acts of these people are sometimes are at variant with the Party and State policies and even breach the law. Some health personnel policies, for their parts, fail to encourage the health personnel in the fulfillment of their tasks and make the best use of their capacity for protective and curative care.

The health status of the Vietnamese people in general, has improved but remains low and characterized by regional variations, specifically between urban and rural areas and people of different strata.

Part 2

Strategic orientations for people's health care and protection from now to the years 2000 and 2020

I. THE GUIDING PRINCIPLES IN PEOPLE'S HEALTH CARE AND PROTECTION

Under the Party's leadership, efforts are being made to build Vietnam, by the year 2020, into a country having a socialist-oriented industry, an ecologically-developed agriculture, a dynamic and multi-sector economy and a healthy society where the human factor and other humane values are respected and promoted. Alongside the improvement in people's living standards, the health needs shall constantly grow and diverse. Also, the development of a market economy shall create social stratification and different income levels. The addition of another 30 million people by the year 2020 to the present population shall also pose new problems to health care. Given the specific conditions in Vietnam's socio-economic development and the needs for health care in the new stage, it is necessary to reaffirm the following guiding principles for health care and protection:

Human being is the most precious resource deciding the development of the country, in which health is the most valuable capital of each individual and of the whole society. It is also the greatest source of happiness for each and every individual and family. Investment in health so that everybody can have access to health care also means investment in socio-economic development of the country and improve the quality of life for each and every individual and family.

The humanitarian nature and socialist orientation of health activities demand equity in the provision of health care. To achieve equity is to ensure that everybody shall have access to health care in accordance with the economic wealth of the society. In addition to that, it shall be the government policy to provide either free or subsidized health care to those who have rendered meritorious services to the country, the poor, people living in disadvantaged areas and people of ethnic groups.

Active prevention constitutes the prominent principle in the process of building and developing of Vietnam's health service. Active prevention must be well aware of and applied in efforts to create a healthy and decent lifestyle, ensure that the environment for study, work and life is beneficial to disease prevention and better health. It is also necessary to be active in the prevention of factors harmful to human health in the course of industrialization and urbanization.

Regarding the combination of modern medicine with traditional medicine. Traditional medicine, the cultural heritage of the Vietnamese nation should be protected, promoted and developed. A sound study into and application of traditional medicine; a combination of traditional medicine with modern medicine without losing the quintessence of traditional Vietnamese medicine should be vigorously promoted. State management over traditional medicine should be strengthened to prevent opportunists from taking vantage of the party and government policy on traditional medicine and causing harm to the people's health.

Regarding the socialization of health care provision. Responsibility for health care provision rests with each and every individual, family and community, level of party and authority, sector and mass/social organization. All levels of party and authority and mass/social organization are responsible for leading, guiding and mobilizing all resources and people of all strata for health care and protection.

To diversify the forms of health care provision (state or community-run or private) in which the state plays the leading role; develop various forms of health care provision to meet the growing and diversified needs of the people within the limited resourses provided by the State to the health sector; encourage, guide and manage well the activities of community-run health facilities to meet the people's needs for curative care and struggle against all negative manifestations in the provision of health care services.

II. OBJECTIVES FOR HEALTH CARE AND PROTECTION DEVELOPMENT

The overall objective is to reduce the morbidity and increase the health status and life expectancy.

The objectives from now to the year 2020 shall be to ensure equity in and improve the quality and efficiency of health care, respond to the

growing health needs of people of all strata, raising the health status of the Vietnamese people to the average of the regional countries.

In the period from 1996 to 2000, efforts shall be made to make the best use of available resources and opportunities for more investment in upgrading the curative health facilities, improving hospital management and education of medical ethics, thus enabling the curative network to meet the growing health needs of the people. All this enables the health services to advance towards modernization.

1. The basic health indicators of the Vietnamese people by the year 2000 and 2020 shall be as follow:

- Life expectancy shall be increased to 68 and 75 years old, respectively by the years 2000 and 2020.

- Mortality rate among children less than one year of age shall be reduced to approximately 35 per one thousand live births by 2000 and from 15 to 18 per cent by the year 2020.

- Mortality rate among the under five children shall be reduced to 42 per thousandth and 20 per thousandth respectively by the year 2000 and 2020.

- The rate of new-borns weighing less than 2500g shall be reduced to 8 percent and 5 per cent by the years 2000 and 2020 respectively.

- The rate of malnutrition among the under five shall be reduced to 30 percent and 15 percent by the years 2000 and 2020 respectively. No case of severe malnutrition shall be reported by that time.

- The average height of Vietnamese youth shall reach 165mm by the year 2020.

- Iodine defficiency disorders shall be eliminated by the year 2005. The rate of goiter among children in the 8 to 12 age group shall be less than 5 percent.

2. A marked reduction of morbidity and mortality rates due to epidemic infectious diseases and parasitic diseases and cardinal improvement in the morbidity patterns of the Vietnamese people by the year 2020.In the periods from 1996 to 2000 and 2020, alongside continued efforts to control epidemic infectious diseases and parasitic diseases, it's

necessary to be active in controlling diseases characteristic of an industrialized country. Specifically:

Elimination of vaccine-preventable childhood diseases including poliomyelitis, neo-natal tetanus in the 1996-2000 period. Reduction to the minimum the morbidity and mortality rates of such diseases as cholera, typhoid, bubonic plague, hepatitis B and Japanese encephalitis B. Efforts shall be made to eliminate in the main rabies, malaria and the above-mentioned diseases by the year 2020.

Efforts should be redoubled to early detect and reduce the harmful effects of cancer, cardio-vascular diseases, injuries due to traffic accidents, mental disorders and occupational diseases etc. which are common in the morbidity pattern of developed countries and becoming a growing problem in Vietnam.

The elimination of leprosy, a limited prevalence of parasitic diseases and an absolute control of TB should be achieved by the year 2000.

The level of HIV infection should be limited and the impact created by AIDS on the community by every possible means.

3. Expansion of the health network; improvement of the quality and efficiency of health care provision and implementation of the policy to achieve social equity in health care.

Efforts should be made to strengthen and develop the national health system to make it technologically modern, convenient to the people alongside the building of high-tech centers and effective use of resources for health.

a) Development of medical high technology:

- Gradually modernize health equipment and develop medical high technology so that by the year 2000, the sending of patients abroad for medical treatment in general shall not be necessary.

- Promote the application of new advances in sciences and technology. Vietnam should strive to become, by the year 2020, a regional pace-setter in some areas in which this country has potential to develop.

- Develop bio-medical technology along the line of industrialization and modernization for the purpose of manufacturing pharmaceuticals and vaccines etc.

Organizationally and technically, the responsibility of each level of the health network should be clearly defined to avoid unreasonable referral to the higher level of health care and facilitate the work concerning health personnel, supply of medical equipment and application of appropriate technology at each level. The aim is to improve the quality of health care for the people right at their community. Lithotripsy, ultra-sound and laser either in diagnosis or treatment should be commonly applied at the provincial level.

An expanded application of different medical techniques to improve the quality of health care activities through community approach. By the year 2000, all expectant mothers should be able to receive the required three pre-natal checks for early detection and/or protection of obstetric complications. All child delivery shall be attended by qualified health workers in accordance with the technical requirements. The provision of home-based health care shall be promoted.

Regarding the attainment of equity in health care. There should be suitable policy and measures to enable everybody, especially those who render meritorious services to the country, beneficiaries from preferential government policies, the poor, people living in mountainous or remote areas to have access to health care, including primary health care and other services at a higher level. Circumstances where a poor and sick patient is denied of medical treatment because of his/her lack of money should be put an end to.

Patients undergoing treatment at health facilities should be given all services they need, particularly essential ones such as preparation of food and provision of clothing and enjoyment of a clean, quiet and good orderliness at these facilities.

b) The attainment of such objectives require the following conditions:

Investment: The provision of health care and protection must rely on the availability of different resources, including state investment, people's contributions, support and assistance from social or economic organizations, foreign countries and international organizations. In all such resources, state investment plays the key role.

Personnel: Health personnel must be adequate in terms of their composition, quantity and quality. The training of personnel qualified in high technology must be focused on in response to the needs for health technology development on the same level with other regional countries. At the same time, efforts should be made to train health personnel in community health to meet the requirements at the grass-roots levels. Medical ethics of a physician should be regarded as important as his/her professional quality. Rational policies should be promulgated to encourage the health personnel to work with creation and be devoted to the patients.

Pharmaceuticals and medical equipment: Sufficient supply of drugs and medical equipment of good quality, in particular essential drugs, drugs for fields of specialty and drugs for children. Education of and guidance on rational use of drugs among users, suppliers and physicians to avoid drug misuse. The pharmaceutical industry should be further developed meet up to 70 % of people's drug needs. A selective inheritance and promotion of traditional medicine; a safe and effective use of traditional herbs and other drugs made from locally-available materials should be promoted for health care services at the community.

III. MAIN POLICIES AND MEASURES

1. Stream-lining the organizational structure and developing the health care network:

The local health network should be strengthened with the local authority exercising management over health activities in the community. The health sector is responsible for providing guidance professionally and technically through the control of funds and health personnel. Health programmes at the community shall be guided by various levels of authority and implemented by the health and other sectors with the participation of all community people.

Regarding the development of the community health facilities. By the year 2000, all the commune health centers shall have been equipped with common medical instruments. Efforts should be made so that 40 % of the health centers shall have a doctor; all shall have a midwife or pedia-obstetric assistant-doctor; all hamlets shall have community health workers. The work style of the commune health centers shall be improved to fulfill the primary task of promoting preventive care and home-based health care with growing community participation. The role of mobile team

of health workers should be consolidated and further strengthened in the mountainous and remote areas to attain the two-fold objective of promoting health education and providing preventive and curative care.

The network of preventive care should be strengthened through organizational work and training and investment in the upgrading of health facilities. The movement for hygiene, prophylaxis and environmental protection should be restored and boosted.

The curative health network must be rearranged to suit different population areas and the effectiveness of their use. The health network of different sectors shall also be reorganized for more effective operations and integration into the common health network (except certain branches having special requirements such as national defence, interior etc.). The forms of health care provision should vary to include public, joint ventures, people-founded and private hospitals. Where conditions permit, certain wards or rooms in some hospitals can be arranged to collect enough fees and provide services satisfactory to the willing users.

The building of two high-tech centers in Hanoi and Ho Chi Minh City should continue to be followed by another center in central Vietnam. By the year 2020, there will be additional high-tech centers in the Northern mountainous region, the Central Highland and the Mekong river delta. These centers should develop medical specialities practically meeting the local people's health care needs.

2. Health personnel training and employment and the development of science and technology:

The training curriculum should be improved to suit the community health needs, concentrating on the training of health managers and technicians who can operate and repair sophisticated medical equipment.

The staff composition at all health facilities must be rational with certain numbers of (assistant) doctors and pharmacists to ensure efficient services for the patients. The training of health personnel at the request of localities should be promoted alongside the promulgation of policies to encourage more health personnel to go to work in remote or mountainous areas or places with many difficulties. The training of health personnel may take various forms but must always ensure good quality.

Regarding the planning of training network. There should be training programmes and criteria for new and annual re-trainings. The formulation

and promulgation of specific policies should be effected to ensure good living conditions for health personnel especially those who go on working missions in disadvantaged areas.

Study and research into sciences and technology should be stepped up. The pathological study characteristic of Vietnam and the inheritance and promotion of traditional medicine should be effected along the application of new advances in medicine and pharmacy in the field of health care.

3. Promotion of investment and management of resources:

The state should invest more in health-related activities, mobilize and effectively use all available resources for the same purpose. Such resources include contributions from the people, production and business enterprises, international aid and cooperation.

The partial collection of user fees should continue alongside the promotion of health insurance to increase the sources of funds for the curative services. Full collection of user fees should be made available to those who are willing to pay for types of health services at request. The funds generated in this way may help ameliorate the financial burden of health care provision for the poor. The health insurance network should be reorganized and its style of work re-geared. The policy of voluntary health insurance should be implemented effectively so that by the year 2005, hospital fees shall have been in the main covered by health insurance.

International cooperation in health should be promoted. More capital should be mobilized in the form of aid, cooperation, joint ventures and investments including wholy foreign-owned ventures. Invesment should concentrate on preventive and curative care, drug manufacture, medical equipment and support for national health programmes.

4.Socialization of health care and protection:

Health programmes should be carried out in the community by the state offices, mass organizations in co-ordination with the health sector. Health education should aim to raise public awareness of health problems and promote voluntary participation in health activities by both the family and the community.

The health sector attaches importance to the task of socializing health activities. It should play an active and key role in co-ordinating and/or co-

operating with other sectors and all mass organizations in the provision of health care to the people.

The Cultural and Information Service should persistently promote health education and community participation in health activities on newspapers, radio and TV and other mass-media channels.

The Sports and Physical Culture Service, for its part, should do its best in conducting campaigns for physical fitness and mobilizing community participation therein.

The Education Service should introduce health education into the curriculum of general schools, educating pupils about wholesome ways of life and hygienic rules, and how best to keep themselves and their families in good health.

The Population and Family Planning Service should well mobilize and provide guidance on family planning to rapidly reduce the birth rates in the implementation of the reproductive health programme.

The Labour, War Invalids and Social Affairs Service should co-ordinate with the health sector in providing health care to those who have made meritorious services to the country, the poor and other beneficiaries in implementation of social policies. The prevention of social evils with an adverse impact on health such as drug abuse and prostitution etc. should be promoted.

The construction service, the agricultural and rural development service and all localities should implement the programme for environmental health, the clean water programme, the green and clean campaigns in the urban areas and solve the problem of toilets along/on rivers, lakes and ponds and encourage a safe use of insecticides in agriculture.

5.Promotion of priority health programmes:

Continued efforts should be made to implement the national health programmes for the attainment of the set objectives in EPI, control of goiter, malaria, TB and upgrading of hospitals and building of commune health centers.

- A simultaneous implementation of various health programmes for the attainment of the set objectives. They are:

- Control of Diarrheal Diseases (CDD), Acute Respiratory Infection (ARI), Nutrition Programmes, Programme for Prevention of Rheumatic Fever in Children.

- Programmes for health education, environmental health, school health, food hygiene and safety and occupational health.

- Programmes for protection and control of cancer, cardio-vascular diseases and injuries due to traffic accidents.

- Programmes for rehabilitation, prevention of consequence of diseases. In this regard, community-based rehabilitation should be promoted.

- Programmes for disaster prevention and preparedness. In this programme, the planning of health facilities must be linked with the socio-economic development plan of disaster-prone localities.

- Programme for improving first and foremost the working conditions of women and other conditions for better health care.

- Reproductive health care including health care for mothers and children, family planning and other issues of reproduction.

- Efforts should be made to ensure safe delivery, rapidly reduce cases of reproductive tract diseases and sexually-transmitted diseases including HIV/AIDS and viral hepatitis.

- The improvement of health care for the elderly should be expected to further enrich the material, cultural and social life of the elderly through various forms of care for the elderly not only for their living conditions but in the family and community.

6. Promotion and development of traditional medicine, combination of traditional medicine and modern medicine shall be effected through

- A comprehensive implementation of the priority programme of the health sector on traditional medicine.

- More investment in research into and application and modernization of traditional medicine, including scientific research training of

personnel, diagnosis and treatment, drug production and material medica,

- The institutional training of traditional practitioners should be stepped up alongside the establishment of a Traditional Medicine Department at the Hanoi Medical College and the Ho Chi Minh City Medical and Pharmaceutical School,

- The growing of medicinal plants and trees should be boosted up among the population through the joint efforts of the health sector, the Vietnam Association of Traditional Medicine and other mass organizations.

7.Ensurance of an adequate drug supply, development of the pharmaceutical industry and supply of medical equipment.

a) Vietnam's national drug policy should be implemented to obtain the following fundamental objectives: A ready and adequate source of high quality drug supply to the population, a safe, rational and effective use of drugs

(The national drug policy is referred to in a separate document)

b) Regarding medical equipment

Medical equipment at all levels of health care should be standardized and the supervision and control of the import of medical equipment strengthened.

The medical equipment industry should be expanded to meet the domestic needs for common medical equipment. The scientific and technological potential of all economic sectors should be tapped to facilitate the manufacture of high-tech equipment.

More training should be given to health personnel in the use and maintenance of sophisticated equipment for long-term and optimum operation .

8. Combination of army medical corps and civilian health services in health care provision

A close combination of the army medical corps and civilian health services to create an aggregate strength of Vietnam's health services for

the provision of health care, fulfill the tasks of national defence and maintenance of law and order. The army medical corps are expected to assist the civilian health services in disadvantaged areas, during the fight against epidemics and consequences of disasters.

9. Administrative reform, raising the effectiveness of State management over the health sector.

Amending and perfecting administrative procedures in examination and treatment to make it more convenient to the patients. Negative aspects in health services should be eliminated. The health services management should be improved by linking responsibility and benefits on the basis of good performance by the health unit and each individual. The responsibility of all health facilities should be heightened and their autonomy rights better exercised.

Refresher training for health personnel of all levels on health organizational structure and management. Legislative work should be strengthened at government offices excercising health management. The role of health inspectors should be promoted from the central to the grass-roots levels; discipline and order in all activities of the health sector should be ensured alongside a strict compliance with the law and regulations on preventive and curative health.

The ties between the offices exercising state management and the Ministry of Health (MoH), the Trade Union of the Health Service and the General Medical and Pharmaceutical Association, the Association of Traditional Medicine and the Vietnam Red Cross should be promoted in the provision of health care and protection to the people in Vietnam.

VIETNAM'S NATIONAL DRUG POLICY

I. The need for a national drug policy:

Pharmaceuticals constitute an important factor in people's healthcare. It is the responsibility of the pharmaceutical sector to ensure sufficient drug supply to satisfy the people's drug needs and carry out all activities necessary for this purpose. These activities include the production, trading, import, export, distribution, storage, guarantee of drug quality, and safe and rational use of drugs.

In recent years, the pharmaceutical industries in many countries, including Vietnam, have seen vigorous development. However, the growing varieties of pharmaceutical products available on the market and the increased drug use in therapy have also created problems for drug management. In the health budget, drug expenditures have been on the increase particularly in the developing countries. The social, economic and cultural distinction between countries prompts each country to seek specific solution for its own drug needs. This view is also shared by the World Health Organization which recommends every country to formulate its own national drug policy.

In Vietnam, quite a few drug policies and regulations have been promulgated by the State over the past years but such policies and regulations still lack cohesion. At present, the amount of drugs available on the market has been considerably increasing with more varieties and higher quality. Drug supply has also been improving. There remain, however, problems of uneven drug distribution, waste of money and damage to health due to drug abuse in treatment, the failure of state management over drug to catch up with the requirements of the new situation. The promulgation by the Government of a National Drug Policy, therefore, provides basis for the pharmaceutical sector in particular and the health sector in general in the task of providing healthcare and protection to the people in the new stage of the country.

II. The objectives of Vietnam's national drug policy

Vietnam's National Drug Policy aims at:

- Ensuring a sufficient supply of good quality drugs to the people.
- Ensuring a rational, safe and efficacious use of drugs.

- The specific objectives of the National Drug Policy are:

- To ensure sufficient supply of good quality drugs at affordable prices; promote equity in the supply of drugs to the patients; give priority to essential drugs and special importance to traditional medicine.

- To make the best use of all resources for the development of the pharmaceutical industry to satisfy most of the people's needs for curative drugs.

- To develop and improve the drug supply network for the community, with priority being given to the disadvantaged, mountainous or remote areas.

- To assure drug quality in production, storage and circulation.

- To raise the effectiveness of state management over the pharmaceutical sectors on the basis of perfecting the legal and regulatory system.

- To re-structure the pharmaceutical sector to make it suit the new mechanism.

- To achieve a rational structure and sufficient quantity of personnel of the pharmaceutical sector; improve the technical knowledge and professional ethics of pharmaceutical personnel.

- To boost scientific research into pharmaceutical science and apply the advances of sciences and technology in drug production, supply and management.

- To promote inter-sectoral cooperation, joint ventures and international cooperation in pharmaceutical field.

Time schedule for implementation of this policy from 1969 to 2010 shall comprise the following phases:

- Phase 1: 1996-2000

- Phase 2: 2001-2005

- Phase 3: 2005-2010

III. Specific Policies:

1. Essential drugs - rational and safe use of drugs:

To ensure a rational and safe use of drugs and minimize risks caused by non-compliance with regulations on prescribing, sale and use of drugs, it shall be necessary to have:

- A policy on essential drugs.

- The state guideline under which other ministries and sectors coordinate with the Ministry of Health in implementing the national policy on essential drugs. Supportive measures should be taken to ensure a sufficient supply of essential drugs to all people including the poor and people of ethnic groups in remote and mountainous regions for preventive and curative care..

- The formulation and issuance of the list of essential drugs, to be revised and supplemented every 3 or 5 years to suit the morbidity patterns, the socio-economic conditions of Vietnam and the applications in therapy of new advances in science and technology.

- The issuance of a national drug list based on such criteria as being suitable to the morbidity pattern and domestic therapeutic methods, highly effective, safe, easy to use and meeting the requirements for treatment at each level of healthcare.

- A policy on antibiotics.

Antibiotics play a very important role in therapy, especially in the morbidity pattern of Vietnam, a tropical country.

The prescribing behaviour and use of antibiotics shall be readjusted and the bacteria resistance identified to facilitate the development of anti-biograms for curative health facilities. The Ministry of Health and the Ministry of Agriculture and Rural Development shall promulgate regulations on antibiotics for animal use to avoid increased resistance to antibiotics among germs that may cause human diseases.

- Drug and Therapy Councils at hospitals shall be set up alongside the issuance of treatment schemes. The publication of a National Formulary shall provide basis for the use of drugs, the compliance

with regulations on prescription and sale of drugs upon prescription, drug names in prescriptions and/or labels.

2. Drug quality assurance:

Efforts shall be made to ensure that all drugs when reached the end-users are of good quality.

- The Quality Control Institute and its affiliates shall be modernized for the promotion of its role as the quality controller of pharmaceuticals and pharmaceutical materials. Also, some drug quality control stations in pilot regions should be upgraded to form a drug quality control network to facilitate quality control, supervision and control of drugs and detection of fake drugs.

- The Pharmacopoeia Council shall be strengthened by the Ministry of Health for the compilation and periodical publications of pharmacopoeia containing all drugs of both western and traditional medicine. Also, efforts shall be made by the Ministry of Health to promulgate regulations on drug quality control, policies in favour of patients participating in drug clinical trials and promote drug inspection, supervision and the use of strong measures against any breaches of drug quality regulations.

3. Manufacture, supply, import and export of drugs.

Vietnam strives for a comprehensive development and modernization of its pharmaceutical industry and drug supply network to meet the people's drug needs by making drugs available, affordable and convenient to the end-users and for an efficient import and export of drugs.

- The planning and re-organization of the pharmaceutical industry is expected at all levels on the basis of centralization and specialization and selective investment, co-ordination between all economic sectors, public, private and collective to promote the planned production of drugs, meet the drug needs at any time, combine the drug-making plan with the plan for the production of pharmaceutical materials. All drug production and distribution units of the state sector shall be restructured so that strong pharmaceutical trading agencies shall be established.

- The Ministry of Health shall provide guidance and support to drug manufacturers to reach the GMP standards, encourage local production of essential drugs, drugs for specialties, pharmaceutical materials from various sources of materia medica (plants and/or animals, processing and extraction thereof), and by pharmaco-chemistry and biological methods.

- Intellectual and industrial property rights in drug production shall be protected.

- Priority in the development of the drug supply network from the city/province to the community shall be given to the remote areas. All economic sectors will be encouraged to participate in the drug retail network, in the supply of drugs and pharmaceutical materials.

- Only drugs which suit Vietnam's morbidity pattern and drug policy shall be imported. Protective measures for locally-produced drugs shall be taken. Cooperation with the World Health Organization shall be promoted to make Vietnam well informed about the drugs imported into this country.

- The Ministry of Health shall draft and issue requirements for Good Storage Practice and encourage and finally compel all drug trading units to meet these requirements.

4. Traditional Medicine:

- Traditional medicine shall be promoted and developed. Traditional recipes and/or cures handed down by the ancestors or within a family, and tested and recognized in the course of time, shall be selectively utilized. Individuals and groups who donated valuable recipes or ingredients of traditional medicine shall be highly appreciated and duly rewarded. Investment in and scientific research into traditional medicine shall be strengthened and the techniques of drug preparation, processing and use shall be standardized.

- Planning the development of the sources of pharmaceutical materials, setting up areas for plantation and animal breeding, combining afforestation with the growing of medicinal herbs/plants.

- Selecting, preserving and developing breeds and genes of medicinal plants. Building a national garden of medicinal plants.

- Promoting the provision of training and refresher courses to traditional practitioners and people involved in the production and preparation of traditional medicine. The aim is to foster a contingent of qualified staff in traditional medicine.

5. Training pharmaceutical personnel

- The training institutions for pharmaceutical personnel, first and foremost medical and pharmacological colleges will be strengthened to meet the demand for higher quality in training and a reasonable expansion of the scope of training. Quality criteria for the training of pharmaceutical staff at all level and the expansion of post-graduate training for such staff shall be jointly determined by the Ministry of Education and Training and the Ministry of Health.

- The assignment and employment of graduates from pharmaceutical schools shall be jointly effected by the Ministry of Health and sectors concerned. The requirements for ethics and professionalism of practitioners in medicine and pharmacy shall be standardized.

6. Drug information

- Provide health personnel, patients and people as a whole full and accurate information about drugs through various mass medical and other forms of communication.

- Introduce into school curriculum necessary knowledge about drugs. Health establishments and pharmaceutical and medical workers are required to also advise on drug use.

- Sale promotion and advertisement of drugs shall be strictly controlled. In accuracy and false information in drug advertisements by any organizations and/or individuals shall be subject to punitive measures.

7. Strengthening of drug management

- Review and re-evaluate all promulgated legal documents on drugs for amendments and supplements thereof. The aim is to gradually systematize all legal regulations on drugs.

- Prepare the elaboration of a Drug Act

- Consolidate the contingent of drug inspectors and improve the quality of their performance.

- Strengthen the role of state agencies in exercising state management over drugs from the central to the community levels as well as drug production, import and export, distribution of and quality control.

- Closely combine the activities of state management agencies with social organizations and the professions to optimize the effectiveness of management.

8. Scientific research, domestic and international cooperation in pharmaceutical field.

- Promote scientific research activities on pharmaceuticals, with special focus on studies to promote the supply of pharmaceutical materials, drug preparation techniques, pharmaco-biology and traditional medicine. The import and transfer of modern technology for drug production shall be encouraged.

- Establish centers for pharmaceutical research in Hanoi and Ho Chi Minh City. Encourage the state-owned an private enterprises to conduct studies on drugs; promulgate policies to dully compensate and reward scientists for any valuable results of their research on drugs .

- Promote cooperation on pharmaceutical research with other countries first and foremost regional countries; seize every opportunity to win support from international organizations, government and non-governmental organizations in the development of Vietnam's pharmaceutical industry and sector./.

STRATEGY FOR PEOPLE'S HEALTH CARE AND PROTECTION FROM NOW TO THE YEAR 2000

Presentation by Prof. Do Nguyen Phuong,

Minister of Health at the Government

Cabinet Meeting in April, 1996.

To prepare for the 8th Party Congress in a realistic way, the Ministry of Health has formulated the "Strategic Orientation for People's Health Care and Protection from Now to the Year 2000" with the following main contents:

- Assessment of current situation, potential and opportunity.
- Objectives, constraints and challenges.
- The guiding principles for people's health care and protection.
- The objectives for development of people's health care and protection
- Main measures and policies.

Following are the main points reflecting the basic contents of the Health Sector's Strategy for the period 1996-2000.

1. Assessment of current situation, potential and opportunity:

Given the country's new period of development, the health sector has the potential and opportunity for regularization and modernization which include the followings:

First, the health sector has a large contingent of health workers of which there are many talented specialists in various fields. Vietnam's ratio of physician per population is relatively high compared with other countries in the region. This figure at present is 4.19 physicians/10.000

population. At the grassroots level, the average number of health workers is 5.59 per communal health center who provide basic health services for about 7000 population. Despite many financial constraints, the leading health specialists have strived their best to keep abreast with the latest medical technologies and are able to perform such techniques as organ transplant, image diagnosis using magnetic resonance, computerized topography, ultrasound, and laser application in diagnosis and treatment or application of informatics in health management, etc. Second, Vietnam has a relatively well established health system which can ensure the provision of preventive and curative health services. This system includes 30 central institutes and hospitals, more than 100 provincial centers for hygiene and prophylaxis and health promotion, approximate 700 provincial and district general hospitals and more than 10.000 communal health centers. This existing health system is the foundation for the health sector to fulfill its tasks in the past recent years.

Third, the government health expenditures at present is around 3 US dollars per capita (approximately equivalent to Indonesian government health expenditures). If added with the expenditures from user fees, health insurance and lottery allocation for health, the total government expenditures on health is almost 5 US dollars per capita. Also putting together with other social contribution and people's out-of-pocket expenses, Vietnam's health expenditures may reach 8 US dollars per capita. This level of health expenditures is not high but not too low to sustain and develop the sector if these resources are well managed and utilized. With state's investment, almost all hospitals at central and local levels have been renovated and upgraded in terms of physical structure and equipment. Some hospitals have been equipped with modern equipment such as CT scanner, lithotripsy machine, colour doppler ultrasound, endoscopier, automatic biochemistry testing machine. Recently, the Friendship Hospital was able to buy an unit of magnetic resonance image. In 1995, the Government has approved 60 billion Dongs for procurement of equipment for the medical high tech center in Hanoi. A majority of provincial hospitals have got investment from central and local level for upgrading their equipment. However the upgrading of hospital equipment is done unsystematically in almost all hospitals which were built 20-30 years ago (some hospitals are as old as hundred years), therefore the infrastructure has been deteriorated, the original water supply, water drainage and waste treatment system in these hospitals can not meet with current demand.

Fourth, the health sector has good relationship with many international organizations such as WHO, UNICEF, UNFPA and many bilateral agencies and NGOs who have been supporting many important health programs including development of scientific and technological capability. Moreover the good relationship between Vietnamese health specialists and international experts has facilitated the information exchange and provided most updated knowledge. Many Vietnamese health specialists have been invited to work as consultant for many international organizations. Indeed the international cooperation has helped Vietnamese health workers to keep abreast with most updated knowledge and technologies.

At present the question is how to develop the health sector in a market economy. The new factors of the health sector in the market mechanism such as health insurance, user fees, private medical and pharmaceutical practice are revealing many issues of social equity, regulation and management of quality and efficiency. The market economy has created on the one hand a new driving force for economic development and the social stratification between the rich and the poor on the other hand. Therefore the question is how to provide health care services for the poor. When the relationship between the patient and the physician is interfered by money, the medical ethics could be deteriorated. A high ranking official has said " hospital should not be allowed to become a market and physician should not be allowed to become a merchant". It is true that the quality of care in hospitals remains a major concern for patients, people and leaders. Social surveys showed that many poor people did not received adequate health care when they were ill. There are about 30% of the total population who are unable to pay the current level of user fees. Although there are many good health facilities and physicians who preserve their professionalism, there are still some physicians and some health facilities who perform their duty with lack of responsibility or have authoritarian attitude toward patients or misuse of public hospitals to increase their income. The demoralization and the bad behaviour of a number of physicians and health workers have reduced people's belief in the health service.

Despite the constraints and shortcomings, one thing is certain that the health service of Vietnam has been developing constantly during the last ten years. This can be seen in the further strengthened primary health care and the progress achieved by hospitals particularly those at central and provincial levels in terms of professional skills and equipment. Successive generations of health workers have made an worthy

contribution to the success of the national liberation, reunification of the country, building socialism and socio-economic development. In spite of 30 years of war and many years of economic hardship, the health status of Vietnamese people has been unceasingly improving. From the basic health indicators, Vietnam ranks number one among the countries with the level of income under 300 US dollars per capita. Some health indicators of Vietnam are as good as those of countries who have the GDP level 2-3 times higher than Vietnam.

2. Objectives and new challenges of the health sector:

The objectives for health development of Vietnam is to achieve, by the year 2000, equity, improved quality of care and efficiency in health care so as to meet the ever increasing demand of all strata of population and improve the health status of Vietnamese people to the average level of regional countries.

Specific objectives:

1. To improve the health indicators and the physical health of the Vietnamese. It is expected that by the year 2000 and 2020 the following health indicators will be achieved:

- The life expectancy will be increased to 68 and 75 by the year 2000 and 2020 respectively.
- The infant mortality rate will be reduced to 35 and 20 per thousand live births by the year 2000 and 2020 respectively.
- The under 5 mortality rate will be decreased to 42 and 20 per thousand by the year 2000 and 2020 respectively.
- The rate of low-birth-weight baby (baby born under 2500 grams) will be reduced to 8% and 5% by the year 2000 and 2020 respectively.
- The under 5 malnutrition rate will be fallen to 30% and 15% by the year 2000 and 2020 respectively. Severe malnutrition will be eliminated.
- The maternal mortality rate will be brought down by 0.8 and 0.2 per thousand live births by the year 2000 and 2020 respectively.

- The average height of Vietnamese youth is expected to be at 1.65 meters by the year 2020.

- The iodine deficiency disorders will be eliminated by 2005.

2. To drastically reduce the morbidity and mortality due to infectious and parasitic diseases, control the newly emerging diseases and considerably improve in the main the people's disease profile by 2020 by means of:

- Eradicating a number of childhood diseases which are preventable by vaccine during the period of 1996-2000 such as poliomyelitis and neonatal tetanus; Doing away with diseases such as rabies, malaria, cholera, plague, typhoid, hepatitis B, Japanese encephalitis B by the year 2000.

- Eliminating leprosy by the year 2000 and minimizing parasitic diseases and tuberculosis.

- Minimizing the spread of HIV/AIDS and its impact in community.

3. To improve the quality, efficiency and social equity in health care:

3.1. Developing medical high technologies by :

- Step by step modernization of medical equipment and development of medical high technologies. By the year 2000 it is expected that evacuation of patients abroad due to shortage of means for diagnosis and treatment will be no longer needed. More strives should be made so that by the year 2000 Vietnam can become a regional pace-setter in some areas in which this country has potential to develop. It is expected that by the year 2000, organ transplant will become a more regular practice in which emphasis is attached to kidney, liver, heart, lung and born marrow transplant.

- Development of modern bio-technology along the line of industrialization and modernization for production of vaccine and biological substances for diagnosis and treatment.

3.2. Applying appropriate technologies at provincial and district level for improvement of the quality of health care and strengthening primary health care at community and family.

Conditions required for achieving the set objectives:

1. Investment: People's health care and protection should rely on different sources of financing from the state, people, domestic social and economic organizations, external donors in which state investment plays the key role. During the past five years, the government has increased the level of investment to the health sector, however the annual increase in real term remains low in comparison with government expenditures allocated for other social sectors. The government health expenditures as percentage of total government expenditures was 4.65% in 1990 and only 3.09% in 1995. This percentage is expected to increase to 5% and 8% by the year 2000 and by 2020 respectively.

2. Health manpower: The health manpower should be sufficient in structure, quantity and quality. Attention should be given to training of health personnel in medical high technologies with a view of further developing the medical technology and catching up the level of development in medical technology in the region. On the other hand emphasis should be attached to training of public health personnel to meet the need of primary health care at grassroots levels. Medical ethics should be considered as an important qualification as professional skills of the physicians. Relevant health personnel policies should be promulgated to encourage creative labour and devotion of health workers. Special attention should be given to work allowance, duty allowance and risk-of-infection allowance as well as appropriate policies to attract health workers to work at grassroots level, mountainous, remote and isolated areas.

3. Drugs and medical equipment: Efforts should be made for sufficient supply of drugs and medical equipment particularly the essential drugs, drugs for fields of specialty and drugs for pediatric use with good quality and reasonable price. Education on rational use of drugs should be promoted for the public, the physicians and drug suppliers with a view of avoiding misuse of drugs. The pharmaceutical industry should be developed so that it can provide 70% of curative drugs for people. Selective inheritance, safe use and efficacy of traditional and herbal medicines should be promoted for people's health care at community.

Challenges of the health sector:

The health sector has the potential and opportunities for development, however it has to cope with new challenges, they are:

- The first challenge is how to solve the contradiction of the negative side of market economy and the socialist humanitarian of health care services, how to encourage physicians and health workers to care for patients with devotion and medical ethics without letting money to decide physician's behaviour, how to ensure that medical ethics will not be interfered by payment of user fees, health insurance or other impacts of the market economy.

- The second challenge is how to link health with development. Health workers should strive their best to keep themselves abreast with the world medical advances. How to demonstrate and make everyone believe that investing in health means investing in development and that adequate budget investment in health also means adequate investment in development.

- The third challenge is how to solve the existing contradictions within the health sector in the socio-economic and health renovation; How to balance between preventive and curative health care, between development of traditional medicine and modern medicine and between medical and pharmaceutical service. Moreover, the inter-sectoral cooperation and mobilization of community participation in preventive health and health promotion should be further promoted. How to clearly define the responsibility of each sector with a view of bringing into full play the potential of all sectors and avoiding duplicated efforts between the health sector and other sectors.

- The fourth challenge is how to make full and good use of the human resource in health given the fact that several generations of health personnel are working in the sector, the contradiction between training and using of health personnel, between inheritance and best use of the new factors. At the same time it is necessary to solve the contradiction between responsibility and interest of health workers. Human lives and health require health workers to perform their task with high responsibility while their salary and bonus remain low compared with the average level of income and the market price (the average salary of a health worker is 280,000 Dong/month).

- The fifth challenge is how to best use of the system of health management and organization and solve the arising contradictions in development of the health system organization and the contradiction between health facilities of the health sector and those

run by other sectors, between health facilities of central and local level, between state management and professional management and management of target program.

3. Regarding the guiding principles for people's health care and protection

To overcome the above-mentioned challenges, the health sector should absolutely rely on the five guiding principles of the resolution adopted by the 4th Plenum of Party Central Committee. They are:

- Health care for all;
- Combination between preventive medicine and quality of curative care;
- Combination between traditional medicine and modern medicine;
- Socialization of health care service;
- Diversification of health care service.

In accordance with the guiding principle that economic growth should go hand in hand with social equity, during this period of economic development, the issues of social equity should be well addressed.

Based on the guiding principle of health care for all, the health sector is focusing on the issue of equity in health care through elaborating suitable mechanisms and formulation of policies which facilitate better health care for the poor, for those who have rendered meritorious services to the country and people living in poor areas and former revolutionary bases. A big question put to the health sector is what can the health sector do for 20-30% of population who are poor (depending on localities) when they are ill? How to adjust the existing health care system, financing mechanism, health insurance, user fees, fees exemption to ensure the best possible care for the poor and those who have made meritorious services to the country. This is not only a guiding principle but also a motto for concrete action of the health sector in an economy governed by market mechanism with socialist orientation at present.

4. Medical ethics

Despite many difficulties and hardship in daily life, many health workers are always at the disposal of the local people, working wholeheartedly in disease prevention and treatment. However, there are a small number of health workers who do not observe the medical ethics and perform their duty with lack of responsibility, thus causing dissatisfaction and complains of people about their behaviour and discrediting the prestige of the health service among the people.

The market economy brings about economic growth and at the same time social stratification between the rich and the poor. Therefore how can health workers preserve their professionalism and provide their service along the line of "Treatment should aim to cure the disease irrespective of the financial status of the patient".

A rather common manifestation of ethical deterioration is "under the table" fees. Although it is not a common practice but there are patients who have to pay the nurse for tender injection or to borrow a mat and there are physicians who is warm with rich patients and cold with poor patients, they even avoid seeing patients without money. There are cases of doctors who prescribe unnecessary and expensive drugs so that nurses in the ward often sell to patients to make profit. This situation is due to lack of attention given to the organization, management and education of health personnel by the health sector. The reward and penalty has not been strictly observed, good personnel have not yet been recognized and rewarded timely, personnel with poor performance and bad behaviour were not strictly penalized.

Therefore education on medical ethics to health workers along the spirit of "physician should be a tender mother" is the number one priority in moral education of the health sector. Medical ethics should be reflected in the routine procedures at health facilities including the quality of examination, treatment, the way of fees collection or exemption for each patient, the behaviour in drug business and distribution, the attitude and behaviour toward patients who are subject to fees exemption and poor patients, and the working spirit of health workers with devotion and sacrifice in carrying out difficult tasks such as control of epidemic outbreaks, working in disadvantage and mountainous areas.

On the other hand, the medical ethics of health workers are to some extend related to their daily life. If all entitlements and allowances such as

20% special allowance, on duty allowance, surgery allowance and allowance for control of epidemic outbreak be provided adequately, the fight against "under the table" fees and the education for improvement of medical ethics could achieve better result.

5. Preventive medicine and basic health service

The vast basic health network with more than 10,000 commune health center had been a pride of Vietnam Health Service. This network is an important condition for realizing health objectives and implementing many health programs including the preventive health care.

Before the economic reform, this network was financed by agricultural cooperatives in the form of work points and paddy paid to health workers. After shifting to market economy, many communes, due to lack of funds were unable to maintain their health centers. For sometimes and in some places, commune health workers did not receive their salary for several months and as a result, the operation of the health centers was not regular. Many commune health centers were downgraded and many others were no longer in existence or many communes were unable to build health center. The government has promulgated decisions No. 123 and 58 to solve the salary for commune health workers. In recent years the state has built more than 700 new commune health centers in remote areas. However there are still about 50 communes without health center and 6000 communes need refurbishment of their health center.

The network of commune health center is a manifestation of community participation in health and at the same time an illustration of state support given in times of difficulty and to the people who have rendered meritorious services to the country.

First, it is necessary to maintain the network of commune health centers with 4-6 health workers in each center to provide basic health care for all and particularly for the poor and for those who have rendered meritorious services to the country.

Second, private medical and pharmaceutical practice including traditional medicine are allowed with the license issued by the provincial health service and subject to the inspection of district health center and local authority at commune/ward level. The question here is how to divide responsibility and to collaborate between communal health center and private medical physicians and traditional medicine physicians in the

locality. In sort, the commune health center is responsible for carrying out preventive activities such as immunization, distribution of vitamin A capsule to children, etc. The commune health center also provides basic curative care and dispenses medicine free of charge to poor people in the commune and at the same time provides services upon request for other people.

Third, the grassroots health service (at commune/ward, hamlet, mountain village) is the first contact point between the local people and the health service, therefore it should closely link with the district health service in implementing primary health care, thus the grassroots health service is also a link between public health sector and people. So beside strengthening commune health center, further efforts should be made to gradually build and complete the hamlet/mountain village health network because at the moment hamlet/village health workers are not paid.

Fourth, the state should continue to support the basic health network in terms of technical facilities, equipment and personnel and help upgrade the poor-functioned health center, build new ones in places where there is no health center and provide additional funds for running health center. Eradication of "white commune" (commune without health center and workers) should be completed by the end of 1996 and continue consolidating and improving the quality of care provided by commune health centers in the following years.

Fifth, expansion of commune health activities down to hamlet/village with more participation from community through payment for services and medicine, etc. Hamlet/village health workers do not have salary, however local community may have some incentives to encourage them to work, on the other hand further actions should be taken so that these workers will receive remuneration or salary for their work.

Among the issues related to the basic health care, assigning doctors to work at communes, creating the posts of assistant pharmacist and traditional physician should be addressed. These issues could be solved step by step with the approval of local authority and people. The health sector is aiming to cover 40-50% of communes all over the country with doctor by the year 2000 which will require changes in health personnel training, particularly training by address or recruitment of assistant doctors working at commune health centers for further training to become doctors.

The issue of basic health service is also the issue of rural health. The management of rural health service with its specific features is posing a question of whether the creation of a Rural Health Department at the Ministry of Health is necessary? This issue requires further study and conclusion.

In the past recent years, there were no major epidemic outbreaks, a number of dangerous epidemics were well checked and controlled. However the threat of epidemic outbreak remains due to environmental pollution, bad hygiene habits therefore the hygiene and prophylactic and health promotion activities in the coming years should concentrate on addressing the following issues:

- Environmental sanitation and provision of portable water in both urban and rural areas;
- Food hygiene including food hygiene standards and the unhygienic food taking habits;
- Management of insecticides used in agriculture and management of industrial waste, hospital waste and daily waste;
- Elimination of social evils such as drug abuse, prostitution and hazardous habits including alcoholism and smoking.
- Promotion of the sport and physical exercise movement and encouragement of civilized life styles which are good for health;
- Establishment and consolidation the activities of the occupational health, school health and sport health.

6. The hospital issue:

Hospital is the "face" of the health service and hospital technologies reflect the development of the medical science of a country. The health service of Vietnam has about 30 hospitals and research institute with beds at central level, almost 700 general and specialized hospitals at provincial/district levels. Most of these hospital are state hospitals, there are few joint-venture or private hospitals (only two or three).

After many years of economic stagnancy, limited expenditures allocated for hospital civil work and equipment, diminished external funding for hospitals have resulted in serious deterioration of hospitals.

In the past, hospital services were free, patients received curative care and referred to hospital by level. The economic reform has created the stratification between the rich and the poor. Health reform has allowed the introduction of partial user fees at public health facilities as well as the practice of private physicians which aim to meet the diversified demand of health care by society. These new forms of health financing have contributed to solving many difficulties and constraints in health care provision. However these financing forms have also changed both physicians' and patients' behaviour. From a public hospital where all services were provided free to a hospital where services are paid in the forms of health insurance, user fees and also fees exemption. Therefore the organization and management of hospitals nowadays should be readjusted in a way to suit the new situation and avoid the circumstances that poor people are denied hospital services and humiliated.

To solve the above-mentioned urgent issues, first and foremost, it is necessary to reorganized the hospital system and the health system. The public health sector receives expenditures from the state which come from people's contribution should provide health care for the poor and the people who have rendered meritorious services to the country. While the health insurance has not yet covered all population, the exemption of fees for the poor at public hospitals is a matter of course. Regulations on fees exemption by level of health service should be transparent and accepted by society. Public hospitals should aim to cure diseases regardless of rich or poor.

Second, while the living conditions of health workers are not sustained at the current market price (the average salary of a hotel guard or a receptionist is 1,000,000 Dong, while the salary of a doctor with second-degree of specialization is only about 500,000 Dong), the establishment of total fees exempted hospitals beside hospitals where fees are collected is very difficult to realized. Therefore the model of hospital such as the one of An Binh hospital in Ho Chi Minh City where voluntary payment of full fees exists at the same time with fees exemption wards, allowing the use of full fees payment to cover the accounted costs of fees exemption services, thus ensuring the quality of care for poor patients should be promoted. This model of hospital ensures the provision of curative care for the urban poor.

Third, the examination and treatment for the rural poor should primarily rely on the basic health network, the district health system as mentioned in the part about basic health service.

Fourth, the relationship between primary health care level and referred hospitals should be a complementary one and reflects the close link between curative and preventive care, traditional medicine and modern medicine at local and central levels.

Fifth, the relationship between military medical corps and civilian health service should be further promoted (At present, military health facilities provide curative services for civilians to an extend of 30% of hospital occupancy), the relationship between basic health service/hospital and target health programs aims at creating and sustaining a sound living environment, changing the disease profile, providing emergency services for life threatening diseases and injuries, treating infectious diseases and malnutrition which is the typical disease pattern of a tropical and low income country should be a systematic relationship. At the same time, study should be carried out for the establishment of joint-ventures or 100% foreign owned hospitals, clinics as well as private hospitals and clinics in major cities together with strict management regulations of these facilities.

Sixth, the quality of curative care should be improved in conformity with advances of world's medical science. The level of health expenditures at the moment does not allow refurbishment of all health facilities at the same time. Therefore priority should be given to places where refurbishment conditions permit, first a number of health facilities at central level in Hanoi and Ho Chi Minh City will be upgraded into two medical high-tech centers. For Vietnam health system at the moment, there is a shortage of high-tech medical facilities and talented specialists. We can be proud of having a well established basic health network and a large contingent of general practitioners. However there are still many weakness in this network and this category of health personnel which require further strengthening in many aspects for immediate future needs.

Seven, user fees and health insurance in some ways have not yet proved their socialist humane characteristics in curative care. For a long term future universal health insurance should be promoted. At present, health insurance is mainly compulsory, other forms of health insurance including voluntary insurance, farmer insurance, school insurance, etc. should be promoted so that universal health insurance could be achieved. A health insurance law should be promulgated. In the coming years the state should formulate policy to expand the coverage of health insurance to the poor. According to experience of many countries where health insurance has well developed, only when universal insurance be

instituted, equity and efficiency could be achieved. Also during the revision of the current health insurance regulations, the issue of whether health insurance should belong to social insurance service or Ministry of Health.

7. Reorientation of health personnel training

The immediate issue of health personnel training is the coordination between planning, training and use of health personnel. At present, these three activities are being carried out with lack of coordination. As a result, many doctors graduated from 1991-1992 remain jobless. The situation of superfluous of health personnel in crowed urban cities while very few working in the vast rural areas, particularly the mountainous and remote areas is very common. The ratio between doctors, nurses and midwives is unreasonable. The skills of trained health personnel do not match with employers' requirements, etc.

The reorientation of health personnel training was first raised in 1986-1987. However when the country and the health sector started reforms, the current health personnel training has further revealed its weaknesses in meeting the needs of the basic health service, the curative care in hospitals and the development of the private health sector. The redefining of training need and formulation of the macro training plan have been done some years ago, still they remained incompatible with the socio-economic and health development at present. The development of a public health training program, the training of gynecological and pediatric assistant doctors and revision of curriculums for post graduate and middle-level training have been put forward for discussion on a number of occasions.

So, what are the issues to be addressed in reorientation of health personnel training? The first thing is to assign community health doctor to communes. This is in fact the transfer of technology to lower level. To solve this problem, the training of community health doctors, commune doctor should be different from training of doctors who will work in hospitals. To do this a training environment should be created so that trainees will acquaint themselves with the environment that they will work in the future. At present, 18% of communes in the whole country have medical doctors.

Second, the assigning 1-2 medical doctors to work in each commune is not difficult for the training sector. The training capacity and the number

of doctors can be solved based on the experience of communes who already have doctors. The difficult issue is the use of these doctors and how to solve the difference in salary between doctor and local commune officials, the acceptance of doctor by local community, the adaptation of doctor with local community and particularly the defined responsibilities of doctor and the means of working at commune. Hence solving the problem of assigning doctors to communes is not the responsibility of the health sector alone but it is the responsibility of administrative authority and the whole society. The training by address and refreshing courses for health centers' assistant doctors to become doctors could be a feasible solution.

Third, a rule stipulated that after graduation, medical doctors are obliged (similar to 2 years military service) to work at grassroots level for a few years (2 years for example) could be promulgated but implementation is not feasible because it involves many things such as provision of housing and the daily essential needs for doctors during this two years period which require community and state contribution and the expectation of local people versus the knowledge and skills of newly graduated doctors.

Fourth, the rotation between commune doctors and district doctors aims at strengthening the district health system and the relationship between commune health center and district hospital and also helps implement continuous training for commune doctors. To do this, it is necessary to improve the managerial skill of district health workers.

Fifth, the generalization and specialization, the establishment of public health faculties, the training of traditional medicine doctors and herbal physicians, bachelor-degree nurses and medical technicians, the equalization between doctors with first degree of specialization and those with master-degree, between doctors/pharmacists with second degree of specialization and those with a Ph.D. degree, the management of teaching quality at medical schools which do not belong to the Ministry of Health, the content of first phase and second phase of medical doctor training to suit with the current needs of the health sector are issues which need to be studied and addressed properly.

Six, the combination between specialized training and the two medical high-tech centers, between military health corps and civilian in training, between research, training and curative care are also issues which need to be examined and carried out properly.

8. Pharmaceutical sector

The pharmaceutical sector includes three areas:

- Drug production,

- Drug provision and drug use,

- Drug quality control.

Drug manufacture or which direction the Vietnam pharmaceutical industry would follow? First, Vietnam pharmaceutical industry can not be separated from the level of industrial development of the country. Pharmaceutical industry links with chemical and biochemical industry. The questions of whether and when the antibiotic industry should be developed, why the previous projects on development of antibiotic industry failed are issues of the correlation between pharmaceutical industry and national industry. (The pharmaceutical industry of Vietnam can provide only 40% of people's drug needs at present).

Second, the development of pharmaceutical industry should base on the existing pharmaceutical enterprises with quality improved, productivity ensured so as to meet market's demand. At the same time it is necessary to formulate immediate and long term plans for capital mobilization for joint venture projects with foreign partners. (At present, the drug annual import of Vietnam is about 285 million US dollars, drug annual export is only 6 million US dollars).

Third, development of pharmaceutical industry should balance with the development of pharmaco-chemical, bio-pharmaceutical and packaging industries.

Fourth, although the medical instrument and equipment industry is a different branch with the pharmaceutical industry, the investment in the development of the pharmaceutical industry should balance with that of medical instrument and equipment industry which may begin with manufacturing of disposable syringe then other kinds of instruments and equipment. It is also necessary to have plan for capital mobilization for joint-venture projects with foreign partners.

Fifth, organization of pharmaceutical enterprises, general companies of medical equipment and instrument, business for supporting production and circulation, distribution of products should be addressed. The

management of these activities should follow government existing rules and regulations which support promotion of health activities.

Drug supply and use: Vietnam has adopted and implemented the policy of essential drug and rational use of drug. In reality there are many forms of drug supply which are being developed including state pharmacies, private pharmacies, drug cupboard attached to commune health centers using self generating funds, commune's funds, Bamako drug revolving funds or funds provided under primary health care program, etc., some have registration, some don't. Drugs sold on the market come from different sources, some are difficult to trace their quality, particularly the smuggled drugs which are available in border provinces without strict control. The user fees in curative care together with free selling of drug have led people to a habit of going straight to pharmacies to buy drugs. Buying drugs is greatly influenced by advertisement particularly when advertisement does not comply with regulations, users are often misled, thus leading to misuse and irrational use of drugs.

Therefore it is necessary to study and assess the current situation of drug supply to see if the diversified forms of drug supply by state business, private business, drug revolving fund are reasonable and whether the existing regulations need to be revised for better provision of drugs in the future.

Second, the reorganization of drug supply and curative care at grassroots level using drugs aims to improve the quality of curative care and on the other hand using curative care to improve the rational use of drugs and better drug supply (Per capita drug consumption was 4 US dollars in 1995).

Third, the reorganization of hospitals' pharmacy and hospitals' drug supply will promote rational use of drugs by patients and avoid unnecessary buying of expensive drugs.

Fourth, drug information should be promoted on the principles of "Essential Drugs", "Rational Use of Drugs" and "Generic Drugs" with a view of avoiding false advertisement of drugs under their trade mark name.

Drug management: The issuance of registration licensee and drug inspection are tools to regulate the behaviour of drug manufacture,

export/import and provision. The state and the health sector have promulgates many legal documents in this regard.

First it is necessary to use legal tools to protect domestic production and facilitate the competitiveness of local drug production.

Second, the legal tools are also to be used to regulate the behaviour of drug providers and consumers with a view of promoting rational use of drugs.

Third, the use of legal tools aims to improve the capacity of drug quality control to ensure the drug quality for consumers.

9. Health system organization and management:

Socio-economic and health reforms require the health sector to change its organization and management to suit with a mix public/private health system.

Differences exist in socio-economic development in different geographical areas, between urban and rural, mountainous and delta, North and South, etc. Therefore, the organization and management of the health system should be tailored to suit specific conditions of each region.

The organization and management of the health system require more attention to horizontal relationship with health service of other sectors, military health corps and vertical relationship between central, provincial, district and commune levels.

The questions need to be addressed in connection with health system organization and management including:

- What would be a reasonable network of curative care?
- What would be a good model for a preventive health center and other centers?
- How best to divide responsibilities and decentralization between levels?
- What would be a good health personnel policy to encourage health workers to work at grassroots level, rural, mountainous and remote areas?

– How to stipulate post relief and retirement?

To answer these questions, first the organization and management of the health system should be considered a science-based task or can be called health organization and management science. Health management is not only based on health organization science but also requires the contribution of other social sciences such as social medicine, medical ethics. On the other hand, health management is not only based on health management science but also requires the involvement of other sciences such as socio-economic science, health economics, health administration and health legislation, etc.

Second, it is necessary to renew the health organization and management to suit with the current objectives of the health sectors. These changes should be implemented gradually in conformity with each geographical region and its concrete socio-economical development conditions. These include clear defining the functions and responsibilities of hamlet/village health post, commune/ward health center, intercommunal polyclinic, district health center, provincial hospitals, central hospitals, the system of research institutes, medical/pharmaceutical schools, pharmaceutical system and medical equipment of central and local level.

Third, it is necessary to stipulate the horizontal relationship with other sector and the vertical relationship by level in carrying out health activities.

Fourth, the renovation of organization and management, the stipulation of horizontal and vertical relationship should rely on analysis of the current curative care network, the current model of preventive health center and other centers with a view of achieving a more equitable and efficient health care system.

Fifth, it is necessary to improve the health personnel policy, post relief and retirement policy for sustaining and developing the health service.

Finally which mechanism of operation the health sector will follow in the current market economy? Changing anew the health management mechanism in present situation should aim to mobilize maximum social potential to people's health care and protection, reduce step by step constraints and shortcomings in curative care, attach obligations of health workers with their privileges and implement by all means the Party's policy of equity in health care.

10. Socialization and diversification of health services:

In the context of social stratification, the diversified demand of health care and the limited government health expenditures the health sector must socialize and diversify its services.

Socialization means mobilization of more social contribution to health care activities, hence making health care not only the responsibility of the health sector but also responsibility of the whole society, of the Party, local authorities at all levels, other sectors, mass organizations, communities and people as a whole. Socialization involves inter-sectoral collaboration and community participation and much more than that as described above.

Diversification means social mobilization in provision of health financing, expansion of other forms of health care provision including public, semi public, peoples' founded, private and health insurance.

To implement the socialization and diversification of the health services, the health sector must first and foremost propose which sector, mass organization and people should be responsible for what. A mechanism and environment should be created which will allow other sectors, mass organization and people to participate in health care activities. Without such concrete proposal there will be no tangible results.

Second, social mobilization should link with the Party's policy and activities on people's mobilization.

Third, the diversification should be carried out together with the process of decentralization and division of responsibility among forms of health activities.

Fourth, diversification and socialization should be implemented hand in hand which means diversification should be accepted and controlled by society.

Fifth, diversification requires increased investment from different sources for both medical and pharmaceutical sectors in which attention should be attached to investment from local and foreign sources through forms of joint venture, joint effort with local and foreign partners with partial or 100% foreign capital investment with a view of wining capital and technologies, particularly high technologies for acceleration of the modernization of the health sector.

④ 食品衛生関連

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THE GOVERNMENT

No. 14/1999/QD -TTg

THE SOCIALIST REPUBLIC OF VIETNAM
Independence - Freedom - Happiness

Hanoi, February 4, 1999

DECISION OF THE PRIME MINISTER
on the Establishment of the Food Administration

THE PRIME MINISTER

- Pursuant to the Law on Organization of Government dated September 30, 1992;
- To strengthen management of food quality, hygiene and safety;
- At the request of the Minister of Health and the Minister, Chief of the Committee of Government Organization and staff Civil Service;

DECIDES :

Article 1.

To establish the Food Administration under the Ministry of Health in order to assist the Ministry of Health to perform State management of quality, hygiene and safety of food nationwide.

The Food Administration Department shall have legal status, its own seal and accounts, and operational expenses provided by State Budget. The Department's headquarters is located in Hanoi.

Article 2.

The Food Administration Department shall have the following main duties and rights:

1. To draft or to participate in drafting regulations on quality, hygiene and safety of food to submit to the Minister of Health for issuance in accordance with his authority or to submit to the Government and the Prime Minister for consideration and decision.

2. To establish or to participate in the establishment of quality standards of food, technical processes and regulations to ensure the quality, hygiene and safety of food for issuance by the Minister of Health or to provide comment to competent agencies.

To promulgate documents in accordance with its authority guiding the implementation of standards, technical processes, and regulations, skill on quality, hygiene and safety of food; to grant certificates for the units meeting requirements on food hygiene and safety.

3. To establish a list of various types of food subject to quality registration for issuance by the Minister of Health and to organize registration of quality of food.

To grant or to withdraw in accordance with its authority certificates of hygiene and safety of food with respect to foods domestically manufactured, including industrially-produces foods.

4. To organize examination and inspection of the implementation of regulations on good quality, hygiene and safety.

To organize examination of quality, hygiene and safety of imported foods in accordance with the law.

5. To participate and to co-ordinate with relevant agencies to prevent or stop production and circulation of foods which do not meet requirements on food quality, hygiene and safety.

6. To co-ordinate with relevant agencies of the Ministry of Culture and Information in the management of advertising on food for children, patients, the elderly and pregnant women and food requiring special control: to organize education and publication of information on quality, hygiene and safety of foods.

7. To carry out international co-ordination in the field of quality, hygiene and safety of foods in accordance with the law and the assignment of the Minister of Health.

8. To manage organization, personnel, assets and budget in accordance with the law and authority assigned by the Minister of Health.

Article 3.

The Food Administration Department shall have a Director and a number of Deputy Directors appointed by the Minister of Health.

The Director shall be responsible before the Minister of Health for the all of the activities of the Department. The Deputy Directors shall assist the Director and take responsibility before the Director for the duties that they have been assigned.

The Minister of Health shall be responsible for detailing the duties, organizational structure, and staff of the Food Administration Department with the approval of the Minister, Chief of the Government Committee of Organization, and staff.

Article 4.

The local Departments of Health shall have the duty to manage the quality, hygiene and safety of foods in the areas.

Article 5.

This Decision shall take effect 15 days after the date of signing. All conflicting provisions issued prior to this Decision shall be revoked.

The Minister of Health, Ministers, Heads of ministerial-level agencies, Heads of agencies under the Government, Chairmen of People's Committees of Provinces and cities under central authority shall take responsibility for the implementation of this Decision.

THE PRIME MINISTER

(signed and sealed)

Phan Van Khai

Recipients:
- Standing committee of the Politburo,
- The Prime Minister, Deputy Prime Ministers,
- Ministries, ministerial-level agencies, agencies under the Government,
- People's Councils, People's Committee of provinces and cities under central authority,
- Office of the National Assembly,
- Office of the President,
- Central Office and Party's Committees,
- People's Supreme Prosecution,
- People's Supreme Court,
- Central bodies of organizations,
- Official Gazettes,
- Government Office: Ministers and Chairmen and Vice-chairmen of Departments, and Committees,
- For file: TCCB(3), record.

④— 2

THE GOVERNMENT
No 08/1999/CT-TTg

THE SOCIALIST REPUBLIC OF VIETNAM
Independence - Freedom - Happiness
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Hanoi, April 15th 1999

CIRCULAR OF THE PRIME MINISTER
on the strengthening for National effort to improve the Food Quality, Hygiene and Safety

Ensuring Food Quality, Hygiene and Safety has a direct impact, and regularly to the health of people, and the race of nation. Use Food of poor quality and unsanitary or Food containing too much pesticide residues over permitted standard, first of all may infected to the consumers food poisoning and acute diarrhea in severe illness lead to the damage of one's life, and if at long time accumulated toxins in human body and after that lead to severe chronic diseases or error inborn diseases and transfer to the continual generation.

In the last years, all Ministries and local administrative organizations do not firmly collaborated with good efficacy on management function of Food Quality, Hygiene and Safety of food manufacturers, traders and food services etc.. It is a principal cause lead to lose not only to the life, health and economy of every people or family, no impact to the labour of society, make influence to the authority of food quality product and service, and decreasing the capacity of food consumption processing from indigenous ingredients. The protection of race with long time of the health people in the communal nation is the common task and the responsibility of all community, especially the task off all level- administrators.

For the restoration of poor managing on Food Quality, Hygiene and Safety, the need to establish in legal order in the domain of production food product, trading and food service, the Prime Minister has circulated:

I. From the year 1999, organize an annual " Action for Food Quality, Hygiene and Safety" for mobilization all people, local Administrators, Ministries and Institutions participated on the prevention of food poisoning and food disease due to Food intakes and established in legal order on the Food production ,trading and Food services ,The time of 'Action for Food Quality, Hygiene and Safety Month" will be fixed by the Minister of Health, based on the prognosticating sources of epidemiology data related to the development of diseases and foodborn intoxication.

c/ Advance co-operate with Ministries and related institutions establish plan of action annual and five years on the ensuring Food Quality, Hygiene and Safety. Plan of action and annual financial support of action will be added in the regularly task-works annually of Ministry of Health. First of all, the need of urgent implementation the following works:

- Co-operate with Ministry of education and training, the mass media institutions for organize the propaganda and education Food Hygiene in all school, on the radio, television, broadcasting journal and books.

- Co- operate with Ministry of Justice, Ministry of Science Technology and environment and other Ministries, related institutions established all legislative orders and regulations in the Administrative actions on Food Quality, Hygiene and Safety

- Co-operate with of department of Government, Organization and Staff civil service other ministries and related institutions, urgent completing project on the structure organization of Food Administration on Food Quality, Hygiene and Safety belong to the ministry of Health and other ministries, related institutions at provinces, cities and submit to the Government.

2. Ministry of Culture and Information instruct all information -agencies with the responsibility keep the enough times of necessary information in the radio - TV sets, for the propaganda and education on the law and awareness related to Food Quality, Hygiene and Safety .

3- Ministry of Police instruct all police-man authorities at all levels, regularly collaborate with Ministry of Health and other related institutions and strictly punish all Food trader services violated Circular No 36 CP, dated 29 May 1995 on the "Ensuring order and safety in transport-Communication of the cities", which awarded the pavements and streets for trading and food services, co-operate with other ministries and related institutions survey, detect and punish on Food falsification with dangerous defects.

4- Ministry of Trade instruct all institutions on the market administration advance callaborated with Ministry of Health for the monitoring and control the falsification of food trading, not ensuring the Food Quality, Hygiene and Safety, not implementation or falsely food labeled and trademark etc.

The Ministers of all ministries, Head of Ministerial Institutions, Head of institutions belong to the Government, Chairpeople Provincial and city Committee belong to the Central Government are responsible with Party Organizations, the Vietnam Fatherland Front Central Committee, the Ho Chi Minh Youth Union's Central Committee, Women Association and mass-social Organizations to prepare for the implementation and upcoming the action month" For the Food Quality, Hygiene and Safety "

Recipients
- Standing committee of the Politburo
- The Prime Minister, Deputy Prime Minister
- Ministries, ministerial- level agencies, agencies under the Government.
- People's Councils, People's Committee of provinces and cities under central Government.
- Office of the National Assembly
- Office of the President.
- Central office and Party's, Committee
- People's supreme Prosecution
- People's supreme Court
- Central bodies of Organization
- Official Gazettes
- Government office: Ministers and Chairmen and Vice-Chairmen of Department and Committee
- For file KG(3), Record(VT)

THE PRIME MINISTER
(signed and stamped)
Phan Van Khai

THE GOVERNMENT
Ref. No. : 08/1999/CT-TTg

THE SOCIALIST REPUBLIC OF VIETNAM
Independence - Freedom - Happiness

Hanoi, 15 April 1999

DIRECTIVE OF THE PRIME MINISTER
on enhancing foodstuff quality, hygiene and safety guarantee

Foodstuff quality, hygiene and safety guarantee has direct and regular impact on health of everybody; in long-term resulting to the influence on race of the nation. The utilisation of foodstuff without hygiene and quality, food with foodstuff protection chemical components exceeding the permitted standard will make customers suffer from the food poisoning and acute digestive diseases, and if seriously, will cause deaths; in addition, toxic components of food will gradually accumulate in the people's body, causing dangerous diseases and deformities for next generations.

For several past years, Ministries, sectors and local administration authorities have conducted not so much closed and effective collaboration with each other, have not fulfilled functions of state control over foodstuff quality, hygiene and safety in food production, food catering services provision establishments. These are main reasons causing impact on health, economy of each citizen and each household, affecting capabilities of labour force, reducing the goods and services reputation, reducing consumption possibilities of foodstuff which is produced and processed with the using of the domestic raw materials.

Protecting race and people's health of all ethnic communities is considered to be common-shared responsibilities of all people, organisations, especially competent authorities. In order to put an end to the situation of lax management over foodstuff quality, hygiene and safety, and restore the order and discipline in the foodstuff production and food catering services provision, the Prime Minister has decided to issue the Directive as follows:

I. Since 1999, every year, the "Month of Action for foodstuff quality, hygiene and safety" will be organised to mobilise all people, local authorities at all levels, ministries and agencies to actively take part in the prevention of and combat against the food poisoning, diseases and plagues caused by food, as well as the restoration of the order and discipline in foodstuff production, food catering services provision. The time for launching the "Month of Action for foodstuff quality, hygiene and safety" will be proposed by Ministry of Health after considering epidemiological forecasting factors relating to the arising and development of plagues and food poisoning.

II. Chairmen of People's Committees of provinces and cities within the Central Government will be liable for regularly carrying out the following tasks

1. To propagate and disseminate legislative regulations on foodstuff quality, hygiene and safety to all individuals and organisations dealing with foodstuff production and food catering services provision in their localities; to mobilise mass media and suitable forms of propaganda to educate and improve the knowledge of food hygiene, foodstuff processing hygiene, prevention from food poisoning and diseases and plagues caused by food.

2. To direct municipal and provincial Health Services to assume the responsibility of coordinating with the concerned agencies in inspecting and investigating the conditions for ensuring foodstuff quality, hygiene and safety in foodstuff production, food catering establishments; in handling violations against regulations on foodstuff quality, hygiene and safety guarantee.

3. To socialise the activities for foodstuff quality, hygiene and safety; By any means, to mobilise human resources from state agencies, socio-economic organisations and public trade unions to take part in activities for foodstuff quality, hygiene and safety in their localities, as well as to facilitate and encourage customers to develop their self-protective spirit, to collaborate with health agencies in finding out and handling in time violations against regulations on foodstuff quality, hygiene and safety of foodstuff production and food catering establishments.

III. Undertakings of Ministries and sectors

1. Ministry of Health will be responsible for carrying out the following tasks:

a. To co-ordinate with Ministries, sectors, political and social organisations in directing the implementation of activities targeted in the "Month of Action for foodstuff quality, hygiene and safety" and the keeping of gained results; to provide the guidance for making action plan, conducting investigation and propaganda, dissemination on foodstuff quality, hygiene and safety; to review, make reports and submit to the Prime Minister for consideration.

b. To direct the Agency of foodstuff quality, hygiene and safety management to co-ordinate with products quality management agencies under the control of concerned ministries and sectors in implementing the activities of specialised inspection and investigation on foodstuff quality, hygiene and safety in accordance with the legislative regulations.

c. To co-ordinate with concerned ministries and sectors in making yearly action plan and 5-year action plan on foodstuff quality, hygiene and safety guarantee. Contents and annual expenses for plan implementation will be added in the yearly regular tasks of Ministry of Health. In short-term, Ministry of Health should focus on taking responsibilities as follows:

- To co-ordinate with Ministry of Education and Training, press agencies in educating, disseminating foodstuff hygiene in schools through radio, television, publications and press releases.

- To co-ordinate with Ministry of Justice, Ministry of Science, Technology and Environment, concerned Ministries and sectors in drafting legal documents on foodstuff quality, hygiene and safety management.

- To co-ordinate with Government Committee on Organisation and Personnel, concerned Ministries and sectors in completing and submitting the scheme of organisation and state control over the foodstuff quality, hygiene and safety in Ministry of Health, concerned Ministries and sectors and localities to the Prime Minister.

2. Ministry of Culture and Information will direct press agencies to spend enough and necessary amount of time in disseminating laws, regulations on and knowledge of foodstuff quality, hygiene and safety.

3. Ministry of Public Securities will direct security force at all levels to regular co-ordinate with health sector and other authorised sectors in inspecting and strictly handling owners of foodstuff catering establishments who have used pavements and streets as foodstuff trading places, violating Decree No. 36/CP promulgated on 29 May 1995 on "ensuring urban traffic order and safety"; to co-ordinate with concerned Ministries and agencies in investigating and handling cases relating to the production of counterfeit foodstuff, causing serious consequences.

4. Ministry of Trade will direct market management agencies to actively coordinate with health sector in inspecting, handling the cases in that individuals and organisations trade and transport counterfeit foodstuffs not ensuring foodstuff hygiene and safety and cases in that individuals and organisations do not abide by regulations on packing, trade marks of foodstuff products.

5. Ministry of Agriculture and Rural Development, Ministry of Fisheries will coordinate with Ministry of Science, Technology and Environment in informing and disseminating extensively requirements and procedures of using plant protection chemicals, chemical fertilizers to the customers to ensure the customers' health safety.

6. Ministry of Science, Technology and Environment will coordinate with other concerned ministries in establishing and promulgating regulations, procedures of environmental pollution management within the areas of foodstuff, agricultural products and sea products production; defining foodstuff, agricultural products and seafood production areas which are now in unsafe conditions because of severely polluted environment; and finding solutions to overcome this situation.

7. Ministries possessing sectoral health system will be responsible for directing health establishments that are directly controlled by the respective ministries to closely co-ordinate with local health agencies in inspecting and supervising the food catering establishments under the direct control of the respective ministries, as well as directing these health establishments to respond and implement the "Month of Action for the foodstuff quality, hygiene and safety".

8. Ministries, which directly control their foodstuff production and processing establishments, will direct these establishments to seriously and strictly implement the regulations on foodstuff quality, hygiene and safety.

9. Ministry of Finance will coordinate with Ministry of Planning and Investment, Ministry of Health in providing financial sources to carry out activities for ensuring foodstuff quality, hygiene and safety, especially activities for improving equipment used for foodstuff quality, hygiene and safety inspection, at central and local levels.

Ministry of Finance will also coordinate with Ministry of Health in drafting and promulgating regulations on collecting fees and charges of registration, certification, technical appraisal in terms of foodstuff quality, hygiene and safety.

10. Based on this Directive and the plan on foodstuff quality, hygiene and safety guarantee issued by Ministry of Health, Ministries, sectors, local authorities at all levels will make their own plan and provide financial sources to carry out activities of foodstuff quality, hygiene and safety guarantee according to the current regulation of the State.

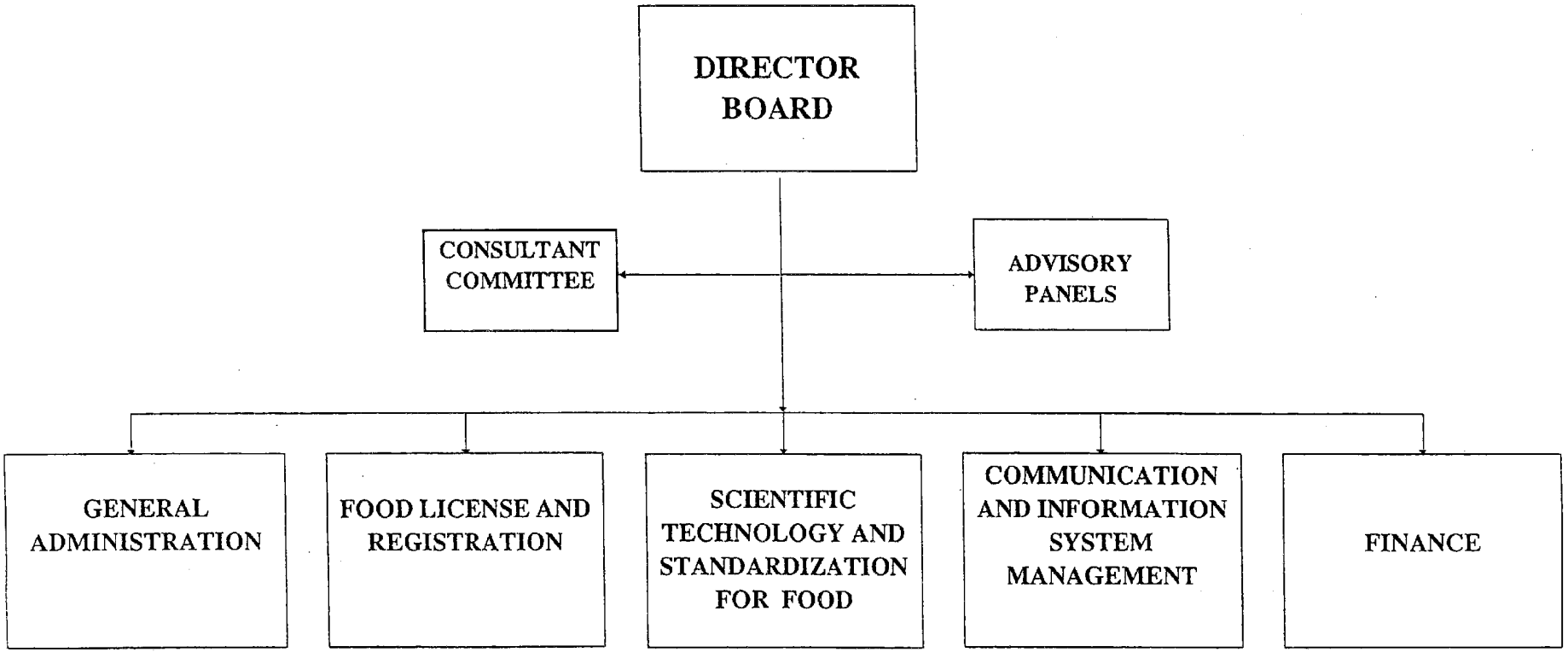
Ministers, Heads of ministerial level agencies, Heads of offices within the Central Government, Chairmen of People's Committees of provinces and cities under the Central Government shall be liable for coordinating with Communist Party's agencies, Central Committee of Vietnam Fatherland Front, Vietnam Women's Union, Central Committee of Ho Chi Minh Communist Youth Union and social organisations, public trade unions in implementing the campaign "Month of Action for foodstuff quality, hygiene and safety".

PRIME MINISTER
(Signed and sealed)

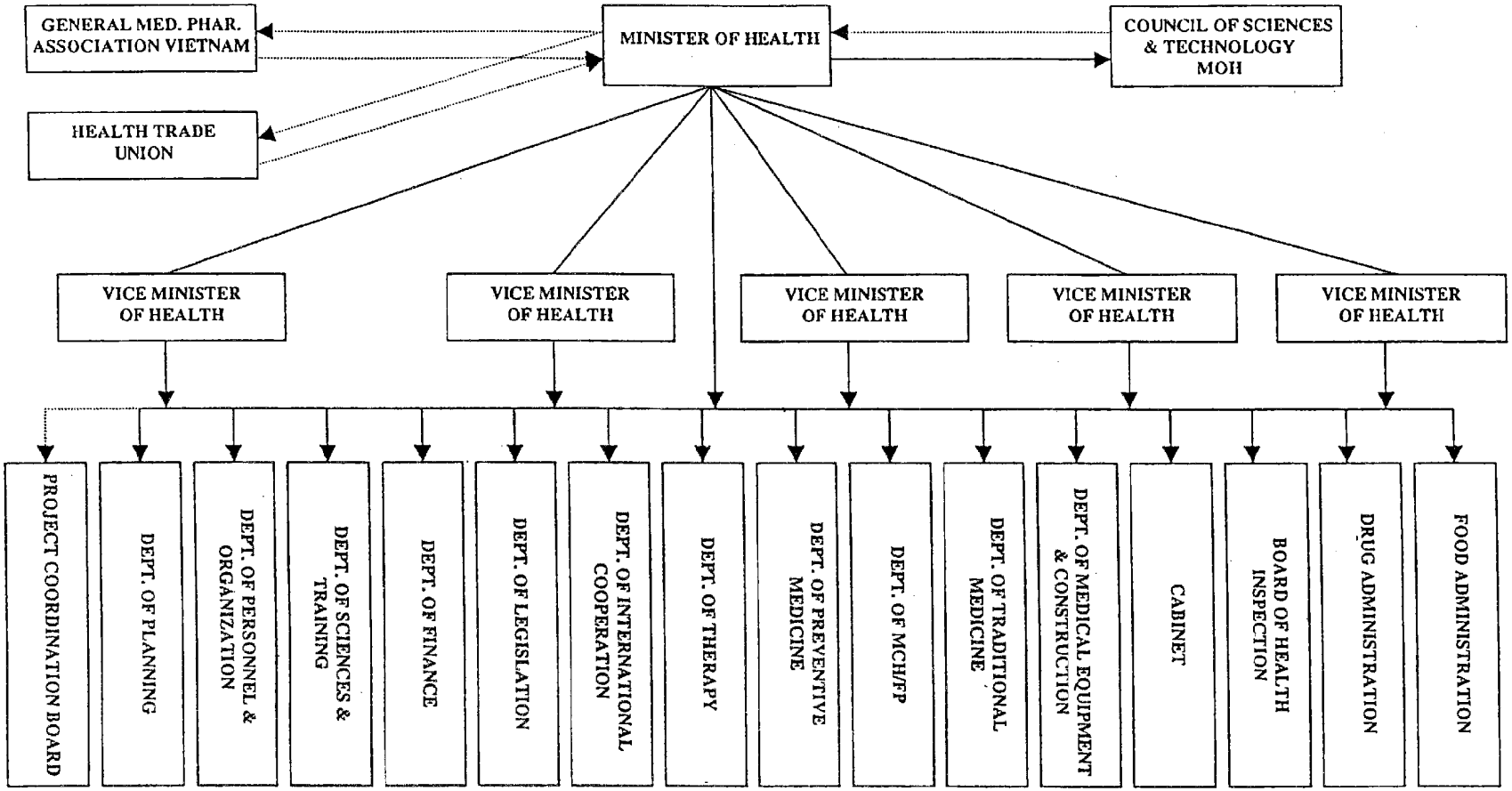
Phan Van Khai

To:
- Politburo Secretariat
- Prime Minister, Vice Ministers
- Ministries, ministerial level agencies, offices within the Government
- People's Councils, People's Committees of provinces and cities under the Central Government
- Office of National Assembly
- Office of the President
- Office and Divisions of Central Party
- The Supreme People's Procuracy
- The Supreme People's Court
- The Central Office of Trade Unions
- Official gazette
- Office of the Government
- File

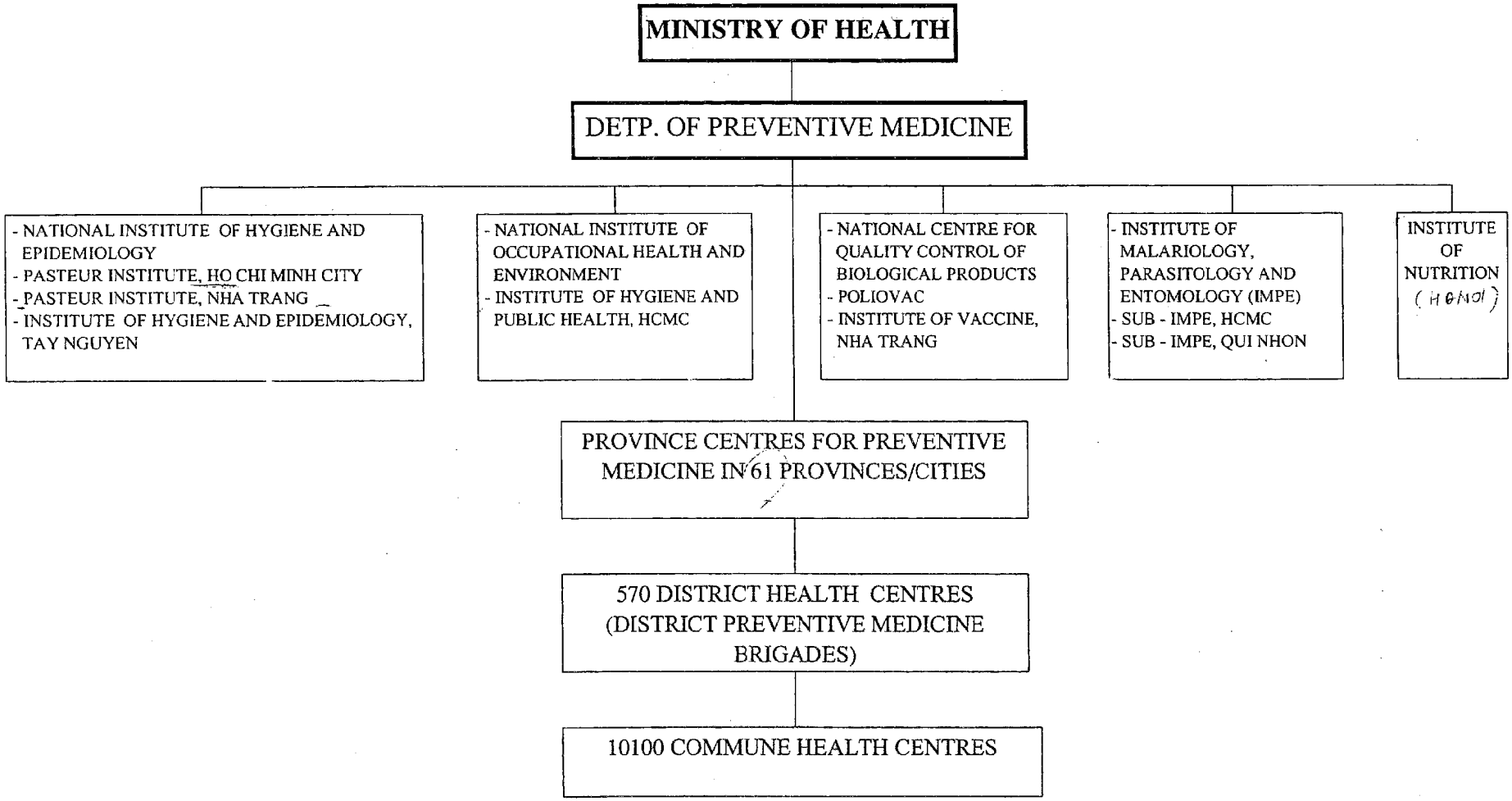
THE CHART OF VIETNAM FOOD ADMINISTRATION - MOH



ORGANIZATIONAL CHART OF MINISTRY OF HEALTH OF VIETNAM



ORGANISATION SYSTEM OF PREVENTIVE MEDICINE



④— 5

MINISTRY OF HEALTH
Ref. No. : 4362/KH-BYT

THE SOCIALIST REPUBLIC OF VIETNAM
Independence - Freedom - Happiness

IMPLEMENTATION PLAN FOR
"MONTH OF ACTION FOR FOODSTUFF QUALITY, HYGIENE AND SAFETY"
aiming to implement Directive No. 08/1999/CT-TTg of the Prime Minister

I. BACKGROUND

Foodstuff quality, hygiene and safety play an important role in the cause of health protection, making contribution to reduce numbers of diseases, strengthening the capabilities of labour force, enhancing the economic, cultural and social development and international cross-exchange, and expressing the civilised life-style of one nation.

To implement Directive No. 08/1999/CT-TTg issued on 15 April 1999 of the Prime Minister on the enhancing the foodstuff quality, hygiene and safety guarantee, the Agency for food quality, hygiene and safety management will coordinate with concerned agencies of medical and non-medical sectors at central and local levels in implementing "Month of Action for foodstuff quality, hygiene and safety" with the purpose of mobilising all people and all organisations to actively take part in the prevention of and combat against the food poisoning, diseases and plagues caused by food and the restoration of order and discipline in foodstuff production, food catering services provision in shops, restaurants, food stalls on the pavements and markets.

II. TARGETS

1. To educate, disseminate and encourage all citizens, all political, social and economic organisations to take part in the "Month of Action for foodstuff quality, hygiene and safety", aiming to widen the knowledge of and change the behavior relating to the foodstuff quality, hygiene and safety guarantee, actively prevent from food poisoning and diseases caused by food.

2. To appeal authorities at all levels for the attention to the ensuring of foodstuff quality, hygiene and safety of people.

3. To gradually restore the order and discipline in the foodstuff production, instant food processing, food catering in restaurants, shops, canteens of organisations, enterprises, schools, food stalls on the pavement and markets.

III. CONTENT

1. To use mass media (details are shown in the annex 1 attached) and other forms of direct communications such as the organising of demonstration, propaganda, seminars, interviews, the conducting of investigation report in order to enlarge the awareness of foodstuff quality, hygiene and safety and change the behavior and habit of unhygienic diet of community.

2. To coordinate with concerned sectors in inspecting the fulfillment of requirements on foodstuff quality, hygiene and safety guarantee of all subjects mentioned in item II.1 (details are shown in the annex 2 attached).

IV. PROPAGANDA MATERIALS

- Book titled "Necessary knowledge of foodstuff hygiene and safety" (5,000 books)
- Panel "Prevention of food poisoning" with dimension of 58 x 78cm (20,000 panels)
- Leaflet "Ten advice on ensuring safety of foodstuff processing" (15,000 leaflets)

3 above materials will be distributed free of charge to all provinces, districts and communes before 20 May 1999.

- Other available materials in localities.

V. IMPLEMENTING AGENCIES

1. Executing agencies

a. At central level: Ministry of Heath

b. At local level: Provincial and district People's Committees, Heath Services, districts' heath centers

2. Coordinating agencies

+ Ministry of Science, Technology and Environment
+ Ministry of Planning and Investment
+ Ministry of Finance
+ Ministry of Fisheries
+ Ministry of Trade
+ Ministry of Rural Development and Agriculture
+ Ministry of Culture and Information
+ Ministry of Public Securities
+ Ministry of Education and Training
+ Ministry of Justice

3. Public Unions

+ Vietnam Fatherland Front
+ Vietnam Women's Union
+ Vietnam Red Cross
+ Ho Chi Minh Communist Youth Union
+ Vietnam Association for customers protection

VI. COST

- At central level: mainly charged by health sectors
- At local level: mainly charged by provincial authorities, and partly supported by health sectors.

1. Financial sources used for dissemination, education in provinces and cities:

- VND183,000,000 (VND3,000,000 per province) will be supported by health sectors as follows:

- Agency for food quality, hygiene and safety management will be responsible for distributing financial sources to 28 northern provinces
- Nha Trang Pasteur Institute will be responsible for distributing financial supports to 11 central provinces
- Central highland's Institute of Hygiene and Epidemiology will be in charge of allocating supports to 3 central highland's provinces
- Institute of public hygiene and health service of HCM City will be liable for financing the activities of 19 southern provinces.

- VND100,000,000 will be used for printing propaganda materials distributed to 61 provinces and cities nation-wide (Payment for expenses will be made regularly by MOH)

- If allocated financial sources do not cover the total expenses, People's Committees of provinces and cities will be requested to provide support through their local budgets.

2. Financial sources for other activities

- Institute of Nutrition will provide Hanoi Health Service with VND40,000,000 among the budget for "Action plan for national nutrition".
- Provincial and municipal People's Committees will support financial sources for inspecting, investigating, disseminating through mass media and for conducting some other activities in localities.
- Ministry of Health now is requesting the Central Government to finance inter-sectoral inspection activities.

3. Tentative time: from 5 July 1999 to 5 August 1999.

4. Specific plan

- To implement propaganda campaign: 10 June ~ 10 August 1999
- To conduct inter-sectoral inspection, investigation campaign in localities: 10 July ~ 10 August 1999
- To inspect and supervise the implementation of "Month of Action": 10 June ~ 10 August 1999
- To distribute propaganda materials before 20 May 1999
- To distribute financial sources to provinces, cities: In June and July 1999
- To organise a launching ceremony of a movement to implement Directive No. 08/CT-TTg and "Month of Action": In July 1999
- To implement propaganda contents at central level (see attached annex)

FOR MINISTRY OF HEALTH
Deputy Minister
(Signed and Sealed)

Nguyen Van Thuong

1999年6月22日（火） VIETNAM NEWS（3面）

National food hygiene campaign starts in July

HÀ NỘI — The Food Administration Department of Việt Nam will carry out a nationwide food hygiene, quality and safety campaign throughout the month of July.

This is one of the two main activities of the annual *Action for Food Quality and Hygiene Month.*

The Ministry of Health department will work with related ministries and branches to mobilise the mass media to raise public awareness of food poisoning prevention and preparation of healthy and safe meals.

The campaign will concentrate mainly on small-scale food production enterprises, private food and beverage manufacturing businesses at markets and popular restaurants where hygiene and safety standards are not observed.

The campaign will also take the safety of imported goods into account.

Up until last Friday, the HCM City food market was still "quiet" in this regard. But powdered milk made by European companies, which lately have been embroiled in a scandal over contamination with the carcinogenic substance dioxin, was still being displayed and sold as usual.

Imported European milk products account for 30 per cent of the milk products displayed and sold in HCM City, say the managers of several large and profitable supermarkets.

These milk products have not been tested for quality, hygiene or safety because such tests are very expensive, say local authorities.

In addition, they add, the test results may not be totally accurate because of the backward state of the local testing centre.

Centre officials have therefore pledged to work with the ministry and Government bodies at all levels to draw up specific measures to improve the situation and play an active role in the *Action for Food Quality and Hygiene Month.* — VNS

Food poisoning and hygiene standards targeted this month

HÀ NỘI — The Government has started a nation-wide month of action on food safety and hygiene aimed at raising community awareness, stamping out food poisoning and re-ordering the food processing industry.

Department of Food Safety and Hygiene Management director Phan Thị Kim told *Thời Báo Kinh Tế* (Economic Times) newspaper that the Government wanted the action month to mobilise the general public to struggle for cleaner and safer food.

"We will co-ordinate with relevant agencies and base our efforts to oversee food safety and hygiene in processing units and households on standards already set by the hygiene rule issued last year by Prime Minister Phan Văn Khải," said Kim.

"For any cases that the rules don't yet cover, we'll study the standards set by the World Health Organisation to deal with them," said Kim.

Hand picked: Hà Nội shoppers have been encouraged to buy organic vegetables. — VNA/VNS photo Phương Thảo

Regarding the validity of reports that the number of people poisoned by contaminated fruits and vegetables had increased by 34 per cent last year, Kim said: "We do not have official figures yet."

Dealing with the issue of contaminated food requires that the Ministry of Agriculture and Rural Development (MARD), the Ministry of Trade (MoT) and the Ministry of Health (MoH) work together closely to control imports of plant protection chemicals.

MARD and the MoH will manage how much the chemicals are used. The MoT and MoH will manage fruit and vegetable trading units to head off cheating in safety and hygiene inspections.

Kim said MARD's veterinary sector was responsible for the conditions under which animals were slaughtered, while the health sector was in charge of the hygiene of slaughterhouses themselves and the safe distribution of fresh meat.

"I believe that these ministries also need to co-ordinate work on animal feed and set up a specialised veterinary branch as other developing countries have," said Kim.

On June 22, the MoT issued a document, 2854/TM-XNK, stipulating that food items imported from the European Community that had the potential to be contaminated with dioxin had to be examined by the Veterinary and Quality Management departments.

Asked about long-term co-ordination between relevant ministries, agencies and localities to implement food safety and hygiene and how to deal with violations of food safety and hygiene, Kim said: "We hope that with the current improvement of administrative programmes, co-ordination on food safety and hygiene will be effective in coming years, when Việt Nam joins Asia- Pacific Economic Co-operation and the World Trade Organisation."

"There will no longer be tax barriers, so the standards for trade in all food items will be defined solely in terms of food safety and hygiene," said Kim, adding that: "We need a specialised system of inspections to uncover and deal with violations."

Asked about specific solutions for socialising food safety and hygiene, Kim said: "First of all, we must effectively implement the action month; after that it will be reviewed to multiply its best features through June 2000, while disseminating educational materials and educating locals to raise their awareness on how to protect themselves from food poisoning."

"The PM has asked the heads of relevant ministries to effectively manage and control food safety and hygiene so as to ensure the quality of all processed food on the market," added Kim. — VNS

1999年7月16日（金） VIETNAM NEWS（6面）

Food poisoning and disease: Epidemics always a risk for the poor in back alleys

A recent spate of food poisonings is only the latest evidence that Việt Nam should focus more attention on preventive health care, says the *Quân Đội Nhân Dân* (People's Army) newspaper in this recent editorial.

HCM CITY — Việt Nam must radically re-think its approach to preventive health care to meet the demands of economic development, some economists warn.

The urgency of such measures is mirrored in just one aspect of health care, that of preventing food poisoning and the spread of diseases related to sanitation.

Last year saw at least 14 cases of food poisoning in HCM City that claimed life of one person and sickened 634 others.

Food safety and hygiene is becoming more vital in the big cities, particularly during the monsoon season. Epidemics are always a risk in back alleys where poor people live.

At the same time, urban populations are on the rise. The number of households that want to dig underground wells is growing, but they often lack the funds to treat the water properly. This also contributes to the spread of disease.

But preventive health efforts to head off such problems are running into several obstacles.

Shortages of money and health workers are hindering efforts to develop a national health care system to provide preventive medicine for the general public.

Preventive medicine should be distributed to the entire population as needed, with the expense shouldered by society as a whole.

The existing regulation that gives only civil servants access to preventive medicine is unfair and should be adjusted.

In addition, the preventive health care network has yet to extend to the commune level, making it far too small to meet society's needs.

Some health authorities say there is a critical need to send preventive health care workers to communes nation-wide to keep local authorities in step with the national disease prevention campaign.

In addition, preventive health care activities should be re-organised and placed under the auspices of a relevant organisation like the Department of Preventive Medicine under the Health Ministry.

Research shows that contaminated food is still available, but the department still has no authority to fine the violators. The culprits remain out the reach of the long arm of the law, despite confiscation of their property by the Department of Preventive Medicine.

As a result, unsafe and unsanitary food is everywhere, affecting a majority of the general public.

It is widely known that the mass media plays an important role in raising people's awareness of how to prepare safe food. But a lack of money places serious constraints on this approach.

The HCM City Centre for Preventive Medicine, is just one of the institutions suffering from money woes.

The entire society must therefore be involved in promoting preventive health care activities, not just the Ministry of Health.

In keeping with this concept, Việt Nam Television should run a programme free of charge to inform viewers nation-wide about food safety and other aspects of preventive health care.

At the same time, authorities at all levels should co-ordinate with other social organisations to raise people's awareness of these issues.

Moreover, strict punishments should be imposed on violators so that they are held up as shining examples of what not to do with food.

Due attention should be paid to helping underprivileged people live a hygienic lifestyle.

Bringing preventive health care activities into school curricula is also critical to creating a healthy environment for younger generations.

When all of these measures are carried out, Việt Nam will be able to head off problems like food poisoning and unsanitary conditions. — VNS

⑤ 看護関連

Ⅰ. Nam Dinh 看護学校の教育目標、カリキュラムの抜粋

Ⅱ. CONFERENCE
ON HEALTH MANPOWER DEVELOPMENT OF NURSE AND MIDWIFE AND MEDICAL TECHNICIAN AT THE THRESHOLD OF 21st CENTURY
HA NOI CITY, 12−14/8/1999

Ⅲ. REPORT
ON TRAINING OF NURSES, MIDWIVES AND MEDICAL TECHINICIANS IN NAM DINH HIGHER SECONDARY MEDICAL SCHOOL AT PRESENT AND IN THE FIRST YEARS OF 21st CENTURY
(Presented in the conference on the development of nurses, midwives and medical technicians workforce)
HA NOI, AUGUST 1999

訓練達成目標

看護学士は優れた道徳観念と正しいふるまい、正しい科学的知識と一般的な知識、専門的な技能、良いケアを行うための管理の技能、人々にリハビリテーションを行う、などを自己学習することで、進歩向上できる能力を持たなくてはならない。

訓練部門の紹介

・レベル　：大学
・訓練部門のグループ　：医学と薬学
・訓練部門　：看護
・卒業後のタイトル　：看護学士
・訓練期間　：4年間
・訓練コース　：フルタイム
・学校教育の目標　：教育庁の訓練の規定に従う

学習コースの期間

年数　：4年制
学習数の合計　：１４２週
試験の合計　：　２６週
年間学習数：
　理論　：２２６６
　実習（すべての実習）　：２３９５
　率：　理論／実習　＝　０．９５

専門分野の時間数
＋看護　：２８６１時間
　理論　：１１４４時間
　実習　：１７１７時間
　率：　理論／実習　＝　０．６７

任務

Ⅰ．健康管理の訓練

1－1　健康チェック、治療、又はアドバイスを受けるために来院した人を受け入れる。
1－2　看護の規則を遵守する。
1－3　疾病の徴候の変化の発見と、治療録への注意深い記録を継続する。
1－4　救急処置、初期処置を行う。
1－5　外科的治療時に医師の介助を行う。
1－6　終末期の患者へ深い哲学的思慮を持って看護する。
1－7　担当業務に関する地域における保健予防教育に関与する。

Ⅱ．看護管理

2－1　病室、外来、働く場所の管理
2－2　医療器械、薬剤、診療録、その他の資産の管理
2－3　病院、看護部門、研究所などの経営管理
2－4　患者へのケア、サービスを行うために人的資源の管理を行う。
2－5　看護部門の活動を監督、支援するための運営に関与する。

Ⅲ．学習—教育—看護学習

3－1　技能を進歩させるために常に学習する。
3－2　大学卒業生を支援し、保健所職員の訓練に参加する。
3－3　患者、患者の家族、地域住民へ健康管理教育を行う。
3－4　健康管理のアドバイザーとしての役割を取る。
3－5　看護の学習と他の科学的学習の可能性をのばすことに関与する。
3－6　継続訓練のコースの機会があった時、関与する。

第２段階の医科大学レベルの訓練に必要な知識の内容と構造

必須の科目

コース	医学	薬学	耳鼻喉	伝統医学	公衆衛生	看護	医学技術士
解剖学１	5	5	5	5	5	5	5
解剖学２	4×2	0	0	0	0	0	0
解剖学３	0	0	4	0	0	0	0
組織学１	3	0	0	3	0	3	3
組織学２	3	0	0	0	0	0	0
組織学３	0	0	1	0	0	0	0
生理学１	5	5	5	5	5	5	5
生理学２	5	0	0	0	0	0	0
生化学１	4	4	4	4	4	4	4
生化学２	4	4	0	0	0	0	0
微生物学１	4	4	4	4	4	4	4
微生物学２	3	0	0	0	0	0	0
微生物学３	0	3	0	0	0	0	0
寄生虫学１	2	2	2	2	2	2	2
寄生虫学２	3	3	0	0	3	0	0
解剖学的病理学１	3	0	3	3	3	0	0
解剖学的病理学２	2	0	0	0	0	0	0
解剖学的病理学３	0	0	3	0	0	0	0
物理と免疫学１	4	4	4	4	4	4	4
物理と免疫学２	3	0	0	0	0	0	0
薬理学	4	4	4	4	4	4	4
薬理学	3	3	0	0	0	0	0
薬理学	0	2	0	0	0	0	0
解剖実習	3	0	0	0	0	0	0
基礎治療学に	3	0	3	3	0	0	0
基づいた診断学１	4	0	4	4	4	0	0
基礎治療学２	3×2	0	0	0	0	0	0
基礎病理学	0	4	0	0	0	0	4
基礎外科学１	2	0	3	3	3	0	0

学習コースの時間調整

（単位：週）

学期	学習	試験	祝祭日と休暇	国家防衛教育	賃金労働	実習	その他の労働	予備時間	合計
Ⅰ	14	2	4	4	0	0	0	2	24
Ⅱ	18	2	4	0	0	0	1	3	28
Ⅲ	18	2	2	0	0	0	1	1	24
Ⅳ	17	2	4	0	0	2	1	2	28
Ⅴ	18	2	2	0	0	0	1	1	24
Ⅵ	18	2	4	0	0	0	1	3	28
Ⅶ	18	2	2	0	0	2	1	1	24
Ⅷ	11	2+10復習と最終試験	0	0	0	4	0	1	28
合計	130	16と10復習と最終試験	20	4	0	8	6	14	208

TỔ CHỨC Y TẾ THẾ GIỚI
W.H.O

BỘ Y TẾ
M.O.H

CONFERENCE
ON HEALTH MANPOWER DEVELOPMENT OF NURSE AND MIDWIFE AND MEDICAL TECHNICIAN AT THE THRESHOLD OF 21ST CENTURY

HA NOI CITY, 12-14/8/1999

PATIEN CARE ORIENTATION FOR NURSING WORKFORCE DEVELOPMENT TO STEP INTO 21ST CENTURY

Department of Therapy

In the national development process, the Health Sector has the longest historical background serving efficiently for the work of national defence and development. During the development process of Viet Nam Health Sector, the work of nurses, midwives and medical technicians has become an unseparatable component, a professional branch whose the number of staff is plenty. Their work plays an important role with the doctors in the people's health care and protection.

PART I
DEVELOPMENT PROCESS OF NURSING PROFESSION

1. Under the guidance of the Ministry of Health

In the past years, the nursing profession has gained much attention and guidance from the Ministry of Health through the background and orientative documents as follows:

1) Decision 1050/BYT-QD, of 21/11/1965, on establishing a policy for chief nurses in the health facilities.

2) Decision 570/BY-QD and Circular No. 12/BYT-TT, of 14/7/19990, on the establishment of a nursing office in the hospitals.

3) Decision 356/BYT-QD, of 14/3/1992, on the establishment of a nursing office under Department of Health Management (Department of Therapy at the moment).

4) Instruction No. 14 BYT/CT, of 16/10/1993 of the Minister of Health, that the training and education of high degree nurses and midwives will be assigned to Ha Noi Medical College, Ho Chi Minh City Medical and Pharmaceutical College and Nam Dinh Higher Secondary Nursing School.

5) Document No. 3890/KHDT, of 15/5/1994, of the Ministry of Training & Education, stating its agreement for the Ministry of Health to open bachelor degree for nurses, midwives and medical technicians.

6) Circular 11/BYT-TT, of 31/8/1996, of the Minister of Health, on the total patient care and strengthening the system of chief nurses.

7) Decision 1895/1997/BYT-QD, of 19/9/1997, on the issuance of hospital regulations, involving also nursing office at hospitals at rank I, II, and III.

8) Decision 1936/1999/BYT-QD, of 2/7/1999, of the Minister of Health, stipulating functions and duties of department of nursing under provincial and city health services at the central level.

The above named documents have assured that nursing is a professional branch and have oriented its development in 3 areas:

- Establishing professional management and guidance system at all levels;
- Improving professional training skill at higher secondary and university degree;
- Improving the quality of care through the implementation of total patient care.

These policies are very sound and suitable to the needs of people's health care, bringing the country's nursing system into integration with the regional and global system.

2. The achievements gained

2.1 Nursing workforce development

(1) In quantity:

Since the first generation of nurses educated by the Democratic Republic of Viet Nam in 1947 aimed at providing nurses to the army and commune levels, the Health Sector has developed a huge quantity of nursing workforce with increasingly improved quality.

Nowadays, the Health Sector has 66 606 nurses, midwives and medical technicians, of which 43 722 are nurses, 13 726 are midwives and 9 158 medical technicians (The Health Statistics Yearbook 1998). The Nursing workforce makes up for 30% of the whole sector. According to data collected by Department of Therapy at 500 hospitals nationwide in 1998, the number of nurses, midwives, medical technicians and nurses' aid is up to 39 689 of the total 82 270, accounting for 48%.

(2) Professional skill:

Based on the Health Statistics Yearbook in 1998:

University and higher secondary degree:	784 (1.2%);
Secondary degree:	40 430 (60.7%)
Elementary degree:	25 227 (38%)

2.2. Administrative management system

There have been a nursing management and guidance system, divided professionally at 3 levels:

- Ministry of Health (Dept. of Therapy): there is a nursing office
- At Health Services: there is a chief nurse
- In the provincial, city hospitals, there is a nursing office, and at Health Centres there is a chief nurse.

The system of chief nurses at all levels has brought into play the effectiveness of the management, supervision and guidance of patient care. This system has also actively contributed to the implementation of the Minister of Health's decision No. 4 on the improvement of patients' sanitary, eating, dressing and accommodation conditions. The working discipline is being set up and going in good order.

2.3. The establishment of Profession Association

with the establishment of nursing offices, the foundation of a Nursing Association was accepted by the State. The Nursing Association has been organized at 3 levels in 41 provinces and cities nationwide. Its activities have attracted the participation of members, assistance of international organizations, its operation has been evaluated as one of the most effective among Profession Associations.

2.4. **Patient care:**

By enforcing regulations on total patient care, nurses have taken care of hospitalized patients, whose material and spiritual demands are adequately met. Among 202 patients leaving the hospitals who asked, 72 % had answered that they satisfied with the nursing care (study report by Viet Nam Nursing Association).

3. **Basic obstacles**

3.1 **Nursing workforce can be summarized as inadequate, weak and inappropriate in terms of structure.**

The inadequacy of nurses is a common situation in most of the central and provincial hospitals. The fact is that in the hospitals, nurses are enough only for following doctors' instructions but not enough for taking total patient care. There is a study on workforce based on the timing calculation method of the nursing office, Department of Therapy. It has shown that in 4 hospitals (Uong Bi Polyclinic hospital, Xanh Pon, Viet Duc and Dong Son hospitals) the intensive care unit is staffed with 76% of nurses in need and the internal, external medicine, pediatrics' departments are staffed with only 62% of nurses in need. At the community level, there are 2 270 communed without nurses or pediatrics & obstetrics assistant physicians nationwide.

In general, the professional skill of nurses is still low. According to Health Statistic Yearbook 1998, there is about 1% of bachelor nurses, 64% of secondary nurses and 35% elementary nurses.

The workforce structure between doctor and nurse is not appropriate. For examples:

The rate of doctors per nurses is 1/1.8 (shown in result of hospital survey in 1998, by Dept. of Therapy). In Thai Binh province, there are 894 doctors and 969 nurses and midwives, the rate of doctors per nurses in the whole province is 1/1.1. (1996 Health Statistic Yearbook - page 39)

In comparison with other countries in the region, Viet Nam has the lowest rate of doctors per nurses, about 3.5 to 12 nurses per 1 doctor, at average (ref.: Nursing in the World - 3rd edition).

3.2. **The management and operation capability of nursing system is limited and far from satisfaction.**

There are currently about 6 800 chief nurses, of which 88.4% are secondary degree, 8.4% higher education and university degree. Among these nurses, nearly 70% have not yet get training on nursing management. The above mentioned figures are still very low compared to the needs of development and establishment of nursing profession.

3.3. **Professional skill of nursing workforce is still limited: low activeness and weal communication skill.**

It is evaluated by experts and managers that skills of carrying out doctors' instructions and doing techniques are relatively good, however, their activeness and decisiveness are weak.

The reasons: (1) there has not been a training system of professional nurses; (2) The independent field of nurses has not yet been identified; (3) the nurses are still dependent.

Although human is the aim of nurses, the communication skill of nurses is generally limited, lacking of salutation, exchanging and consoling whenever patients worry. For examples: interviews and surveys showed that in 202 patients leaving hospitals who asked, 41% answered that before doing nursing procedures, nurses gave very brief explanation or nothing. 36% patients answered that nurses either shouted, threatened or did nothing when patients complained.

3.4 The leadership of the health facilities has not paid enough attention and investment to facilitate the nurses' working condition for patient care.

They have not yet focused on establishing the nursing workforce and civil employment system equivalent to the duties. It is said that more than 50% of patient care is nurses' work but funds invested is limited. In some hospitals, expensive equipment and facilities were bought but nobody uses or only on request of patients; while there is a lack of normal ones such as speculum, suction tools, etc., as a result, patients have to wait for the tools to be steamed again or have to use recycled ones which are unsafe.

3.5. Disciplines for patient care have not yet been developed and practical techniques have not yet been standardized

The total patient care has just been developed at low level. Patients' relatives are asked to look after the patients' hygiene, eating, changing position. In some hospitals and health centres, the routine work of a nurse is simply to give injections, change bandages, feel the pulse, get temperature, measure blood pressure as instructed by doctors. Almost hospitals face the shortage of workforce, therefore, the shifting mode has not yet been applied, and there is only one nurse on duty overnight. After 22:00 PM, relatives of patients have to look after them and inform the nurse or doctors if something is abnormal.

The techniques of care, hygiene and prevention of infection have not yet been standardized and formed into regulations. In addition, the lack of tool causes crosscut of technical procedures, the recycling suction tubes is very risky and unsafe.

3.6. With regard to improved training and re-training for nurses graduated for a long time, it is still difficult because:

- There is short of complete system of trainers.
- The training programme is not really stable.
- There is short of practice basis.
- Other elements such as economic geography.

PART II
ORIENTATIONS ON NURSING WORKFORCE DEVELOPMENT AND QUALITY IMPROVEMENT OF PATIENT CARE

1. Trends related to orientations on nursing development

(a) the social and economic development leads to higher needs of health care of patients. There is a conflict between limited capacity of the hospitals, in general and of the nursing

profession, in particular: the overload in the central and provincial hospitals is common, nursing workforce is inadequate.

(b) Disease pattern: the increasing rate of morbidity of infectious diseases, social diseases, tuberculosis, mental diseases, HIV/AIDS, sexually transmitted diseases; and morbidity of new diseases such as cardio-vascular diseases, cancer; maternal, child and elderly health care, is pushing the health sector, in general and the nursing profession, in particular, to strengthen and expand types of nursing care.

(c) The increasing application of science and techniques in health sector requires to improve the average rate of degree of general nurses. Especially, the development and expansion of health centres of speciality and speciality departments in the hospitals requires knowledge and special skill to work for higher specialities.

(d) In the future, while concentrating on hospitalized patients, health care service will be oriented to provide community health care service, in order to enhance people's accessibility and pursue equity in health care. Apart from knowledge of patient care, nurses should be equipped with knowledge of primary health care and home care. Especially in the remote and faraway areas or ethnic areas, the intellectual ceiling is low, therefore, in the near future, the health workers in these areas should be given separate training to meet the demands of the community.

(e) The health sector, in general and the nursing profession, in particular, is providing service to human, therefore, the ethics, culture and communication skill should be shown clearer than any other professions.

2. Objectives and targets:

Based on the economic, social and health background and the needs of people's health care mentioned above, we propose hereby objectives and targets of nursing profession:

2.1. Objectives:

1. To ensure adequate nursing workforce to implement total patient care at the hospitals and people's health care at the community.
2. To strengthen professional and speciality skills of nurses. To strengthen the number of higher secondary nurses into the main workforce within the nursing workforce structure and to specialize hospital nurses.
3. To use nurses with regard to certificate, skills and capability.

2.2. Targets:

2.2.1. To implement 1st objective:

(1) to ensure the quantity:

#	Targets	1999	2005	2010
1	The rate of nurses per beds as planned: - central hospitals - provincial hospitals	 0.49 0.37		

	- district hospitals - in 3 levels	0.36 0.38		
2	The rate of midwives per beds - central hospitals - provincial hospitals - district hospitals - in 3 levels	 0.02 0.058 0.07 0.06		
3	The rate of medical technicians per beds - central hospitals - provincial hospitals - district hospitals - in 3 levels	 0.13 0.06 0.075 0.07		

2.2.2. To implement 2nd objective:

(1) Indicators of hospital nursing degree:

Degree	1999 (%)	2005 (%)	2010 (%)
- University	0	5	10
- Higher secondary	2.35	10	30
- Secondary	79.6	85	60
- Elementary	18.0	0	0

(2) Indicators of hospital & community nursing care:

#	Degree	1998 (%)	2005 (%)	2010 (%)
1	- University: 0	0	5	10
2	- Higher secondary: 860	1.2	20	30
3	- Secondary: 42 708	63.80	65	55
4	- Elementary: 23 572	25.0	10	5

3. Using nurses with regard to certificates:

3.1. Commune health workers:

Duty station: commune health stations
Main duty: to implement Primary Health Care

3.2. Secondary nurses:

Duty station: health stations, clinics and hospitals
Main duty: to assist bachelor nurses, to support treatment and take basic care.

3.3. Higher secondary nurses

Duty station: at the community or in hospitals
Main duty: to take total patient care, in-charge of management at department level, to give guidance on hospital practice, to act as facilitators and give lectures on nursing practice in the nursing school.

3.4. Bachelor nurses

Duty station: hospitals, medical college and medical secondary school
Main duty: to give total patient care, lectures and carry out studies on nursing, to be in charge of nursing management.

3.5. Higher secondary/university nurses having certificate of nursing management.

Main duty: in charge of chief nurses at all levels.

3.6. Nursing speciality

In order to strengthen professional skill of nursing workforce to meet the demand of scientific and high-tech development in the Health sector, system of nursing speciality is required. In the years ahead, it is necessary to develop nursing specialities of nursing profession as:

- Nursing management
- Intensive Care unit
- Anaesthetology
- Surgery
- Pediatrics'
- Mental health
- Community
- Opthomalogy, Odonto-Stomatology and Maxillo-facial surgery, Ear-Nose-Throat
- Rehabilitation
- Clinical lectures
- Training possibilities for midwives with the orientation of nursing speciality (or also called obstetrics nurses)

ACTUAL SITUATION OF HUMAN RESOURCES: NURSES, MIDWIVES, MEDICAL TECHNICIANS; FORECAST ON DEMANDS AND ORIENTATIONS FOR DEVELOPMENT OF PATIENT CARE STAFF

I - BACKGROUND:

The Resolution of the 4th Vietnamese Communist Party's Central Committee, session VII, The Resolution of the National Congress of the Vietnamese Communist Party, session VIII, the Law on Health Care and the Resolution 37/CP have all affirmed the core role of the health sector in the people health care and protection, which is a hard but glorious task.

In order to fulfil the historical mission entrusted by the Party and the Government, besides the task of coordination and mobilization of all branches, all levels and of everyone in self and community health care and protection, the health sector should also study and rearrange its labour force properly to meet step by step the increasing demands of the people for the quality of health services.

Over more than 22 years of implementation of the Resolution 15/CP from 1975 to 1997, the nation-wide health network covering urban and rural areas has developed its effectiveness for the long period of the budget subsidies mechanism. However, since the innovation and open-door policy was implemented with the effects of the market economy mechanism, the old organization model of the health sector has been no longer appropriate.

In conformity with the real situation, the Government issued the Decision No. 01/1998 on 3 January 1998, and the Ministry of Health and the Division of Organization and Manpower of the Government issued the Joint-Circular No. 02/1998 to provide the guidelines for implementation of the Decision No. 01/1998/ND-CP on local health system, which is an replacement for the Resolution 15/CP.

The organization structure of the health sector has been renovated, however, the team of nurses, midwives and medical technicians working in the health facilities, which constitutes the biggest part of the health personnel and plays an important role in the patient care activities, has not received proper attention from the society for many years. It is now necessary that the Party, the Government and the health sector re-evaluate nursing capability and affirm the top importance of this team, and at the same time work out the orientations for development of the patient care staff in conformity with the common development of the country.

In the framework of this report, our focus is only addressed to the objectives, surveys and evaluation remarks mentioned below.

II - OBJECTIVES:

1. General objectives:

To strengthen, to stabilize and to develop human resources (Nurses - Midwives - Medical Technicians), to gradually improve the quality of total nursing care at health facilities from central to peripheral levels.

2. Specific objectives:

- To survey and assess the current situation of human resources (Nurses - Midwives - Medical technicians) for patient care at health facilities;
- To forecast the demands and orientations for development of human resources (Nurses - Midwives - Medical technicians) for patient care at health facilities.

III - CONTENTS:

1- Survey on the actual organization and staff situation (particularly the situation of nurses, midwives and medical technicians)
   - Quantity
   - Quality
   - Age
   - Working experience

2- Forecast on demands and orientations for development of patient care resources until the year 2010.

IV - OBJECTS, SCOPE AND METHODOLOGY:

1- Objects: Nurses, midwives, medical technicians

2- Scope: Some central, provincial and city health facilities

3- Methodology:
   - ***Indirect***: To send questionnaires to the Health Services of Ha Noi, Ho Chi Minh City, Lam Dong, Tay Ninh, Long An, Quang Ngai, Thua Thien Hue, Khanh Hoa and some local health stations.

   - ***Direct***: To carry out direct surveys at Cho Ray Hospital, Thong Nhat Hospital, Paediatric Hospital No. 1, Health Services of Ho Chi Minh City, Long An and of Quang Ngai.

   - ***Processing of data*** from yearly periodic reports of provincial and city Health Services, of Ministry of Health related institutions and of health facilities belonging to different sectors, and from the Health Statistics Yearbook issued by the Planning Department, Ministry of Health.

V - RESULTS OF SURVEYS:

A - ACTUAL ORGANIZATION SITUATION OF THE HEALTH SECTOR:

1. General organization situation of the health sector:

In order to fulfil the state management functions, the health sector is organized into three sections:

- The section under the management of the Ministry of Health (central level)
- The section under the management of provincial/city people's committees directly dependent on the central government (local level)
- The section under the management of other ministries and other branches (sectorial level)

1.1. The section under the management of the Ministry of Health:

This section is divided into 7 categories including the Office of the Ministry of Health and 72 institutions under the Ministry with 24 893 officials and civil servants. These categories are:

- **State management**: The Office of the Ministry of Health currently consists of 15 departments including administrations, divisions, inspection board and the Cabinet of the Ministry.
- **Curative care and consultation**: There are totally 30 institutions including 17 general and specialized hospitals, 9 research institutes with patient beds (which are really specialized hospitals), 1 medical quality control institute, 2 leprosariums, and 1 nursing and rehabilitation hospital.
- **Preventive medicine**: There are totally 13 institutions including 9 institutes, 2 sub-institutes and 2 centers.
- **Training of staff**: There are totally 14 schools of medicine and pharmacy including 5 colleges, 1 school of public health, 1 higher secondary school, 6 secondary schools and 1 technical school.
- **Pharmacy and medical equipment**: There are totally 4 institutions including 3 institutes and 1 sub-institute.
- **Health sociology**: There are totally 6 institutions including 1 institute, 2 centers, 1 newspaper and 2 magazines.
- **Business**: There are totally 5 institutions including 2 corporations, 1 publishing house, 1 centre, and the Viet Nam Health Insurance.

1.2. The section under the management of provincial/city people's committees dependent directly on the central government:

This section covers a health network organized from provincial to commune levels, including 61 Health Services, health centres of 600 districts and districts' capitals, of 10 381 communes, quarters and townlets. The health facilities consist of:

- Provincial level:
  + 91 provincial and regional general hospitals;
  + 65 specialized hospitals;
  + 37 traditional medicine hospitals;
  + 34 nursing and rehabilitation hospitals and centres;
  + 7 specialized clinics

There are preventive medicine units such as centres of preventive medicine, centres for protection of mother and child health and family planning, antimalarial centres/stations, etc. in all the 61 provinces and cities under the central government.

- District level:
  + 600 health centres of districts, districts' capitals and of cities under the provincial governments;
  + 525 facilities with departments of therapy (district hospitals);
  + There are teams of preventive medicine, teams for protection of mother and child health and family planning, and mobile teams (in mountainous and highland districts) in all district health centres;
  + 923 regional general hospitals;
  + 38 regional maternity units;
  + 10 381 communes, quarters and townlets have their health workers, of which 9 837 communes, quarters and townlets have their health stations;
  + Only 41 135 among 93 729 villages have village health workers.

1.3. Health service of other sectors: Currently there are:

- 78 general hospitals;
- 30 polyclinics;
- 65 nursing and rehabilitation facilities;
- 1 123 health stations

2. Actual situation of total nursing care and strengthening of chief nurse system (source of material: Nursing Office, Department of Therapy)

2.1. Total nursing care has been currently implemented:

- 80% of hospitals transferred from duty allocation to patient allocation.
- 15% of departments of resuscitation and emergency.
- 90% of patients use patient record cards.
- There are remarkable improvements in terms of quality of patient care.
- Career skills of nurses have been improved through training activities and through competitions for skillful and courteous nurses and midwives.
- More instruments for patient care have been provided.

2.2. Strengthening of chief nurse system:

2.2.1. Hospitals of I and II levels:

- 100% of hospitals have their Nursing Offices working under the hospitals' regulations.
- Position, functions and duties of Nursing Offices; duties and power of Heads of Nursing Offices in hospitals; of chief nurses of hospitals and of departments have been identified clearly (Hospital Regulations) with increasingly effective operation.

2.2.2. Health centres of districts, districts' capitals and of townlets:

10% of district health centres set up their Nursing Offices in accordance with the Decision 570/BYT-QD, which are mainly the health centres with a capacity of more than 100 beds functioning as a regional hospital; 60% of district health centres have nursing teams and 25% have only chief nurses.

2.2.3. Health Services:

Currently, 18 of 61 Health Services have chief nurses to monitor nursing and midwifery activities, the other Health Services assign one doctor from the Professional Unit to monitor nursing and midwifery activities.

2.2.4. The Office of the Ministry of Health: There is a Nursing Office in the Department of Therapy with its activities focused on:

- Formulation of regulations, guidelines for nursing and midwifery;
- Inspection, supervision of patient care in hospitals;
- Taking part in guidance for anti-infections, management of hospital waste;
- Taking part in training of chief nurses;
- Taking part in formulation of training curricula for nurses and midwives.

3. General remarks on the organization:

- There are too many clues at the central level, the management and supervision are, therefore, still limited.
- In the past years, the Ministry of Health issued many guidelines for the related institutions to proceed with the reorganization by category such as preventive medicine, training, etc.
- Functions of institutions have been rechecked to avoid possible overlaps, to gradually strengthen their organization status for effective operation.
- Training system: There have been plans for reorganization and upgrading of the system of colleges and higher secondary schools, for innovation in curricula and learning materials for each category of health personnel to be trained, especially for local health workers such as village ones.

- Research system: Research facilities have been rearranged, great importance has been attached to the science and technology, with a focus on the research of basic medical and pharmaceutical sciences, and on the dealing with disease models of Viet Nam.
- Local health facilities: At present, the implementation of the Governmental Decision No. 01/1998/ND-CP on the local health systems is under development; functions and duties of each unit under the Health Services are being set up by the Ministry of Health; the surveys were carried out; labour norms and personnel structure of the administrative units belonging to the provincial and district health systems are being formulated.
- Health system of other ministries and of other branches: The Department of Preventive Medicine has been assigned by the Ministry of Health to collect the comments and proposals from other branches on the sectorial health organization models in the years to come.

B - ACTUAL PERSONNEL SITUATION:

1. Quantity and quality:

- As of 31 December 1998, the total of health personnel is 230 029 persons, of which 16.28% are medical doctors, 21.82% are assistant physicians, 26.98% are nurses, midwives, and medical technicians, and 32.94% are other health workers; if we include assistant physicians, nurses, midwives and medical technicians, the percentage will be 50.78% (Health Statistics Yearbook 1998).
- Health workers are allocated to work in health facilities at national-wide level (as indicated above).

1.1. General indicators:

Table 1

Indicators \ Year	1996	1997	1998
No. of inhabitants per doctor	2 253	2 256	2 083
No. of inhabitants per nurse, midwife, medical technician	1 143	1 190	1 172
No. of doctors/10 000 inhabitants	4.40	4.40	4.80
No. of nurses, midwives, medical technicians/10 000 inhabitants	8.75	8.40	8.53
No. of assistant physicians/10 000 inhabitants	6.40	6.32	6.43

The data in Table 1 show that there is no big changes in the number of inhabitants per doctor of 1996 and 1997, however, in 1998, the number of medical doctors increased, making the number of inhabitants per doctor decreased by about 200; there is no considerable change in the number of nurses, midwives and medical technicians per 10 000 inhabitants in three years (1996, 1997 and 1998).

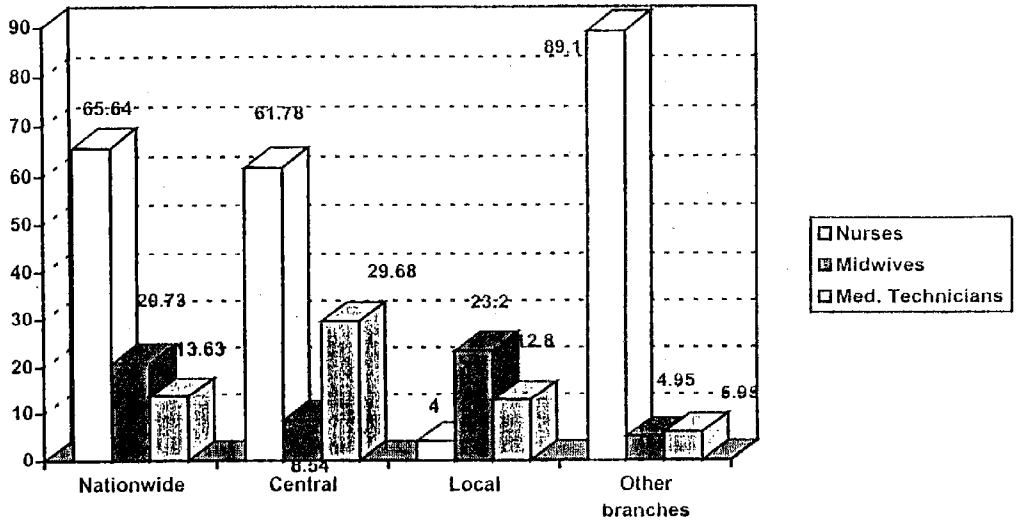
The number of doctors per 10 000 inhabitants in 1998 has been improved; meanwhile the number of nurses, midwives and medical technicians per 10 000

inhabitants were decreased, compared to 1996-1997. The number of assistant physicians were not included, as in some mountainous and highland areas, they functioned as a teacher, and as a nurse in some delta areas.

1.2. Number of doctors per nurse, midwife and technician:

Table 2

Level	Nationwide	Central	Local	Other branches
Proportion of doctors to nurses, midwives and medical technicians	1/1.78	1/1.18	1/1.87	1/ 2.47



- In accordance with the Decision No. 07-UB/LDTL of 23 January 1975 issued by the State Planning Committee, this proportion must be 1/3. However, the current proportion is only 1/1.78, which reflects exactly the real situation of unbalance between the number of "teachers" and "nurses"...
- The total of nurses, midwives and medical technicians in the whole country is 66 606, of which 65.64% are nurses, 20.73% are midwives, and 13.63% are medical technicians. Among 43 722 nurses , 0.75% are university degree nurses, 54.89% are secondary degree nurses; and 44.37% are elementary nurses. Among 13 806 midwives, 0.61% are university degree midwives, 69.19% are secondary degree midwives, and 30.23% are elementary midwives. As to medical technicians, there is no university degree, 83.37% are of secondary education level, and 12.63% are of elementary education level.
    + Central level: The proportion of doctors to nurses, midwives and medical technicians is only 1/1.18. Among 3 473 nurses, only 1.3% are university degree nurses, the main part consists of secondary degree nurses (82.98%), 15.72% are elementary nurses; as to midwives, 98.13% are secondary degree midwives and 1.88% are elementary midwives; 100% of medical

technicians are of secondary degree, there is no university degree medical technician.

+ Local level: The proportion of doctors to nurses, midwives and medical technicians is 1.87%, which is higher than the proportion of the whole country (1.78%). Among 36 110 nurses, 0.78% are university degree nurses, the percentages of secondary degree and elementary nurses are almost the same (>49%); among 13 096 midwives, 0.61% are university degree midwives, 68.22% are secondary degree midwives, and 31.17% are elementary midwives; as to medical technicians, 65.51% are secondary degree and 11.26% are elementary technicians.
+ Health personnel of other branches: The proportion of doctors to nurses, midwives and medical technicians is highest (1/2.47); among nurses, 80% are secondary degree and 20% are elementary nurses, there is no university degree; among 230 midwives, 64.35% are secondary degree midwives, and 35.65% are elementary midwives; 1.64% of medical technicians are secondary degree and 1.37% are elementary technicians.

1.3. Health personnel by territorial region:

The proportion of doctors to nurses, midwives and medical technicians

Table 3

Territorial region	General local	Northern highlands and midlands	Red River delta	Central coast	Central highlands	South-East region	Mekong River delta
Proportion of doctors to nurses, midwives and medical technicians	1/1.87	1/ 2.05	1/1.82	1/ 2.17	1/ 2.2	1/ 2.04	1/ 1.89

In general, this proportion in the delta regions is lower than that in other regions, as it is easy to attract medical doctors to work there. In most regions, the proportion of doctors to nurses, midwives and medical technicians is higher than the general proportion of the whole country, 4 of 6 regions have the proportion > 2, including the Northern highlands and midlands, the Central coast, the Central highlands and the South-East region, the 2 others with the proportion < 2 are the Mekong River delta and the Red River delta.

2. Quality of patient care staff:

The data collected from questionnaires and from direct surveys carried out at central and local levels were analysed as follows:

2.1. Some surveyed central institutions (including preventive medicine units):

Table 4

Institutions	General Central	ENT	Vaccine Inst.	IPMN	Tue Tinh Medical School	Ha Noi Dental Hosp.	Thai Nguyen General Hospital	Uong Bi General Hospital	Da Nang C Hospital	Cho Ray Hospital
Doctors	1.18	0.77	1.60	2.64	0.33	1.32	1.56	2.32	1.71	2.46
Nurses-Midwives-Medical Technicians										

There are big differences between these institutions. In general, this proportion in the research institutes with beds is lower than in the hospitals (except for the Institute for the Protection of Mothers and Newborns), as such institutes have another function of scientific research. There is a difference of 0.9 in this proportion among the hospitals (the highest proportion is 2.46 and the lowest is 1.56).

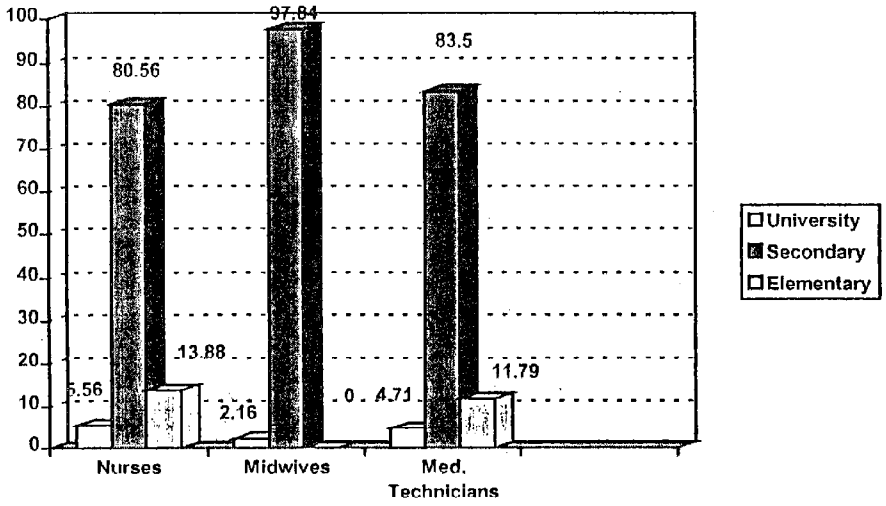
Three of 9 institutions with the high proportion of doctors to nurses, midwives and medical technicians (>2) are the Institute for the Protection of Mothers and Newborns, Cho Ray Hospital and Uong Bi General Hospital; 2 of 9 institutions with the lowest proportion are Tue Tinh Secondary School and the Institute of Otorhinolaringology; the 4 others with the proportion less than 2 are the Institute of Vaccine, Ha Noi Institute of Odonto-Stomatology and Maxillo-facial Surgery, Thai Nguyen General Hospital and Da Nang C Hospital (statistics 1998).

2.2. Professional qualification, age and period of service of patient care staff in some surveyed central institutions:

Table 5

Designation	Total	Professional qualification			Age			Period of service (year)		
		Univ. degree	Secon-dary degree	Elemen tary	< 30	30-50	> 50	< 10	10-20	> 20
		(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)	(%)
Nurse	1 068	5.56	80.56	13.88	22.22	61.11	16.67	25.00	36.11	39.98
Midwife	139	2.16	97.84	0	5.76	87.05	7.19	20.14	43.88	35.97
Medical technician	297	4.71	83.50	11.79	21.89	72.73	5.39	22.90	62.29	14.48

In general, the most of nurses are of secondary degree, the percentage of university degree nurses is very low, and the availability of elementary nurses at central level is a concern to be solved by the possible plans of training and fostering to improve the professional qualification of these staff.



The general rate of doctors per nurses - midwives - technicians in some units at the central level is 1 per 2.0.

- Nurses: there are 1068 nurses, of which:
  - *in terms of professional degree:*
    5.56 % at university degree
    80.56% at secondary education degree
    13.88% at elementary education degree
  - *in terms of ages:*
    22.22%: under 30 years old
    61.11%: from 30 to 50 years old
    16.67%: above 50 years old
  - *in terms of the period of service (Period of service):*
    25%: less than 10 years
    36.11%: 10 - 20 years
    38.89%: over 20 years.

- Midwives: there are 139 midwives of which
  - *in terms of professional degree:*
    2.16 %: at university degree
    97.84%: at secondary education degree
  - *in terms of ages:*
    5.76%: under 30 years old
    87.05%: from 30 to 50 years old
    7.19%: above 50 years old
  - *in terms of the period of service (Period of service):*
    20.14% have worked for less than 10 years
    43.88% have worked for 10 - 20 years
    35.97% have worked over 20 years.

- Medical technicians: there are 297 medical technicians of which:
  - *in terms of professional degree:*

4.71 %: at university degree,
83.5%: at secondary education degree,
11.79%: at elementary education degree;

- *in terms of ages:*
  21.89%: under 30 years old
  72.73%: from 30 to 50 years old
  5.39%: above 50 years old
- *in terms of the period of service:*
  22.9% have worked for less than 10 years
  62.29% have worked for 10 - 20 years and
  14.48% have worked over 20 years.

2.3. Results from some surveyed places (in 1999)

The rate of doctors per nurses - midwives - medical technicians in 5 among 7 provinces surveyed:

Table 6

Unit	General rate at local level	Ho Chi Minh City	Lam Dong Province	Khanh Hoa Province	Thua Thien - Hue Province	Long An Province
Rate of doctors per nurses - midwives - medical technicians	1/ 1.87	1/ 1.47	1/ 2.97	1/ 2.65	1/ 1.50	1/ 2.73

There is a great gap among provinces (more than two times), therefore it is certain that the function of nursing care at health facilities is highly different.

3 among 5 provinces having higher rate of doctors per nurses - midwives - medical technicians than the general rate of local health care (Lam Dong, Khanh Hoa and Long An). 2 of 5 provinces having the above mentioned rate lower than the general rate of local health care (Ho Chi Minh City, Thua Thien - Hue).

The following table shows the general rate of 5 provinces in terms of professional qualification, ages and period of service for 3 designations:

Table 7

Designation	Total number	Professional qualification			Thua Thien - Hue Province			Long An Province		
		UNI (%)	SE (%)	EE (%)	< 30 (%)	30 - 50 (%)	> 50 (%)	< 10 (%)	10 - 20 (%)	> 20 (%)
Nurses	5850	1.60	55.20	43.13	19.30	76.48	5.93	30.67	47.16	21.20
Midwives	2176	2.48	74.54	22.98	31.02	63.83	5.15	47.01	35.66	17.97
Medical Technicians	1199	8.01	69.81	22.19	21.10	67.81	5.09	29.69	50.29	18.43

(UNI: University degree; SE: Secondary Education degree; EE: Elementary Education degree)

In the provinces, number of nurses graduated from elementary education is rather high, accounting for 43.13%. And in comparison with the numbers of midwives and medical technicians, it has the highest rate of elementary education and lowest rate of university degree.

Most of nurses are from 30 to 50 years old with period of service from 10 to 20 years. The midwives, in particular, are almost under 30 years of age so that the rate of their Period of service under 10 years is higher than that of the other two designation.

2.4. According to the data collected from 217 communes survey on ages of nurses, midwives, medical technicians and assistant physicians, conducted by the Nursing Office, Dept. of Therapy in 1999:

Table 9

Designation	Total number	Under 30 years of age (%)	From 30 to 50 years old (%)	Over 50 years of age (%)
Nurses	201	26.37	70.65	2.99
Midwives	183	38.80	59.02	2.19
Medical technicians	17	41.18	58.82	0
Assistant physicians	309	33.01	65.37	1.62

The table above indicates the highest ages, average ages and lowest ages of nurses, midwives, medical technicians and assistant physicians and the percentage of each level.

2.5. General overview of personnel

- The general rate of doctors per nurses - midwives - medical technicians at all levels is still low, especially at the central level: the number of doctors and nurses - midwives - medical technicians is nearly the same. The sectoral health care has the highest rate of doctors. The rate at the local health care is nearly the same as the one of the whole country. As a result, it is certainly that the current staff structure can not meet the demand of total nursing care.

Staff structure and professional degree of nurses - midwives - medical technicians have developed unequally. The rate of nurses - midwives graduated from university is highest at the central level. There is a slow increase in the number of medical technicians with university degree. The number of those of secondary education degree at all levels has considerably gone up, especially at central and sectoral levels. However, number of elementary education graduates at the local level is still very high, especially in the disadvantaged areas; this number at the central and sectoral levels is still considerably high (at 15 - 35%). Among the three Designations (nurses - midwives - medical technicians), there is still large shortage of midwives, mainly at the local level - in the disadvantaged areas.

The number of nurses - midwives - medical technicians having worked for 10 to 20 years falls mostly from 30 to 50 years of age, the number under 30 years of age and under 10 years of service accounts for 30%, the number over 50 years of age and over 20 years of service accounts for only 7%. This means we have to replace annually 5 - 7% of the health workers. This occurs at the central as well as local level. The age of nurses - midwives - medical technicians at the local level is mostly from 30 - 50 or under 30 years of age, the number over 50 years of age is lower than that at the district, provincial and central levels.

3. POLICY FOR THE HEALTH WORKERS

3.1. Policy

- There are 2 points of interest regarding the salary of the health workers, in general and of nurses - midwives - medical technicians, in particular:

- The basic salary is too low compared with the basic living needs, regardless of the feeding the family. Most of the civil servants in health are main labour source in the family so it is very hard for their living. Most of nurses - midwives - medical technicians have to be on duty 24/24 hours so that they are unable to get extra work to earn more, except in some cities, towns, they can work part time for private health clinics.

- There is a great oscillation in terms of extra income among provinces and branches. The extra income is even much higher than the salary. However, this happens mostly in the large hospitals and in the cities. Branches such as Leprosy, Mental Health, Tuberculosis get almost no extra income, that makes the inequity in the health sector itself.

3.2. Allowances additional to salary

- Allowance for harmfulness, contagiousness
- Allowance for being on duty, and surgery operation
- Allowance for responsibilities
- Allowance for post adjustment
- Allowance for mobile work

This allowance system is still out of control so the implementation is still thoughtless: it will be payable if there is money, otherwise it is to wait. In general, health workers at the central level receive allowances as stated in the policy. However, the health workers working at provincial, city levels meet some difficulties. In some places, there is not enough budget to fully implement the policy, especially in the poor areas.

- Policy for the local health workers:

Many health workers have been employed as civil servant of district and assigned to work in the communes, they are given social and health insurance. However, there are over 15 000 health workers at the local level have not yet been entitled to contribute to social and health insurance. When they are retired, it is unable to decide which policy should be applied for them, especially in case they die. The health workers at commune, village levels in the mountainous, remote areas and sea islands have been given monthly VND 40 000/each, however, this is not applicable in other places.

3.3. Incentive policy

There is an inequity in terms of rewarding Medal "For the sake of People's health" as well as salary scale between Education and Health sector: the same kind of work, even though the training and working period of the health workers is longer and harder, to be rewarded, the period of service is 25 - 30 years (while it is only 15 years for the Education), the salary of the Education is 1.5 times higher than the salary of the Health.

In general:

+ The salary is not the basic income, unable to cover the living costs, and to encourage the health workers.

+ The allowances are still low

+ Income rather than salary is highly oscillated, making an inequity.

FORSIGHT OF THE DEMAND AND DEVELOPMENT ORIENTATION OF NURSING FROM NOW TO THE YEAR 2010

1. FORESIGHT OF THE DEMAND:

1.1. General indicators:

	Up to date	by the year 2010
· Population (million)	78 millions	90 millions
· Number of doctors per 10 000 inhabitants:	4.8	5.8
Number of doctors	-	52 200
· Number of nurses - midwives - medical technicians per 10 000 inhabitants	8.53	10.5
Number of nurses - midwives - medical technicians	-	94 500
· Number of doctors per nurses - midwives - medical technicians	1.78	3.0
Number of nurses - midwives - medical technicians estimated on 60% of treatment doctors	-	93 960
· There are about 6% of people need to be replaced annually (in 10 years)	-	56 700

1.2. General standards for health care at all levels:

Branch/post	Central level	Provincial level	District level	Commune level
- Therapy:				
+ general staffing (patient/bed) at highest rate	1.7	1.2	1	
+ Rate of doctor / nurse/ nurse's aid	1 / 1.5 - 2.0 / 0.8	1 / 2.1 - 2.5 / 0.5	1 / 1.7-2.8 / 04 - 06	
+ Rate of doctor / bachelor nurse/ secondary nurse	1 / 0.16 / 2.1	1 / 0.14 / 1.96	1 / 0.12 . 2.1	1 / 0.08 / 3
- Prevention;				
+ Doctor/ other medical Designation	1 / 0.8	1 / 1.2 - 1.7	1 / 1.25-2 (Bach Mai Hospital)	There is a elementary nurse
+ Doctors, assistant physician/ other medical Designation			1 / 0.43 - 0.33 (Preventive Medicine) 1 / 0.49 - 0.33 (Occupation al Health)	

2. ORIENTATIONS AND RECOMMENDATIONS

2.1. Organization:

2.1.1. Administrative management:

- Ministry of Health:

There is a Nursing Office under Dept. of Therapy, one responsible deputy director with Master degree in Nursing.

- At Health service:

There should be a bachelor of Nursing as deputy-chief of office of medical profession, responsible for nursing (MoH has issued regulations on their functions and responsibilities)

- The health centre at the districts and towns:

To assign a bachelor of Nursing or a Nursing secondary education graduate as a chief nurse, belonging to the Planning - Profession Unit (possibly assigned as vice-chief of the unit).

- The health station at the communes, quarters and townlets:

To assign a bachelor of Nursing or a Nursing secondary education graduate to be responsible for nursing as well as administrative management, statistics, reporting. This person will be vice-chief of the health station and concurrently the administrative assistant physician (for commune health stations with doctors).

2.1.2. Professional system:

- Hospitals at rank I - II:

+ There is a nursing unit. The chief of this unit and the hospital's vice director with the university degree or higher education degree on Nursing will be in-charge of this area.

+ There is a chief nurse of Nursing department and vice chief of department responsible for nursing care, with university degree of nursing.

- Hospital at rank III: regional specialized or general hospitals equipped with 100 -200 beds can establish a nursing unit or nursing team, whose degree is bachelors or secondary education graduates of nursing.

The health centres whose number of beds less than 100 should be staffed with a chief nurse and concurrently vice-chief of Planning - Profession office or with a nursing team. Based on the needs of each health centre, the degree of nurses is either bachelor or secondary education graduate.

2.2. Functions and responsibilities of nurses, midwives, medical technicians and chief of the nursing unit, chief nurse of a department, chief midwife of a department, chief medical technicians of a department.

2.2.1. The system of nurses - midwives - medical technicians:

Under the guidance of director and chief nurse of the department or chief midwife or chief medical technicians of the department, the nurses - midwives - medical technicians must fulfill functions and duties given.

- Functions:

+ to follow up vital signs of patients, healthy people as pulse (vein), temperature, breath rate, blood pressure, eating, motion.

+ to make scheme for total nursing care of patients at the hospitals or community or families (with regard to community nurses)

+ to practice nursing technics at the hospitals or provide treatment at home and community (with regard to community nurses), to provide guidelines on personal hygiene to the families for helping patients in: washing, bathing, changing clothes, replacing sedge mat or bed cloth.

- Duties:

Duties stipulated for each designation will be implemented based on Hospital Regulations issued in accordance with Decision No. 1895/1997/BYT-QD of the Minister of Health, dated 19 September 1997.

2.2.2. Administrative system: chief of the nursing unit, chief nurse of the department, leader of nursing team.

Under the guidance of the director of hospitals or district health centres and directors of departments, chiefs of units (of nurses, midwives, medical technicians) and chief nurses of departments should fulfill all functions, duties given.

- Functions:

To be responsible in front of managers, department directors, for managing work, following up the total nursing care; to join in the studying, training activities; to foster professional ability for nurses - midwives - medical technicians and trainees.

- Duties and rights:

Duties and rights stipulated for each post based on Hospital Regulations issued in accordance with Decision No. 1895/1997/BYT-QD of the Minister of Health, dated 19 September 1997.

2.3. Policy:

2.3.1. Administrative system:

- The policy of post and duty allowances applied for managing officers of nursing staff is implemented according to the Ministry of Health's Circular No. 13/BYT - TT dated 27 November 1993 on ranking medical administrative units.

- According to administrative ranking: officers working in the Ministry of Health (Nursing Office), provinces, districts and health stations are beneficiary of post allowance (if concurrently hold two posts)

- According to technical ranking: officers are beneficiary of allowances stated in the table below:

Levels of allowance:

No.	Administrative post	Hospital at rank I	Hospital at rank II	Hospital at rank III	Hospital at rank IV
1	Vice-Director	0.7	0.5	0.4	0.3
2	Chief of department	0.5	0.4	0.3	0.2
3	Vice-chief of department	0.4	0.3	0.2	0.1
4	Chief of nursing unit in the hospital	0.4	0.3	0.25	0.2
5	Vice-chief of the unit, chief nurse of the department	0.3	0.2	0.15	0.1

Based on the standards of officers and needs of each unit, levels of allowances will be applied equivalent to the post described above.

2.3.2. Professional system:

Nurses, midwives and medical technicians work in the departments:

- First of all, it is requested that state policy on duties, harmfulness, contageousness, surgery allowances be implemented in units, local health care.
- It is requested that the state consider to upgrade salary scale for the health sector equivalent to the salary scale of the education sector.
- There should be incentive policy to attract officers to the local level, especially to the remote, disadvantaged areas.
- The State should sooner issue labour norm and structure of civil servants for medical administrative units as a replacement of Decision 07 - UB/LDTL, which has not yet been suitable.

ANNEX
SITUATION OF MANPOWER OF NURSES, MIDWIVES AND MEDICAL TECHNICIANS; NEED ASSESSMENT AND DEVELOPMENT DIRECTION OF MANPOWER FOR PATIENT'S CARE AND SERVICES

1. SITUATION ON MEDICAL STAFF

***Table 1*: General indicators**

Time	1996	1997	1998
Number of doctors per inhabitants	2253	2256	2083
Number of Nurses, midwives, technicians per inhabitants	1143	1190	1172
Number of doctors per 10,000 inhabitants	4.40	4.40	4.70
Number of Nurses, midwives, technicians per 10,000 Inhabitants	8.75	8.40	8.53
Number of Assistant physicians per 10,000 inhabitants	6.40	6.32	6.43

***Table 2*: The patient care staff at nationwide level**

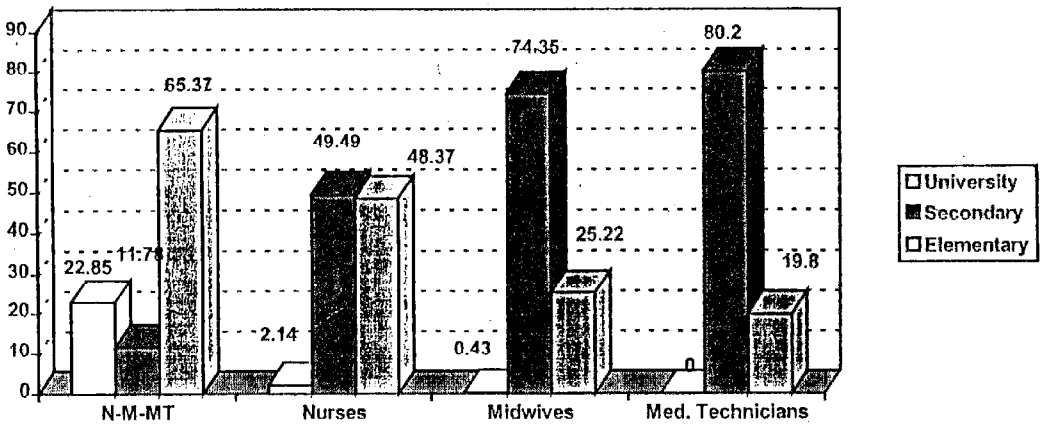
No.	Designation	Nationwide	Central	Local	Other sectors
1	Doctors	37458	6547	29081	1830
2	Assistant physicians	50201	379	47860	1962
3	Nurses	43722	3473	36110	4139
	- Post-graduated	326	45	281	0
	- Secondary degree	23997	2882	17839	3276
	- Elementary	19399	546	17990	863
4	Midwives	13806	480	13096	230
	- Post-graduated	80	0	80	0
	- Secondary degree	9553	471	8934	148
	- Elementary	4173	9	4082	82
5	Medical technicians	9078	1668	7134	276
	- Post-graduated	0	0	0	0
	- Secondary degree	7921	1668	6103	150
	- Elementary	1157	0	1031	126

Table 3: **Number of Doctors per Nurses - Midwives - Medical Technicians**

Doctors /	Nationwide	Central	Local	Other sectors
Nurses-Midwives-Medical Technicians	1/1.78	1/1.18	1/1.87	1/2.47

- *In the South-east region: the proportion of doctors to nurses, midwives, technicians is 1/2.04*

Table 4:



- *Cuu Long Delta: the proportion of doctors to nurses, midwives, technicians is 1/1.89*

Table 5:

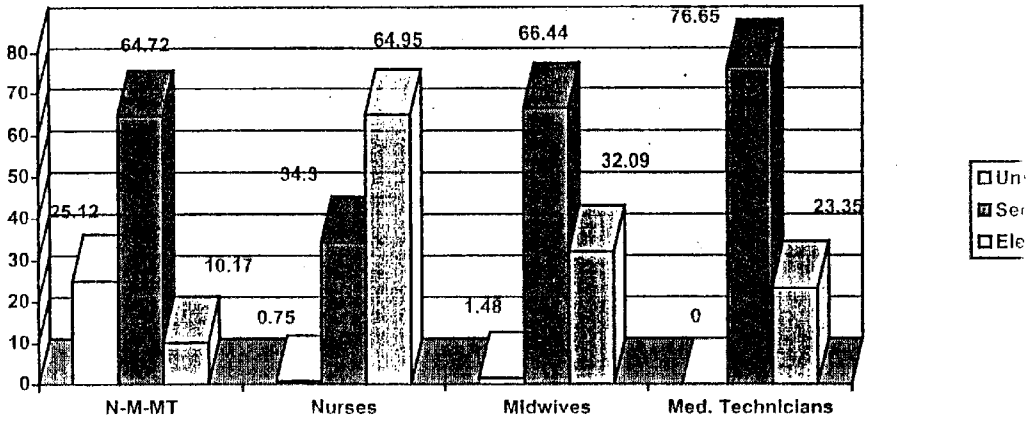
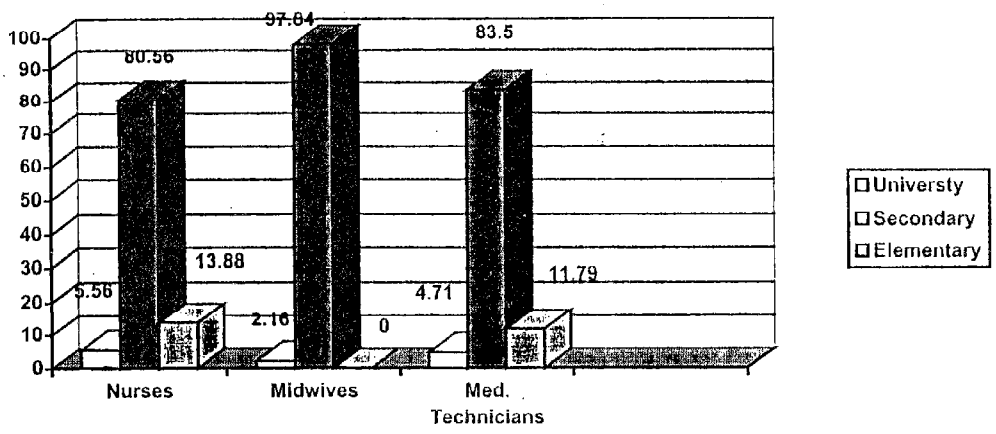


***Table 6*: 9 Institutes/Hospitals belongs to the central level**

Doctors / Nurses-Midwives-Medical Technicians	General	ENT	Vaccin Inst.	IPMN	Tue Tinh Medical School	Ha Noi Dental Hosp.	Thai Nguyen General Hospital	Uong Bi General Hospital	Da Nang C. Hospital	Cho Ray Hospital
	1/2.0	1/0.77	1/1.60	1/2.64	1/0.33	1/1.32	1/1.56	1/2.32	1/1.71	1/2.46

***Table 7*: General proportion of 9 Institutes/Hospitals with 3 designations**

Designation	Total	Professional qualification			Age			Period of service (year)		
		University (%)	Secondary (%)	Elementary (%)	< 30 (%)	30-50 (%)	>50 (%)	<10 (%)	10-20 (%)	>20 (%)
Nurses	1068	5.56	80.56	13.88	22.22	61.11	16.67	25.00	36.11	38.98
Midwives	139	2.16	97.84	0	5.76	87.05	7.19	20.14	43.88	35.97
Medical technicians	297	4.71	83.50	11.79	21.89	72.73	5.39	22.90	62.29	14.48



1. The institute of protection for mother and newborn: The proportion of doctors to nurses, midwives, technicians is 1/2.64

Table 8:

Designation	Total	Professional qualification			Age			Period of service (year)		
		University (%)	Secondary (%)	Elementary (%)	< 30 (%)	30-50 (%)	>50 (%)	<10 (%)	10-20 (%)	>20 (%)
Nurses	47	0	57.45	42.55	31.91	29.79	38.30	31.91	6.38	61.70
Midwives	111	2.70	97.30	0	3.60	87.39	9.01	20.72	40.45	38.74
Medical technicians	37	8.11	89.19	2.70	5.41	67.57	27.03	2.70	56.76	40.54

2. Cho Ray Hospital: The proportion of doctors to nurses, midwives, technicians is 1/2.64

***Table 9*: The patient care staff in Cho Ray Hospital**

Designation	Total	Professional qualification			Age			Period of service (year)		
		University (%)	Secondary (%)	Elementary (%)	< 30 (%)	30-50 (%)	>50 (%)	<10 (%)	10-20 (%)	>20 (%)
Nurses	555	3.06	85.23	11.71	40.36	54.41	5.23	40.36	54.41	5.23
Midwives	0									
Medical technicians	152	5.92	82.89	11.19	31.58	65.79	2.63	31.58	65.79	2.63

3. Thai Nguyen General hospital: The proportion of doctors to nurses, midwives, medical technicians is 1/1.56

***Table 10*: The patient care staff in Thai Nguyen General Hospital**

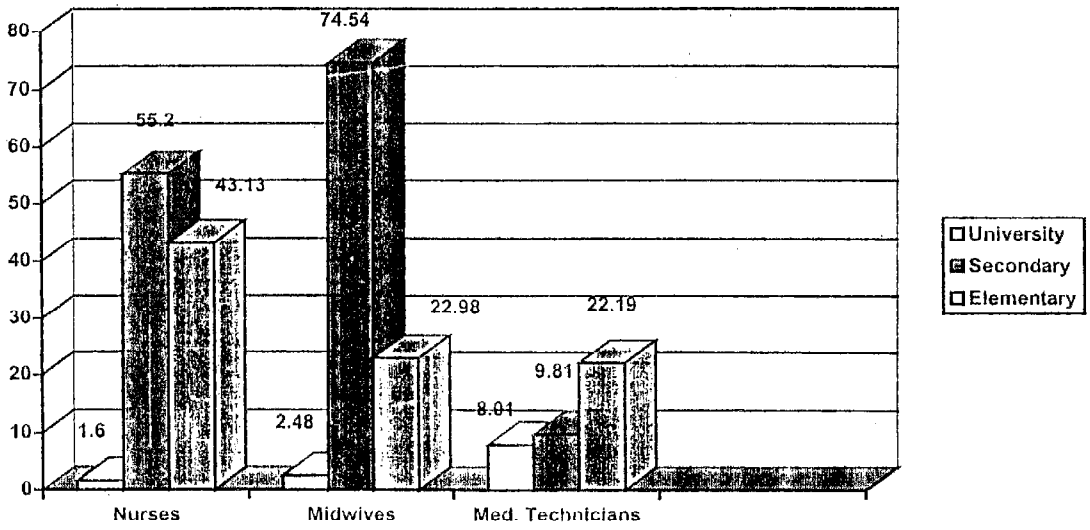
Designation	Total	Professional qualification			Age			Period of service (year)		
		University (%)	Secondary (%)	Elementary (%)	< 30 (%)	30-50 (%)	>50 (%)	<10 (%)	10-20 (%)	>20 (%)
Nurses	164	0	84.76	15.24	20.73	67.07	12.20	30.49	44.51	25.00
Midwives	14	0	100.0	0	14.29	85.71	0	21.43	42.86	35.71
Medical technicians	26	0	100.0	0	26.92	73.08	0	38.46	53.85	7.69

Some localities surveyed:

The proportion of doctors to nurses, midwives and technicians is 1/1.75

***Table 11*: Combine of 5 districts, towns**

Designation	Total	Professional qualification			Age			Period of service (year)		
		University (%)	Secondary (%)	Elementary (%)	< 30 (%)	30-50 (%)	>50 (%)	<10 (%)	10-20 (%)	>20 (%)
Nurses	5850	1.60	55.20	43.13	19.30	76.48	5.93	30.67	47.16	21.20
Midwives	2176	2.48	74.54	22.98	31.02	63.83	5.15	47.01	35.66	17.97
Medical technicians	1199	8.01	69.81	22.19	21.10	67.81	5.09	29.69	50.29	18.43



1. Ho Chi Minh City

Doctors / Nurses, midwives, technicians	3 levels	Central level	District level	Commune level
	1/1.48	1/1.77	1/0.84	1/1.57

Table 13: Nurses

Age, specialist and Period of service / Level	Total	Professional qualification			Age			Period of service (year)		
		University	Secondary	Elementary	< 30	30-50	>50	<10	10-20	>20
General	5850	1.68	55.20	43.13	19.30	76.48	5.93	30.67	47.16	21.20
Provincials (towns)	2921	1.30	66.72	31.98	25.74	73.02	5.75	40.30	41.90	17.70
Districts	560	4.82	33.21	61.96	6.43	85.89	8.21	11.79	51.61	36.61
Commune	287	2.09	32.06	65.85	2.44	79.79	6.27	8.71	66.55	24.74

Table 14: Midwives

Age, specialist and Period of service / Level	Total	Professional qualification			Age			Period of service (year)		
		University	Secondary	Elementary	< 30	30-50	>50	<10	10-20	>20
General	1016	4.13	78.94	16.93	23.73	71.36	4.92	44.69	36.22	19.09
Provincials (towns)	588	2.55	87.24	10.20	22.62	71.26	6.12	58.67	20.27	21.09
Districts	245	9.80	67.35	22.86	29.39	67.76	2.83	27.76	54.29	17.96
Commune	183	1.64	67.76	30.60	19.67	76.50	3.83	22.40	63.39	14.21

Table 15: Medical technicians

Age, specialist and Period of service / Level	Total	Professional qualification			Age			Period of service (year)		
		University	Secondary	Elementary	< 30	30-50	>50	<10	10-20	>20
General	771	7.13	66.02	26.85	21.79	71.06	7.13	29.05	46.17	24.77
Provincials (towns)	646	6.97	67.65	25.39	23.22	70.59	6.19	27.55	47.83	24.61
Districts	123	6.50	58.54	34.96	14.63	73.17	12.20	37.40	38.21	34.39
Commune	2	100.0	0	0	0	100.0	0	0	0	100.0

2. Khanh Hoa

Table 16:

Doctors / Nurses, midwives, technicians	3 levels	Central level	District level	Commune level
	1/1.48	1/1.77	1/0.84	1/1.57

Table 17: Nurses

Age, specialist and Period of service / Level	Total	Professional qualification			Age			Period of service (year)		
		University	Secondary	Elementary	< 30	30-50	>50	<10	10-20	>20
General	607	2.31	68.04	29.65	16.80	78.75	4.45	26.19	44.98	19.60
Provincials (towns)	258	2.71	66.28	31.01	16.67	77.52	5.81	22.09	46.51	31.01
Districts	229	1.31	79.04	19.65	6.11	89.96	3.93	11.35	51.09	14.85
Commune	102	3.33	50.83	45.83	37.50	60.00	2.50	63.33	30.00	4.17

Table 18: Midwives

Age, specialist and Period of service / Level	Total	Professional qualification			Age			Period of service (year)		
		University	Secondary	Elementary	< 30	30-50	>50	<10	10-20	>20
General	200	1.00	68.50	30.50	26.00	70.00	4.00	43.00	45.00	19.00
Provincials (towns)	27	7.41	55.56	37.04	0	85.19	14.81	18.52	40.74	48.15
Districts	63	0	79.37	20.63	20.63	77.78	1.59	23.81	63.49	28.57
Commune	110	0	65.45	34.55	35.45	61.82	2.73	60.00	35.45	6.36

Table 19: **Medical technicians**

Age, specialist and Period of service / Level	Total	Professional qualification			Age			Period of service (year)		
		University	Secondary	Elementary	< 30	30-50	>50	<10	10-20	>20
General	125	12.00	68.80	19.20	16.68	81.60	1.60	27.20	60.00	4.80
Provincials (towns)	60	16.67	66.67	16.67	18.33	78.33	3.33	25.00	66.67	8.33
Districts	60	8.33	75.00	16.67	11.67	88.33	0	25.00	56.67	1.67
Commune	5	0	20.00	80.00	60.00	40.00	0	80.00	20.00	0

According to the survey of 217 communes of the Nursing Office, Dept. of Therapy in 1999, the age of nurses, midwives, medical technicians and assistant physicians are as follows:

1. Nurses

Age / Gender	Total	< 30 years old	30 - 50 years old	> 50 years old
Male	71	23.95	70.42	5.63
Female	130	27.69	70.77	1.54

2. Midwives

Age / Gender	Total	< 30 years old	30 - 50 years old	> 50 years old
Male	3	0	100	0
Female	180	39.40	58.33	2.22

3. Medical technicians

Age / Gender	Total	< 30 years old	30 - 50 years old	> 50 years old
Male	6	66.67	33.33	0
Female	11	27.27	72.73	0

4. Assistant physicians

Age / Gender	Total	< 30 years old	30 - 50 years old	> 50 years old
Male	139	28.06	69.78	2.16
Female	170	37.06	61.76	1.18

REPORT ON THE SURVEY RESULTS ON NURSING WORKFORCE AND PATIENT CARE ORGANIZATION AT HEALTH FACILITIES.

The Nursing Office of the Ministry of Health
The Viet Nam Nursing Association

I. BACKGROUND

In the paragraph on Manpower requirement to meet with the objectives for the development of the people's health care and protection, stated in "strategic orientation of the people's health are and protection from the year 2000 to 2010" of the Ministry of Health, it is said that "Ensure of having enough health workers in terms of structure, quantity and quality. Focus on training for high-tech health workers to meet with the development of the medical techniques to meet with the regional standard of qualification, at the same time focus on training health workers with knowledge on community health to meet with the requirement of health care at local level. The medical ethics must be considered a criteria, which is as vital as the quality of the health workers' profession. An appropriate policy will be issued to encourage the creative contribution and total hearted serve to the patient of the health workers."

In order to evaluate the real status of the workforce of nurse, midwife and medical technician to have adequate proposal to develop the human recourses to provide service on health care as indicated above, the Nursing Office of the Ministry of Health and the Viet Nam Nursing Association had carried out a survey on the workforce of nurse, midwife and medical technician in three months of February, March and April 1999.

II. OBJECTIVES OF THE SURVEY

To describe the real status of the nursing manpower and organization, to carry out patient care in the clinical and treatment system and to propose an orientation for health manpower development.

III. OBJECTS OF THE SURVEY

Nurses, midwives and medical technicians of all categories at:

- Health facilities
- Hospitals and Institutions with beds
- Commune health stations

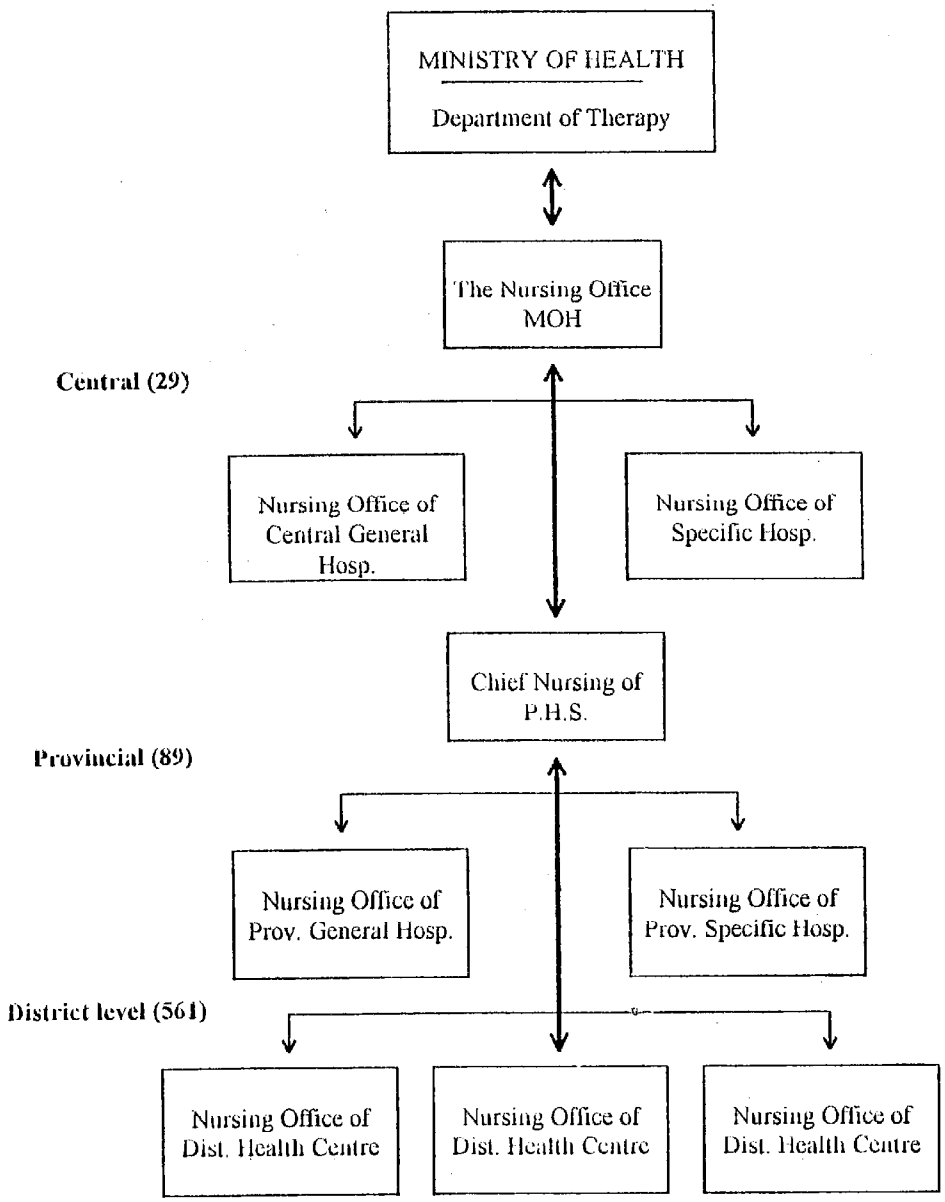
IV. SURVEY METHODOLOGY

- Data were collected and analysed from 55 of 61 survey questionnaires taken from Health Services (N = 55, i.e 90%), 361 of 826 questionnaires taken from hospitals (N = 361, i.e. 44%), and 217 questionnaires taken from direct interviews conducted in 217 commune health stations (N = 217, i.e. 100%).

According to us, the above-mentioned N indicators are high enough to represent the current status of nurses, midwives and medical technicians.

V. SURVEY RESULTS

A. Organization system: *Organization chart of the nation-wide nursing system:*



B. MANPOWER

1. Nursing management workforce:

The results of the survey show that currently, there are 6 800 chief nurses, allocated as follows:

- At MOH, there are 2 nursing bachelors, one of them is now attending the course for master degree in Thailand.

- 24 of 61 Provincial Health Services have appointed chief nurses (39%), among them, there are 13 holders of bachelor degree in nursing and 1 holder of bachelor degree in midwifery. According to the decision 1936/1999/QD-BYT dated 2 July 1999 of the Ministry of Health on the issuance of "Definition of the functions and duties of chief nurses at provincial health services", it is clear that, from now on, Provincial Health Services can appoint their chief nurses with bachelor degree to be the deputy-heads of the professional divisions in charge of nursing management (14 provinces did this).

- Currently, there are 1 111 hospital chief nurses (including deputy-heads of professional divisions), of which 115 are holders of bachelor degree (10.4%) and 442 (38%) were trained at the nursing management courses.

- Currently, there are 5 688 chief nurses - heads of departments, among them 458 (4.1%) are holders of bachelor degree, 1 612 (28%) were trained at the nursing management courses.

2. Workforce of nurses, midwives and medical technicians in hospitals:

At present, there are 826 state-own hospitals in the whole country, of which there are 29 hospitals and institutions with beds under the management of the Ministry of Health (4%), 189 hospitals under the management of provincial levels (23%), 511 district hospitals (67%) and 48 hospitals of other sectors (6%). With a total registed number of beds of 101 084.

According to the Health Statistics Yearbook 1998, there are 66 606 nurses, midwives and medical technicians, of which 51 054 are nurses (76%), 13 726 midwives (20.1%) and 9 158 medical technicians (3.9%).

Results of the surveys carried out in 361 hospitals show the total number of 31 086 nurses, midwives and medical technicians, of which 23 129 are nurses (74.4%), 3 565 are midwives (11.5%) and 4 392 are medical technicians (14.1%).

2.1. Classification of duties:

Table 1

Hospitals	Number of nurses, midwives and technicians	Nurses		Midwives		Technicians	
		Number	%	Number	%	Number	%
22 hospitals under the management of the Ministry of Health	3 877	2 983	76.9	130	3.6	764	19.7
157 provincial/city hospitals	20 180	15 202	75.3	2 380	11.8	2 598	12.9
185 district hospitals	7 029	4 944	70.4	1 055	15	1 030	14.6
TOTAL	**31 086**	**23 129**	**74.4**	**3 565**	**11.5**	**4 329**	**14.1**

2.2. Proportion of nurses, midwives and medical technicians to beds:

Table 2

Hospitals	Total			Proportion of nurses, midwives and technicians to beds at the surveyed hospitals (registered staff and contract holders)					
				Nurses		Midwives		Technicians	
	Beds	Fix-term appoint-ment	Proportion of nurses, midwives and technicians to beds	No.	%	No.	%	No.	%
Central hospitals	6 052	3 512	0.58	2 983	0.49	130	0.02	764	0.13
Provincial/ city hospitals	41 178	18 170	0.44	15 202	0.37	2 380	0.058	2 598	0.06
District hospitals	13 671	6 694	0.49	4 944	0.36	1 055	0.077	1 030	0.075
TOTAL	**60 910**	**28 376**	**0.47**	**23 129**	**0.38**	**3 565**	**0.06**	**4 392**	**0.07**

2.3. *Workforce of nurses, midwives and medical technicians being civil servants and contract holders:*

Table 3

Hospitals	Number of nurses, midwives and technicians	Registered staff		Contract holders	
		Number	%	Number	%
22 hospitals under the management of the Ministry of Health	3 877	3 512	90.6	365	9.4
157 provincial/city hospitals	20 180	18 170	90	2 010	10
185 district hospitals	7 029	6 649	95	335	4.8
TOTAL	**31 086**	**28 376**	**91.3**	**2 710**	**8.3**

Table 3 shows that there are 31 086 nurses, midwives and medical technicians working in the 361 surveyed hospitals. Among them, only 28 376 are civil servants (91.3%), 2 710 are contract holders (out of plan) (8.7%).

2.4. *Education qualification of nurses, midwives and medical technicians:*

Table 4

Hospitals	Number of nurses, midwives and technicians	Bachelor degree		Secondary degree		Elementary	
		Number	%	Number	%	Number	%
22 hospitals under the management of the Ministry of Health	3 877	90	2.3	3 340	86.1	447	11.5
157 provincial/city hospitals	20 180	518	2.6	15 801	78.3	3 861	19.1
185 district hospitals	7 029	122	1.7	5 610	79.8	1 297	18.7
TOTAL	**31 086**	**730**	**2.35**	**24 751**	**79.6**	**5 605**	**18.0**

Following the most up-to-date criteria for classification of hospitals set up by the Ministry of Health, and with the existing number of hospitals, within a period of 5 years, until the year 2005, there shall be a need to train 7 000 bachelor degree nurses, midwives and medical technicians to make up the proportion of bachelors to total nursing manpower of 10%.

2.6. Patient care allocation by shift at the Intensive Care Units

Table 5

Hospitals	Total number of nurses	24 hrs working		2 shifts working		3 shifts working	
		Number	%	Number	%	Number	%
Central and provincial/city hospitals	112	77	68.5	21	19	14	12.5
District hospitals	124	113	91.1	6	4.8	5	3.2
TOTAL	**236**	**190**	**80.5**	**27**	**11.4**	**19**	**8.0**

According to the hospital regulations (page 165), it is said that ***"The Director of hospital has the responsibility to arrange the Intensive Care Unit to work on shift or group gradually to follow up 24 hours in hospital of level I and II; to work as normal and regularly as it is stipulated for the hospitals of level III"***. However, the results of the survey show that only 21 of 112 surveyed hospitals of level I and II (19%) were arranged with the Intensive Care Units where the patient were cared by two shifts/day and 14 of 112 hospitals of level I, II (12.5%) were arranged with the ICU, where patients were cared by 3 shifts/day, as the arrangement of patient care by shift or group requires adequate manpower.

3. Workforce of nurses, midwives and medical technicians in commune health stations:

3.1. Classification of duties:

The survey carried out in 217 communes and wards showed that there are currently 1 121 health workers working in commune health stations, making up an average of 5.16 health workers per commune. Among them, 8.4% are medical doctors, 52.9% are assistant physicians; 18.0% are midwives, 15.7 % are nurses; 1.2% are medical technicians and 3.9% are assigned to other duties.

Table 6

Designation	Total number	%
Medical doctors	94	8.4
Assistant physicians	591	52.9
Midwives	202	18.0
Nurses	176	15.7
Technicians	14	1.2
Others	44	3.9
TOTAL	**1 121**	**100**

3.2. Classification of professional qualification:

Table 7

Designation	Total number	Bachelor degree		Secondary degree		Elementary	
		Number	%	Number	%	Number	%
Nurses	202	1	0.5	83	41.1	118	58.4
Midwives	175	1	0.6	112	64.0	62	35.4
Technicians	18	1	5.5	7	38.8	10	55.6
Assistant physicians	294	4	1.4	290	98.6		
TOTAL	**689**	7	**1.0**	**492**	**71.4**	**190**	**27.6**

The above mentioned data show that the qualification of nurses, midwives and medical technicians at commune level is mainly elementary and secondary degree. The holders of bachelor degree make up only 1%, and more than a half of them are higher secondary assistant physicians.

3.3 Situation of training after graduation:

Table 8

Training subjects	Total number	%
Management	35	8.9
Profession	188	48
Political	19	4.8
Foreign languages	6	1.5
Others	7	1.8
TOTAL	255/392 currently available nurses, midwives and technicians	**65**

The above data shows that the commune health stations have paid attention to continuing training and training after graduation for their health workers. Approximately 50% commune health workers were professionally trained, mainly through the National Health Programme, 8.9% were trained on management and only 1.5% were accessed to foreign language training courses. Thus, the National Health Programme has played a very important role in upgrading the knowledge of commune health workers.

VI. REMARKS AND DISCUSSIONS

1. Chief nurse manpower:

The education qualification of chief nurses is still poor, only 8.4% of chief nurses are holders of bachelor degree. 3% of chief nurses of departments are elementary. There is no post-graduate degree chief nurse.

A problem to be taken into account is that currently, there is still out-dated thinking existing in many institutions that more importance should be attached to experience rather than to education qualification. Such institutions may not attach importance to nursing management, considering chief nurses as administrative workers, assisting superiors and medical doctors only, and, therefore, even elementary nurses can be appointed to be department chief nurses. Many institutions have established their Nursing Office with hospital chief nurses, but until now, the allocation of duties and power has not been defined. In reality, looking at the patient care activities in hospitals, we found that the more qualified chief nurse the higher quality of patient care. The chief nurse can function well once the proper attention is paid by the leaders of institution to nursing and education of nursing management workforce.

In terms of management knowledge, since 1993, when the Ministry of Health issued curricula for 3-month training of department chief nurses, the schools belonging to the Ministry have trained a lot of chief nurses. According to survey data, 2 078 chief nurses (30%) were trained at the nursing management training courses, however they could not meet the current needs for the nursing management.

2. Patient care manpower in hospitals:

The above mentioned data show that there is a lack of our nursing manpower in both quantity and quality, and that the nursing structure is still not appropriate. The lack of nurses is a popular situation encountered in most of hospitals, particularly in the hospitals belonging to the Ministry and provincial hospitals.

In reality, hospitals have to spend budget taken from the health services to pay salary for the contract holders (8.7%). However, this number of contractual nurses can only cover the duties such as implementation of doctor's instructions on treatment and patient monitoring, but not total nursing care. Many hospitals had tried to mobilize the human recourses to balance the workload of various groups/shifts within a day at units with many serious patients, such as Intensive Care Units, and Post Operative Units. However, the number of those is still limited. The results of the survey (table 4) show

that at the Intensive Care Units in 361 survey hospitals, only 8% are arranged with 3 shifts, 11.4% are arranged with 2 shifts and 76.3% are arranged with total nursing care (24/24). We have known that patients can not have serious illness in the morning, get better in the afternoon and recover at night, to meet with the old style of arrangement. But with the existing manpower, it is difficult to arrange nurses by shifts/groups to serve the patient. Therefore, if we are allowed by the Government to officially recruit the nurses , midwives and medical technicians working under contracts in hospitals now, then the number of registered staff will be increased by 6 000.

The current proportion of nurses, midwives and medical technicians (including registered and contractual ones) per beds in the surveyed hospitals is 0.5 persons/bed. However, at present, nurses in hospitals carry out not only patient care activities, but also a lot of other administrative duties such as health insurance, statistics, etc.

The proportion of nurses to doctors in hospitals is inappropriate. According to the data of the Department of Manpower and Organization, reported at this Conference, the proportion of doctors to nurses is 1/1.78, while in other countries in the region, this proportion is from 1/1.35 to 1/1.2 (*The Nursing in the World - Third Edition)*. This effects dramatically the patient care manpower, as we all know the number of staff is now allocated based on the number of beds, therefore, if the number of doctors is increased, then as a consequence, the number of nurses must be decreased. Many hospitals have the intention to recruit doctors more than nurses, because whenever required, the doctors can replace the nurses but the nurses can never be able to replace the doctors. So many reasons make the hospitals continue to recruit doctors while they do not have enough nurses and even when they have more than enough doctors.

VII. PROPOSALS AND RECOMMENDATIONS

1. The Ministry of Health should attach special importance to the training of nursing instructors who are expected to acquire full knowledge, skills and proper attitudes to train nurses, midwives and medical technicians in both theory and practice. This is the key stage in the plan of patient care workforce development. It should be planned that until the year 2 010, patient care instructors must be nurses whose qualification must be a-level higher than the level of the training courses they conduct. At next stage, leaders of the nursing schools and of the nursing speciality must be nurses.

2. The health authorities at all levels should invest in the training of all level chief nurses in nursing management. There should be stratification of nursing management training to the colleges and secondary schools belonging to the Ministry of Health or the regional colleges and schools. Should it now be the time to conduct training courses for bachelor degree of nurses specialized in nursing management for the secondary degree chief nurses working in hospitals to meet the needs for hospital management. The reason is that managers' capability plays an important role in the renovation of nursing management model and in the improvement of patient care quality. Efforts should be made so that after the year 2000 there will be no more elementary chief nurses.

3. The Government should define soon the number of nursing civil servants by bed, by level hospital and by speciality to ensure enough patient care staff. For this purpose, there should be a research project at ministerial level to work out the labour norm for each hospital level and each speciality. The Nursing Office, Ministry of Health, and the Vietnamese Nursing Association would provide manpower for this job.

4. There should be no more training of elementary nurses for hospitals. The training courses of elementary nurses should only be conducted for village level. There should be plan for upgrading training for elementary nurses working in hospitals to become secondary degree nurses. Efforts should be made so that there will be no more elementary nurses working in hospitals to the year 2005. Besides, the training of specialized nurses after graduation from secondary schools or of nursing bachelors is also required. The Ministry can collaborate with the leading specialities to develop specialized training curriculum and assign those specialities to collaborate with medical secondary schools to conduct training courses.

5. In this National Nursing Conference, the Nursing Office and the Vietnamese Nursing Association would like to request the Ministry of Health to consider the proposal by the Department of Organization and Manpower that there should be in each hospital a deputy director in charge of nursing activities who is a nurse and, certainly, such an appointee should acquire all the required criteria in accordance with the regulations made by the Government.

6. The authorities of all levels of the health sector and of other sectors should pay more concern to the nursing workforce, firstly to the nursing instructors and nursing managers, since they are the ones who set up plans, develop the implementation as well as evaluate patient care activities in hospitals. Only this approach can put the patient care in hospitals and the community health care activities into an regular and modern routine to meet the needs for the people health care until the year 2000 and 2020 as stated in the Strategic Orientations for the People Health Care developed by the Ministry of Health.

NURSING AND MIDWIFERY TRAINING ISSUE IN THE COMING 21ST CENTURY

For quite a long time, the role of Nurses and Midwives has been asserted in our health system. The nursing and midwifery profession has been dedicated and creative in taking care of intensive cases under the wars, providing health care and protection for our people, contributing dramatically to the work for the national liberation and unification in the past, and the national construction and defence at present.

Training and continuing education of nurses and midwives have made an important contribution to the nursing and midwifery development in terms of both quantity and quality.

Stepping to the 21st century, the period of industrialization and modernization of the country, there shall be a need for nursing and midwifery training and education in our country to be **renovated**, the real meaning of this is that it is necessary to make a sudden breach through the current one to meet better and better the needs for health care and protection of our people. At the same time, the driving force to push up our nursing and midwifery practice to reach soon and join other countries in the region and worldwide can only be created through training and education activities.

In this Conference on the Development of Nurses, Midwives and Medical Technicians Workforce for 21st Century, we would like to mention some issues related to training and education of the above mentioned categories of health workers for our discussion.

I. ACTUAL SITUATION OF NURSING AND MIDWIFERY TRAINING

1.1. Profiles on the development of nursing and midwifery training in our country

Since the victory of our revolution in August 1945, the nursing and midwifery profession in our country has been developed and grown up. Starting to be hygiene workers, fist-aid workers in the resistant war against the French colonialist for national defence, after the peace came back in 1954 and in the 1950s, our team of nurses and midwives consisted mainly of elementary workers, then later in 1960s, we started to train the secondary degree nurses to provide health care service for the resistant war against the USA and the construction of socialism. After the unification of the nation, the nursing and midwifery received a considerable number of nurses trained in the South. At the end of the 80 decade, we started training of high level nurses and midwives, later called higher education nurses and midwives. In 1995, the first training courses for nursing bachelor degree was conducted in the Ha Noi Medical College and in the College of Medicine and Pharmacy in Ho Chi Minh City. In 1996, the Ministry of Health selected 5 secondary medical schools to carry out the pilot training specialized on secondary community nursing based on the family health care pattern. Since 1999, the Ministry of Health and the Ministry of Education and Training have widened the scale of full time higher secondary nursing training. At present, there are still many different levels of qualification among our nurses and midwives, partly because of technical classification and partly because of the training development from low to high levels.

1.2. Number of nurses and midwives:

According to the Health Statistics Yearbook 1997, the number of nurses and midwives in our country is as follows:

*	**Total of Nurses:**		**43 696**
	Of which:	Elementary:	20 786

		Secondary degree:	22 672
		Higher-education:	256
*	**Total of Midwives:**		**13 178**
	Of which:	Elementary:	4 479
		Secondary:	8 563
		Higher-education:	136

* Proportion of Nurses/10 000 population is 8
* Proportion of Nurses/Medical Doctors is 1.5

1.3 Network of nurses and midwives training network:

This network has been developed at nation-wide level, including central and local levels as follows:

1.3.1. Schools under the management of the Ministry of Health

1. Central Secondary Medical and Technical School No. 1 in Hai Duong
2. Central Secondary Medical and Technical School No. 2 in Da Nang
3. Nam Dinh Higher Secondary Medical School
4. Ha Noi Medical College
5. College of Medicine and Pharmacy in Ho Chi Minh City
6. Secondary Medical School in Bach Mai Hospital

1.3.2. Schools under the management of the Ministry of Education and Training:

1. Hue Medical College

1.3.3. Schools under the management of the Ministry of Defence:

1. Military Medical College
2. Military Secondary Medical School in Ho Chi Minh City

1.3.4. Schools under the management of local authorities: including

1. 42 provincial/city medical secondary schools;
2. Centre for training and upgrading for health workers in Ho Chi Minh City
3. Medical Faculty of Hong Duc University in Thanh Hoa;

1.4. Training capability:

According to the 1998 annual reports made by schools, the following indicators have been shown:

Enrolment:

University Nurses:	100
Higher-Secondary School Nurses:	350
Secondary Nurses:	3 450
Secondary Midwives:	1 646
Elementary Nurses:	695
Health Workers:	2 695

Graduation:

University Nurses:	400
Secondary Nurses:	5 715
Secondary Midwives:	2 710
Primary Nurses:	2 498
Health Workers:	5 955

Current number of students at schools:

University Nurses:	240
Higher-Secondary School nurses:	370
Secondary Nurses:	10 080
Secondary Midwives:	5 698
Elementary Nurses:	760
Health Workers:	1 813

1.5. Categories of education and training duration:

Up to the school year of 1998-1999, in implementation of 90/CP Decree of our Government, the categories of education had been divided as follows:

– Professional training:	3-6 months for health workers
– Elementary:	1 year for elementary nurses
– Secondary:	2 years and a half for Secondary degree nurses
	2 years and a half for Community nurses
– Higher Secondary:	4 years for in-service training of higher nurses
	4 years for in-service training of higher midwives
– University:	4 years for University Nurses

Since 1 June 1999, when the Education Law came into effect, there would be some changes in duration of long-term and short-term training as well as professional secondary training.

1.6. Conditions to facilitate training process:

- Since 1996-1997, training curricula for various education levels have been recompiled and standardized in conformity with the general regulations issued by the Ministry of Education and Training and the Ministry of health.
- The textbooks and teaching materials for secondary and higher secondary degree nurses have been developed and issued.
- Approximately 100% of teachers taking part in training on nursing and midwifery have been trained in terms of knowledge and basic skills on Educational Study, Medical Education. The teaching and learner assessing methodology has been improved and implemented in most of schools.
- In terms of material basis, the purchase of supplies and equipment has been invested in. Schools have acquired basic equipment to conduct training courses for nurses and midwives.
- Most of schools have their facilities for professional practice in provincial and central hospitals, and the areas for practice in districts, communes, etc.

1.7. Some remarks

- Training facilities for nurses and midwives are sufficient and well distributed all over the country. Almost all provinces and cities have possibility of training or linking up with secondary medical schools to train preliminary and secondary degree nurses and midwives. However, in general, such schools are still poor, especially some local ones, there have been no comprehensively strong schools. There is a lack of schools with the same standard as of nursing and midwifery training schools in other countries of the region.
- Training quality has been increasingly improved in recent years and, in general, suitable to meet current needs, however, there have been shown some shortcomings and deficiencies in training on practical skills.
- There are many different categories of nursing and midwifery training (preliminary, secondary, higher secondary and university degrees), of which the preliminary and secondary training constitutes the main part, the number of higher nurses and midwives training schools (higher secondary schools, universities) is too small.
- There is a big number of teachers including part-time ones, but most of them are doctors taking part in teaching of nurses and midwives, there is still a lack of teachers who are nurses or midwives of high qualification.
- The problem of "output" (difficulties in job seeking) had direct impact on the quality of "input" and of training. This is also a cause of imbalance in the proportion of nurses to doctors at health facilities.

2. DEVELOPMENT ORIENTATIONS FOR NURSING AND MIDWIFERY TRAINING AND EDUCATION

2.1. General orientations

There should be further improvement in annual enrolments to ensure sufficient staffing and strengthening of trained nursing and midwifery workforce, and to

improve the proportion of nurses and midwives to other categories of health workers.

- To define working positions of nurses and midwives at each level of health system, based on which training curricula for each level will be developed so that appropriate workforce can be trained to meet the requirements for people health care and protection.

- To focus on and to strengthen higher nursing and midwifery training (in higher secondary schools and universities) to gradually increase the proportion of nurses of higher qualification in the whole nursing workforce.

- To re-plan the network of nursing and midwifery training schools, to gradually standardize schools for setting up national, regional and local schools. In one or two decades, there shall be an upgrading of nursing and midwifery training schools to higher secondary schools.

- To enhance the quality of nursing and midwifery training by investment in upgrading training schools in terms of infrastructure conditions, supplies and equipment, textbooks, teaching and learning materials; by standardization of teacher workforce; and by renovation of teaching and learning methodology.

- In line with the quality improvement in training of new nurses and midwives, there shall be a need to focus on and to speed up continuing education, fostering and retraining of the currently working nurses and midwives. It has been defined that retraining and fostering to improve the qualification of this number of nurses and midwives are only a short-term solution for the time being, but make an essential and decisive contribution to the quality of nursing and midwifery practice.

- To closer combine training with staffing requirements for the improvement in training in terms of both quantity and quality.

2.2. Some immediate specific tasks

Currently, there are numbers of specific tasks to improve the quality of our nursing and midwifery training. Within the scope of the management at ministerial level, we would like to touch on some main tasks as follows:

2.2.1. Establishment of Nam Dinh Nursing University

There should be further requests to the Ministry of Education and Training and to the Government for approval of the proposal to establish Nam Dinh Nursing University, to step by step establish a Nursing University with the regional standard in Viet Nam. The Nam Dinh Nursing University will be:

- A place for training of highly qualified nursing bachelors
- A national research and training centre for nurses and midwives
- A training institution for teachers of nursing and midwifery in nation-wide scale

In order to fulfil the above mentioned tasks, besides dramatic efforts made by the Nam Dinh Nursing University, there shall be required intensive investment from the Government, the Ministry of Health and the local authorities.

2.2.2. Training of teachers

To ensure a well staffed workforce of nursing and midwifery teachers at present, the Health Sector together with the Sector of Education and Training should make daring and synchronous decisions to further improve and formulate a team of specialized teachers. The immediate tasks are:

- To give priority to investment in training of teachers to standardize the whole team of teachers of nursing and midwifery in schools, as stipulated by the Education Law. To combine local and overseas training for teachers.

- To pay attention to training and fostering of leading nurses and midwives for each speciality, for professionally keen areas and for management from central to local levels.

- To set up a teachers training unit which shall become a Nursing Teachers Training Faculty in the Nam Dinh Nursing University to train and foster teachers for the whole country.

2.2.3. Renovation of training curricula and teaching materials

- According to the new regulations stated in the Education Law, almost all the current nursing and midwifery training curricula need to be revised to meet the general requirements in terms of training duration and training curriculum outlines. In this revision, there shall be shown innovations in views, in nursing and midwifery training curricula and in training methodology as well as general achievements gained by the World.

- To work out soon a plan for development of teaching, learning and reference materials on nursing and midwifery for each level of training to meet with the newly revised curriculum. To translate foreign teaching materials which are suitable to our requirements on training of nurses and midwives to meet the needs of training schools.

- To set up and formulate working groups consisting of professional and semi-professional compilers to ensure the quality and unity of the textbooks and materials for nursing and midwifery training.

2.2.4. Renovation of training methodology

Currently, renovation of training methodology is an urgent and, at the same time, essential task to improve the quality of our nursing and midwifery training. In order to renovate the training methodology, there shall be required some certain conditions, of which the role of teachers, managers of schools and training managers at various levels is extremely important. Firstly, it is necessary to push up the application

of active teaching methods including effective utilization of objective assessment test kits. In renovation of teaching methodology, focus should be paid on improvement of practical capabilities and possibility of professional skills perfection of learners and students through practical courses in laboratories and clinical practice in hospitals as well as through community practice.

2.2.5. Upgrading of training facilities

On the basis of rearrangement of training school network, an important and decisive measure for the quality of training is to strengthen and upgrade nursing and midwifery training facilities. There should be a comprehensive concern paid to the investment in training facilities, particularly, the following fields should be focused on:

- Appropriate measures of staff mobilization should be taken to ensure sufficient staffing of schools with synchronous team of teachers to suit the training capability of such schools. On the basis of quite stable number of teachers, further education shall be required so that schools can acquire well qualified teachers who are capable to conduct training activities in the new period of development.
- The infrastructure conditions of schools should be invested in to make sure that such schools are proper with the training environment gradually compatible with the process of industrialization and modernization of the country.
- The purchase of supplies, equipment and teaching tools should, at least, be in conformity with the List of supplies and equipment items required for a secondary medical school as stipulated by the Ministry of Health. The next step is to set up a national standard for almost all the nursing and midwifery training schools to follow.

After the year 2005, there shall be a need to recheck and reassess real capabilities of schools. The schools which cannot meet minimum standards must suspend their training activities or be closed.

2.2.6. Regulations and policies to promote nursing and midwifery training

- There should be regulations and policies for teachers to promote their responsibilities and make them happy in training of nurses and midwives. Attention should be paid to the policy of recruitment and training of teachers for schools.
- There should be required some privileges granted for students, learners during training process (the same with those for staff of the Pedagogy Sector). The privileges granted for nurses and midwives will attract young people to nursing and midwifery training courses.
- Regulations on structure and categories of health workers for health facilities, especially for clinical and curative facilities shall be required to gradually increase the number of nurses and midwives in such facilities. The next step is to reach an appropriate number of nurses per 10 000 population and a balanced proportion of nurses and midwives to doctors as well as to health workers of other categories.

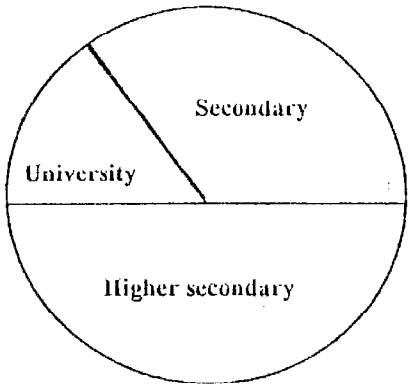
II. SOME PROPOSALS ON NURSING AND MIDWIFERY TRAINING

With the views that the *Conference on the Development of Nurses, Midwives and Medical Technicians Workforce for 21st Century* is an important conference with the task to provide consultation and to propose solutions for the Ministry of Health on the field of training and utilization of above mentioned health staff, we would like to propose the following issues for your comments.

1. Main training levels:

At present, secondary degree nurses and midwives constitute a high proportion. On the basis of the socio-economic development orientations of the country and the needs for people health care and protection, training of elementary and secondary nurses and midwives needs to be continued, and at the same time, training of higher secondary nurses should be widened and developed. It is expected that at the beginning of the 21st century, higher secondary nurses will make up a major part in

nursing workforce. University and post-university degree nurses and midwives are expected to be available widely at central and provincial levels.



2. Training of professional nursing

According to the regulations on professional training and speciality training groups, nursing and midwifery training is available in profession group. In other words, at present there is only general (polyclinic) nursing and midwifery training. In the future, speciality training in nursing should be made available to meet the increasing demand of the employers of health staff.

3. Nursing and midwifery training

At present, secondary nursing and midwifery training is divided into 2 different training groups: secondary nursing belongs to group coded 17.02; secondary midwifery belongs to group coded 17.03. The duration of training for 2 groups above is 2 years and a half (as per Government's Circular 90/CP), applied to graduates of secondary schools. When the Education Law comes into effective, the duration is reduced to 2 years, however, it is necessary to divide secondary level into 2 professional training groups to ensure the training quality, except for the higher secondary and university level with the duration of 3 and 4 years, respectively.

4. Training of nurses and medical technicians

Among the professional training group, there are some specialities whose titles are not clearly determined: nurses for anaesthetization-intensive care and technicians for anaesthetization-intensive care; dental and tooth restoration technicians; rehabilitation technicians and physiotherapy technicians, etc. It is necessary to identify needs of training, job description and responsibilities of each object, in order to place a background for developing appropriate objectives, contents and training programmes.

5. To identify training level based on Education Law

Based on the national education system stipulated in the Education Law, the training levels and training objects can be classified as follows:

- Career education:

- Professional training:
  - Short-term (under 1 year): training of health staff
  - Long-term (1 - 3 years): training of commune nurses
- Vocational secondary training (1 - 2 years):
  - Secondary nurses
  - Secondary midwives
- University and post-university training:
  - Higher secondary degree (3 years): higher secondary nursing
  - University degree (4 years): university nursing
  - Post-university degree:
    - Master of nursing
    - Doctor of nursing

5.1. Professional training:

+ Short-term professional training under 1 year: for health staff working at health facilities (assistant nurses), manufacturing factories (pharmaceutical workers) and community (commune health workers).
+ Long-term professional training from 1 to 3 years: for training of commune nurses and prescription clerks.

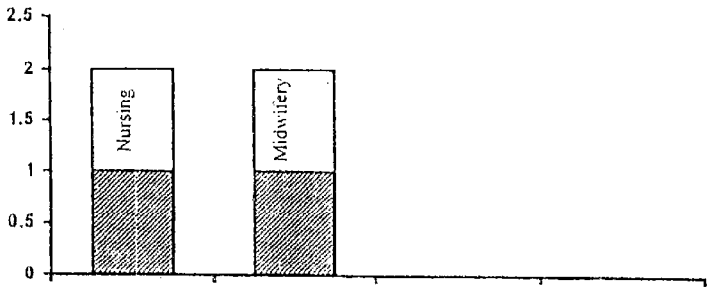
Types of professional training are to be carried out in provincial or city secondary medical schools, medical-pharmaceutical schools and in the commune health centres as well.

Graduates of short-term training will be given Certificates; graduates of long-term training will receive diplomas.

The commune health staff and nurses will work in villages and mostly in mountainous communes.

5.2. Vocational secondary level:

The secondary nurses and midwives are trained at vocational secondary level. The duration of training is 2 years so there are 2 secondary nursing and midwifery branches as follows:



Picture 1

5.3. Higher secondary training:

At the higher secondary training will not divided into 2 branches of nursing and midwifery (see the following chart)

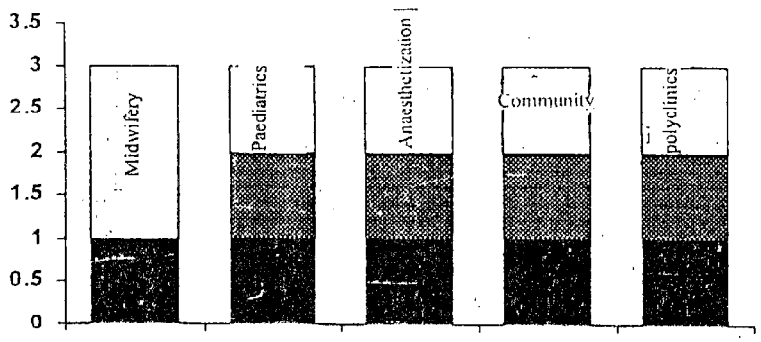


Chart 1

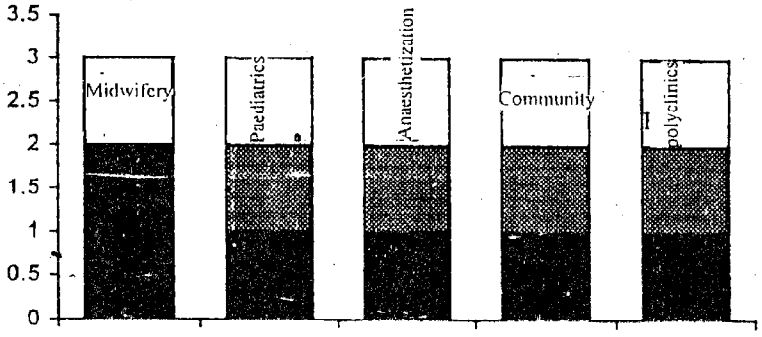


Chart 2

6. Network of nursing and midwifery school:

On the progress to standardization of school of nursing and midwifery in our situation, in the years ahead, there are existing 3 types of nursing and midwifery schools:

* *National institutions:* (directly dependent on MoH, MoTE):

These are nursing and midwifery schools at university, higher secondary and secondary level.

These schools should meet national standards of: - Teachers
- Practising facilities
- Training programmes

and curricula

Training scale: nationwide

* *Regional institutions:*

Including the ones: - under MoH's management
- Under management of in-focus provinces
- With foreign investment

Training scale: the provinces within the region.

* *Local schools:*

- Under control of the health service
- belonging to a hospital

Training scale: in provinces, towns or hospitals.

7. *Distribution of nurses and midwives according to levels:*

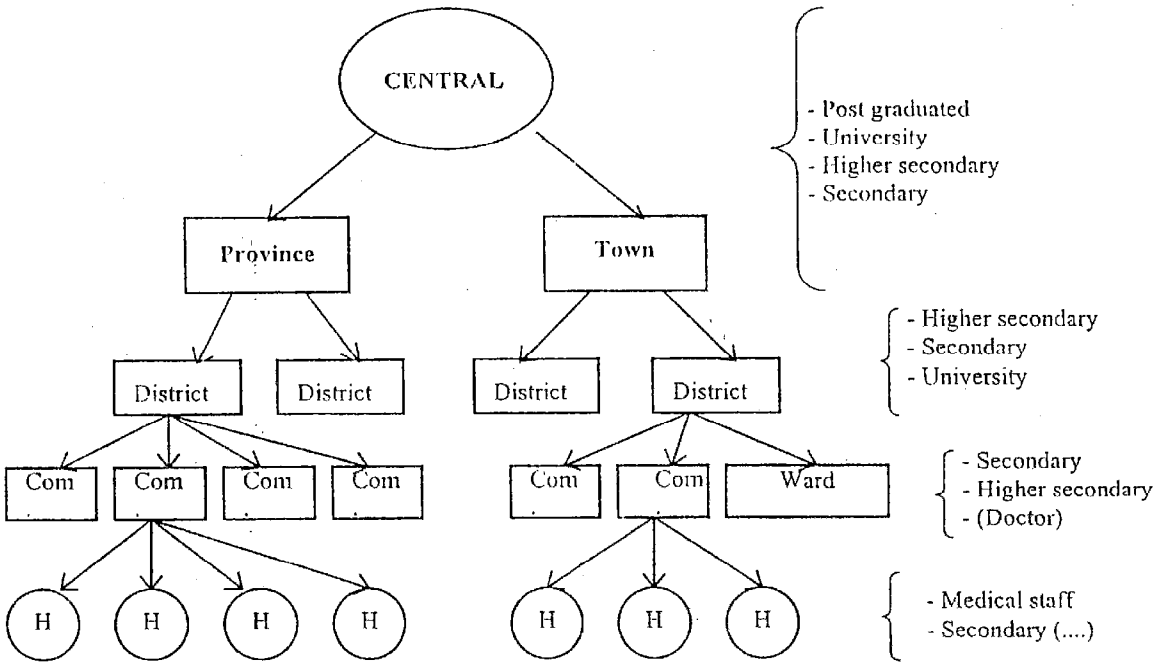

CENTRAL
Province
Town
District
District
District
District
Com
Com
Com
Com
Com
Com
Ward
H
H
H
H
H
H
H
- Post graduated
- University
- Higher secondary
- Secondary
- Higher secondary
- Secondary
- University
- Secondary
- Higher secondary
- (Doctor)
- Medical staff
- Secondary (....)

Table 2

PROPOSED PLAN OF SECONDARY NURSING TRAINING IN THE YEAR 2000

No.	NAME OF SCHOOL	No. of students in early 2000		No. of graduates in 2000		Newly enrolled students in 2000		Average of students in 2000	
		total	budgeted	total	budgeted	total	budgeted	total	budgeted
		a	a'	b	b'	c	c'	d	d'
1	SM School of Phu Yen	113	102	0	0	50	50	126	115
2	SM School of Dong Nai	124	124	37	37	50	50	124	124
3	SM School of Ninh Binh	415	0	162	0	100	0	386	0
4	SM School of Thai Binh	0	0	0	0	30	30	8	8
5	SM School of Quang Nam	133	152	57	50	40	30	124	143
6	SM School of Thai Nguyen	507	117	131	24	230	50	521	122
7	SM School of Ben Tre	97	97	35	35	30	30	93	93
8	SM School of An Giang	105	105	25	25	45	45	108	108
9	SM School of Lai Chau	0	0	0	0	50	50	13	13
10	SM School of Ha Noi	725	408	280	172	200	120	682	381
11	SM School of Tuyen Quang	40	40	0	0	93	93	63	63
12	SM School of Nghe An	308	250	154	102	100	100	282	241
13	SM School of Kien Giang	139	139	38	30	50	50	139	142
14	SM School of Binh Phuoc	40	40	0	0	40	40	50	50
15	SM School of Binh Duong	133	54	22	10	30	20	133	56
16	SM School of Ha Tay	113	0	0	0	50	0	126	0
17	SM School of Dong Thap	96	96	30	30	30	30	94	94
18	SM School of Lam Dong	124	70	37	24	40	30	122	70
19	Centre for THW in Soc Trang	0	0	0	0	50	0	13	0
20	Centre for THW in Tra Vinh	0	0	0	0	30	0	8	0
21	SM School of Vinh Long	173	120	45	38	50	50	171	120
22	SM School of Binh Thuan	82	69	17	12	30	30	84	73
23	SM School of Bac Giang	232	125	68	43	50	50	222	123
24	SM School of Thua Thien-Hue	212	53	58	0	50	50	205	66

* SM School = Secondary Medical School
* Centre for THW = Centre for Training of Health Workers

Table 2

PROPOSED PLAN OF SECONDARY NURSING TRAINING IN THE YEAR 2000

No.	NAME OF SCHOOL	No. of students in early 2000		No. of graduates in 2000		Newly enrolled students in 2000		Average of students in 2000	
		total	budgeted	total	budgeted	total	budgeted	total	budgeted
		a	a'	b	b'	c	c'	d	d'
25	Centre for THW in HCMC	660	596	180	158	200	200	650	593
26	Centre for THW in Lao Cai	21	0	21	0	0	0	14	0
27	Centre for THW in Quang Tri	40	40	0	0	40	40	50	50
28	SM School of Son La	30	30	30	30	60	60	35	35
29	Centre for THW in Vinh Phuc	50	50	0	0	40	40	60	60
30	SM School of Tien Giang	122	97	45	39	30	30	115	92
31	SM School of Quang Ninh	261	150	0	0	45	45	272	161
32	SM School of Yen Bai	91	91	37	27	30	30	86	90
33	SM School of Lang Son	37	32	0	0	11	11	40	35
34	SM School of Hai Phong	354	180	134	50	100	50	334	176
35	SM School of Dac Lac	183	68	40	15	60	30	185	71
36	MTS School 1 in Hai Duong	40	28	0	0	40	28	50	35
37	Centre for THW in Bac Can	28	0	13	0	15	0	27	0
38	SM School of Bac Ninh	148	148	51	51	50	50	144	144
39	HSM School of Nam Dinh	807	552	256	175	50	50	734	506
40	SM School of Cao Bang	43	33	43	33	0	0	29	22
41	SM School of Quang Ngai	244	113	57	31	0	0	225	103
42	SM School of Bach Mai	215	170	101	60	80	80	201	170
43	SM School of Quang Binh	50	50	0	0	0	0	50	50
44	SM School of Long An	71	71	10	10	50	50	80	80
45	SM School of Ca Mau	85	85	19	19	50	50	91	91
46	SM School of Khanh Hoa	81	81	0	0	50	50	94	94
	TOTAL	7,572	4,826	2,233	1,330	2,519	1,892	7,457	4,856

* SM School = Secondary Medical School
* Centre for THW = Centre for Training of Health Workers
* HSM School = Higher Secondary Medical School
* MTS School = Medical technique secondary school

Table 3

PROPOSED PLAN OF SECONDARY MIDWIFERY TRAINING IN THE YEAR 2000

No.	NAME OF SCHOOL	No. of students in early 2000		No. of graduates in 2000		Newly enrolled students in 2000		Average of students in 2000	
		total	budgeted	total	budgeted	total	budgeted	total	budgeted
		a	a'	b	b'	c	c'	d	d'
1	SM School of Phu Yen	81	40	81	40	50	50	67	39
2	SM School of Ninh Binh	42	0	0	0	40	0	52	0
3	SM School of Thai Binh	0	0	0	0	30	30	8	8
4	SM School of Quang Nam	73	60	33	30	40	30	72	58
5	SM School of Thai Nguyen	72	29	19	13	25	5	72	26
6	SM School of Ben Tre	56	56	0	0*	30	30	64	64
7	SM School of An Giang	45	45	0	0	0	0	45	45
8	SM School of Lai Chau	0	0	0	0	50	50	13	13
9	SM School of Tuyen Quang	0	0	0	0	50	50	13	13
10	SM School of Nghe An	321	263	124	73	100	100	305	264
11	SM School of Kien Giang	120	120	25	25	50	50	124	124
12	SM School of Binh Phuoc	0	0	0	0	30	30	8	8
13	SM School of Binh Duong	70	35	21	7	30	20	71	38
14	SM School of Hoa Binh	40	40	0	0	40	40	50	50
15	SM School of Dong Thap	66	0	21	0	30	0	67	0
16	SM School of Lam Dong	103	73	41	33	40	30	99	70
17	Centre for THW in Soc Trang	0	0	0	0	50	0	13	0
18	Centre for THW in Tra Vinh	30	0	0	0	0	0	30	0
19	SM School of Vinh Long	124	100	29	16	50	50	127	107
20	SM School of Binh Thuan	25	25	0	0	25	25	31	31
21	SM School of Bac Giang	138	71	63	38	50	50	130	71
22	SM School of Thua Thien-Hue	198	59	99	2	50	50	178	71
23	School of PH of Hung Yen	0	0	0	0	40	140	10	35
24	Centre for THW in HCMC	54	54	54	54	50	50	49	49

* SM School = Secondary Medical School
* Centre for THW = Centre for Training of Health Workers
* School of PH = School of Public Health

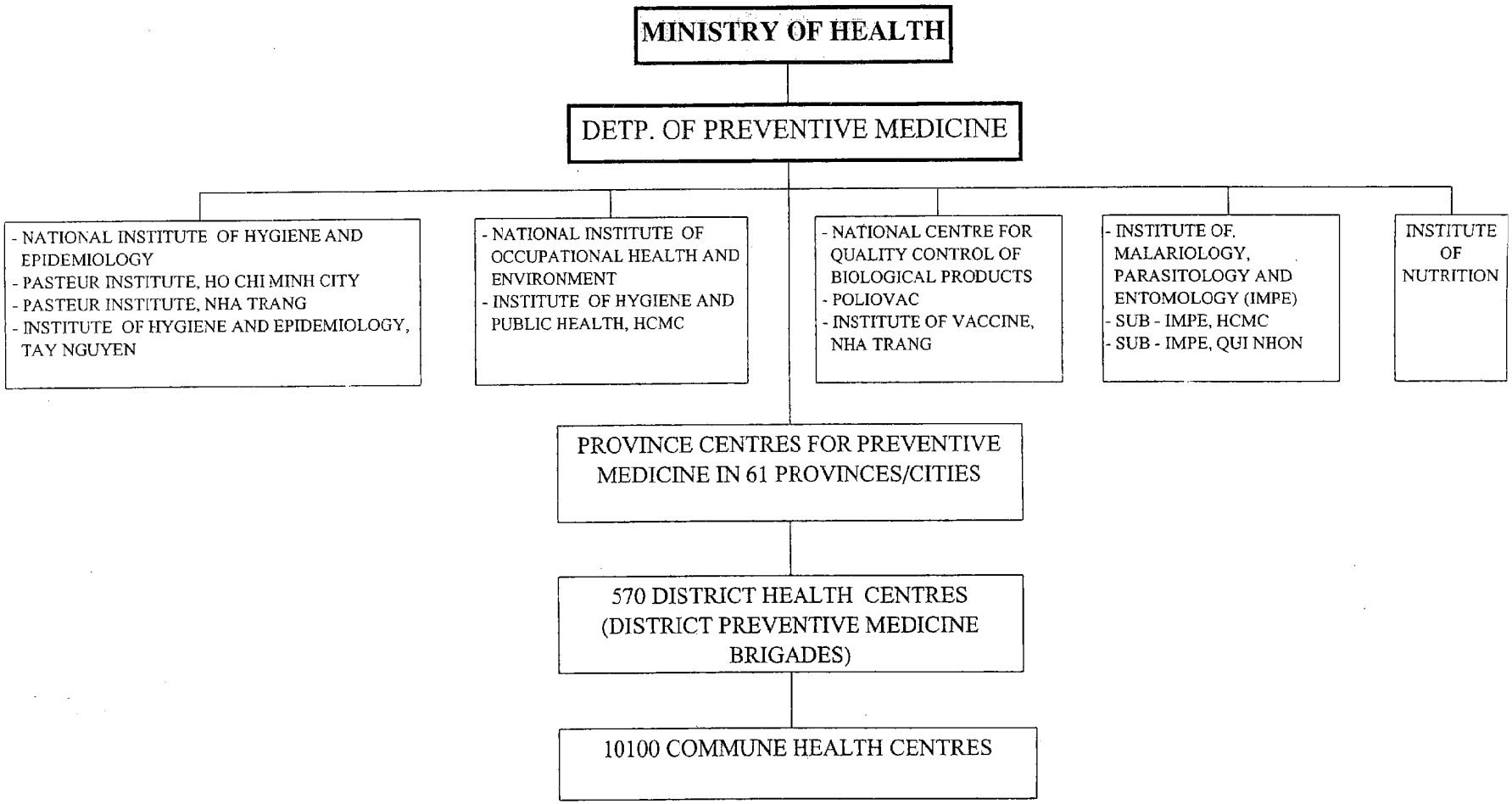
Table 3

PROPOSED PLAN OF SECONDARY MIDWIFERY TRAINING IN THE YEAR 2000

No.	NAME OF SCHOOL	No. of students in early 2000		No. of graduates in 2000		Newly enrolled students in 2000		Average of students in 2000	
		total	budgeted	total	budgeted	total	budgeted	total	budgeted
		a	a'	b	b'	c	c'	d	d'
25	Centre for THW in Lao Cai	54	0	23	0	0	0	46	0
26	Centre for THW in Quang Tri	40	40	0	0	40	40	50	50
27	SM School of Son La	30	30	30	30	30	30	28	28
28	Centre for THW in Vinh Phuc	0	0	0	0	20	20	5	5
29	SM School of Tien Giang	58	43	18	13	40	40	62	49
30	SM School of Quang Ninh	45	40	0	0	45	45	56	51
31	SM School of Yen Bai	212	144	69	42	0	0	189	130
32	SM School of Lang Son	93	80	38	30	30	30	88	78
33	SM School of Hai Phong	108	25	0	0	50	25	121	31
34	SM School of Dac Lac	63	15	33	0	0	0	52	15
35	MTS School 1 in Hai Duong	208	208	45	45	40	40	203	203
36	Centre for THW in Bac Can	10	0	0	0	10	0	13	0
37	SM School of Bac Ninh	90	90	0	0	50	50	103	103
38	HSM School of Nam Dinh	389	349	95	71	80	80	377	345
39	SM School of Cao Bang	110	82	76	55	0	0	85	64
40	SM School of Quang Ngai	127	113	50	36	0	0	110	101
41	SM School of Quang Binh	95	95	35	35	0	0	83	83
42	SM School of Long An	40	40	0	0	50	50	53	53
43	SM School of Ca Mau	62	62	19	19	25	25	62	62
44	SM School of Khanh Hoa	50	50	0	0	50	50	63	63
	TOTAL	3,542	2,576	1,141	707	1,510	1,405	3,539	2,692

* SM School = Secondary Medical School
* Centre for THW = Centre for Training of Health Workers
* HSM School = Higher Secondary Medical School
* MTS School = Medical technique secondary school

ORGANISATION SYSTEM OF PREVENTIVE MEDICINE



感染症対策（１）

MINISTRY OF HEALTH
SOCIALIST REPUBLIC OF VIETNAM

No 01/HTQT-99

The Ministry of Health of the Socialist Republic of Vietnam presents its compliments to JICA Vietnam Office and has the honor to inform the latter that:

In the strategy for people's health care and protection of Vietnam from now to the year 2000 and the following years, the prevention of HIV infection and the control of communicable diseases such as STD, Tuberculosis, Malaria, Dengue Fever, Cholera, Typhoid... have been defined to be the top prioritized actions.

In accordance with this strategy and to obtain these above objectives, the Ministry of Health attaches its great concern to training those who work in the preventive health care system to strengthen the system's capacity. Thanks to ODA projects granted by the Government of Japan, a number of training programs namely ***"country focused training programs"*** have been successfully implemented in different fields such as politics, finance, taxation... Given the above reasons, the Ministry of Health would kindly request that the training of preventive health workers be included in ***the country focused training programs*** sponsored by the Government of Japan.

- Fields of training: communicable disease surveillance, HIV/AIDS surveillance and community health project management.
- Duration of the training program: 5 years from 2000 - 2005
- Number of trainees: 10 people per year
- Duration of each training course: 1 - 2 months

The Ministry of Health would appreciate it if JICA Vietnam Office could forwards the Ministry of Health's request to the Government of Japan for consideration.

The Ministry of Health of the Socialist Republic of Vietnam avails itself of this opportunity to renew to JICA Vietnam Office the assurance of its highest consideration.

Hanoi, 07 May 1999

To: **JICA Vietnam Office**

Enc: Minute of Discussions on the Basic Design Study on the Project for Prevention and Control of HIV/AIDS Transmission in Vietnam

cc: **- Embassy of Japan**
- Ministry of Planing and Investment
- National AIDS Committee of Vietnam

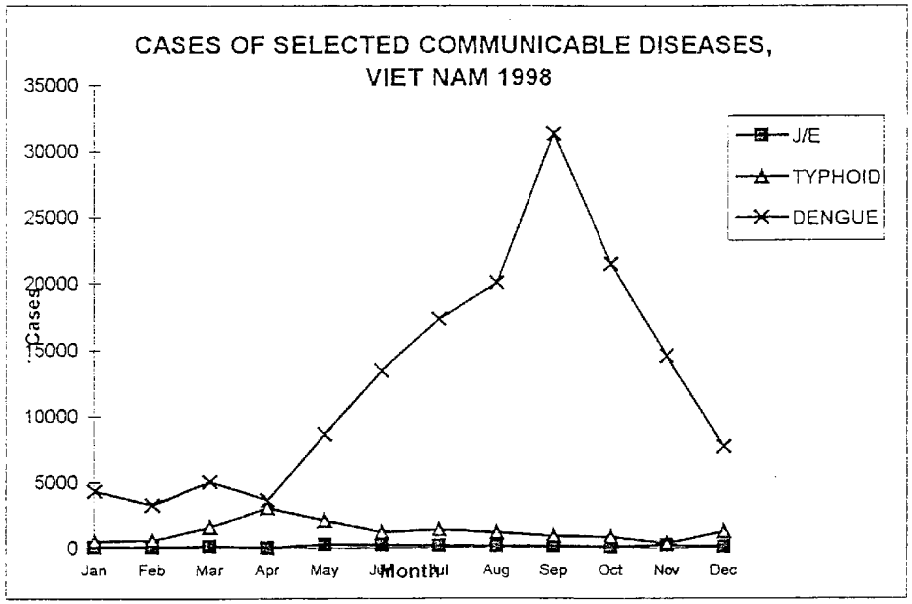
Table 2: CASES OF SELECTED COMMUNICABLE DISEASES,

BY PROVINCE-VIET NAM 1998

(Source: Department of Preventive Medicine, Ministry of Health, Viet Nam)

(NOTE: Monthly data by province are shown on the preceding table)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
J/E	34	47	149	n.a	280	207	173	119	153	90	220	113
TYPHOID	479	572	1596	3043	2068	1220	1414	1179	887	852	348	1258
DENGUE	4290	3287	5032	3638	8610	13440	17341	20080	31365	21509	14587	7719
CHOLERA	0	0	0	0	0	0	0	0	7	1	0	0
PLAGUE	1	1	26	27	4	4	4	0	2	4	1	0



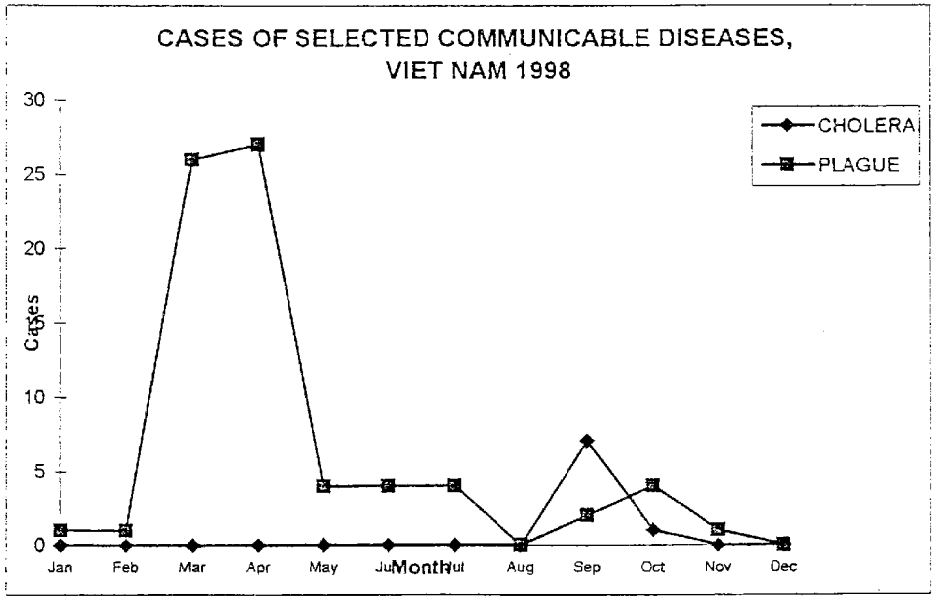
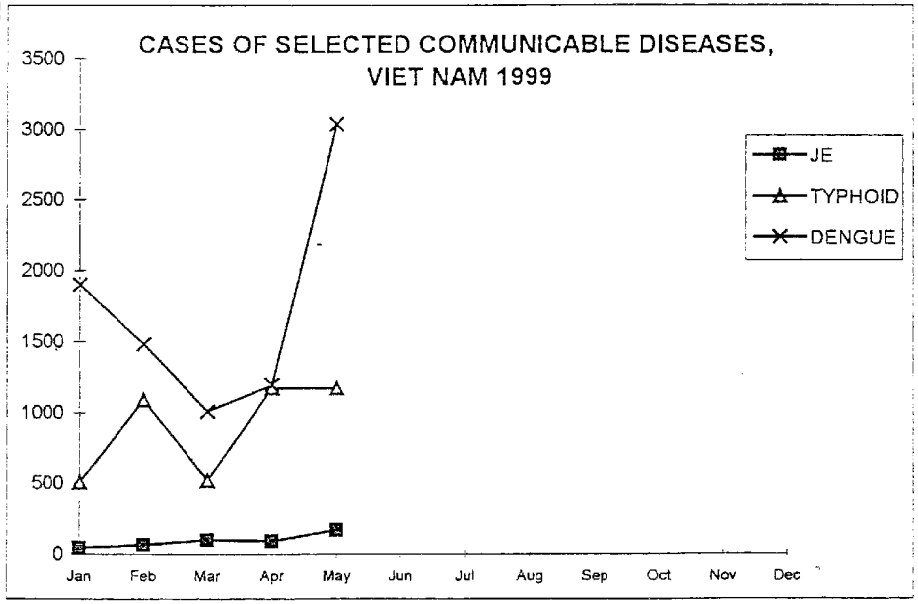
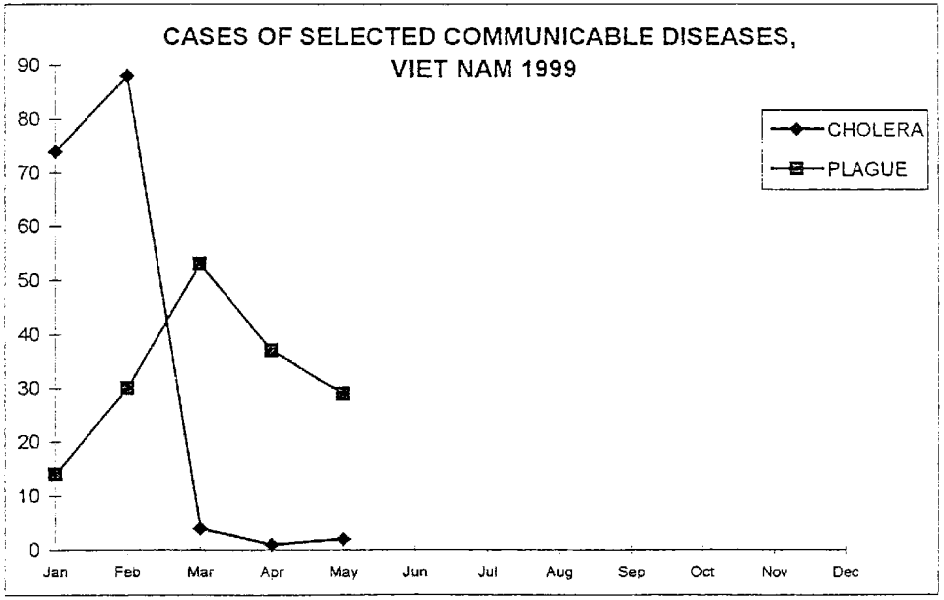


Table 2: CASES OF SELECTED COMMUNICABLE DISEASES,
BY PROVINCE-VIET NAM 1999
(Source: Department of Preventive Medicine, Ministry of Health, Viet Nam)
(NOTE: Monthly data by province are shown on the preceding table)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
JE	41	62	99	90	170							
TYPHOID	507	1087	518	1173	1174							
DENGUE	1897	1481	1005	1192	3038							
CHOLERA	74	88	4	1	2							
PLAGUE	14	30	53	37	29							





麻疹ワクチン（Ｉ）

SUPPORT FROM THE GOVERNMENT OF JAPAN TO THE EXPANDED PROGRAMME ON IMMUNISATION IN VIET NAM, 1993-1999

1. EPI S/E provided by the Government of Japan to Viet Nam, 1993-1998

Further to the request from the Government of Viet Nam, since 1993 the Government of Japan (GOJ) has provided support to the EPI in Viet Nam through the Japan-UNICEF Multi-Bi EPI Co-operation Initiative as follows:

Supplies/Equipment	1993	1994	1995	1996	1997	1998	1999
1. Equipment							
Cold room	1	--	--	--	--	--	--
Freezing room	1	--	3	--	--	--	--
Refrigerator	120	--	130	--	--	--	--
Freezer	--	--	45	--	--	--	--
Voltage stabilizer	--	--	170	--	--	--	--
Cold box	120	--	1,300	--	--	--	--
Vaccine carrier	3,400	--	5,500	--	--	9,000	--
Toyota Landcruiser	--	--	20	--	9	--	--
Refrigerated truck	--	--	3	--	1	--	--
Motorcycle	--	--	130	--	--	--	--
Spare tyre/tube for car	--	--	80	--	--	--	--
Spare tyre/tube for Hi-Luk	--	--	8	--	--	--	--
Fermentor (for vaccine production)	--	--	--	--	--	1	--
2. Vaccines (1000doses)							
Polio vaccine	4,000	6,600	11,300	11,300	23,000	3,000	--
Measles vaccine	--	--	--	--	1,100	--	2,000
Tetanus Toxoid	--	--	--	--	--	1,700	--
DPT	--	--	--	--	--	--	1,600

2. Accomplishments

2.1 EPI Development

Up to now, EPI has been expanded in the whole country, covering 10,516 communes (100%) of 610 districts (100%) of 61 provinces (100%).

2.2 Immunization Coverage

The UCI 80% goal was achieved since 1989 and has been sustained and increased. The NIDs and SNIDs have got good success:

	1993	1994	1995	1996	1997	1998	
						Report	Survey(*)
Fully immunized (children <1 year)	91%	94%	94%	95%	95%	95%	80.5%
TT2+ (pregnant women)	71%	79%	82%	82%	84%	82%	92%
TT2+(women 15-35 years)	86%	92%	94%	97%	91%	92%	NA
OPV2 (children <5 years)	98%	99.6%	99.2%	99.8%	99.7%	98.5%	98.2%

Note: (*) Survey conducted in October 1998 in 5 provinces selected at random from 5 ecological regions of the country.
NA Not available/applicable

2.3 *Incidence of EPI Diseases*
The incidence of three EPI target diseases have been decreased steadily.

Disease	No. of cases							1998 compared to 1985
	1985	1993	1994	1995	1996	1997	1998	
Poliomyelitis	1,600	452	124	136	52	1	0	Reduced
Wild polio virus isolated	NA	152	31	12	2	1	0	Reduced
Neonatal tetanus	NA	333	422	330	257	257	242	Reduced
Measles	82,231	12,015	11,853	6,171	5,156	6,507	10,284	Reduced

3. Coordination mechanism between JICA, MOH, UNICEF and other partners

Discussions were made between JICA, the Japanese Embassy and the Ministry of Health (MOH) of Viet Nam, in consultations with UNICEF and WHO on EPI needs and possible assistance from the GOJ. Then, official requests from the MOH were made and submitted to the GOV for approval and submission to the GOJ through the Japanese Embassy and JICA Office in Viet Nam. The procurement of S/E and vaccines was made by JICA through UNICEF Supply Division in Copenhagen.

In April 1997, a GOJ's mission arrived in Viet Nam to review and had good impression on the utilisation and management of vaccines and cold chain, transportation equipment provided by the GOJ through the Multi-Bi EPI Cooperation in Viet Nam.

4. Recommendations & Proposals

4.1 Continued support to the EPI in Viet Nam

To achieve the four EPI-related end-decade goals (UCI maintenance, polio eradication, NNT elimination, measles control), Viet Nam still needs financial support from the international community and the Government of Japan for procurement of vaccines, especially measles vaccine. Further to the request from Viet Nam, in 1999 JICA has agreed to provide 2 million doses of MV and CIDA 1.2 million doses.

4.2 Support to local vaccine production (LVP) of measles vaccine

To sustain EPI/UCI, the MOH plans to strengthen LVP, aiming at attaining self-sufficiency in vaccine supply for the EPI by the year 2000 and beyond. The GOJ's support to the Institute of Vaccine in Nhatrang by provision of an additional fermentor for DPT production is a very cost-effective contribution.

It is proposed that a project of cooperation and technology transfer in production of measles vaccine between Japan and the National Centre of Polio Vaccine Research and Production (POLIOVAC), Ministry of Health, in Hanoi would be considered and accepted for support.

SOME DOMAINS NEED TO SUPPORT TO HIV/AIDS PREVENTION STAGE 1999 - 2000 - 2005

1.Surveillance activity:

- Supply laboratoy equipment (ELISA) for Highland and Middle provinces.
- Training surveillance staffs
- Establishing behavioral.surveillance system

2.Sexual transmissive Diseases Services:

- STD surveillance
- Training staff
- Supply equipments for STD diagnosis and treatment
- Promotion of condom.

3.HIV/AIDS Treatment:

- AIDS Treatment for pregnant women and children infected by HIV
- Establishing counselling network

4.Information - Education - Communication:(IEC)

- HIV/AIDS prevention at workplace
- HIV/AIDS prevention in countryside
- HIV/AIDS prevention in minority regions
- HIV/AIDS prevention in border regions
- HIV/AIDS prevention for special groups as pupil, student and other(CSWs, IDUs, Prisoner)

5. Safe blood supply:

- Supply HIV screening equipment
- Produce blood components
- Build national blood bank

6.Program management:

- Evaluate HIV/AIDS program effectiveness in Vietnam (inside and outside)
- Formulate stratergy for HIV/AIDS in Vietnam stage 2000-2005.

7.Research:

7.1.Bio medical researchs:

- Type and subtype of HIV in Vietnam
- Natural history of HIV infection in Vietnam
- Clinical manifestations of HIV/AIDS infection in Vietnam
- HIV/AIDS Treatmnet trials.
- Trend of HIV/AIDS infection and predict HIV/AIDS epidemic in Vietnam.

7.2.Intervention researchs:

- Change behavior in population groups.
- Legal Impact to HIV/AIDS epidemic
- Socio-economic impact of HIV/AIDS epidemic in Vietnam
- HIV/AIDS Prevention and care in Community
- Role of NGOs in HIV/AIDS prevention.

MINISTRY OF HEALTH
AIDS DIVISION

HIV/AIDS SITUATION IN VIETNAM

HANOI, JANUARY 1999

PART I

ORGANIZATION OF AIDS DIVISION - MOH

AIDS Division Ministry of Health was established in 3/5/1995, it has function following:

1. Assisting the Minister of Health in managing the implementation of AIDS prevention responsibilities assigned by the Government.

2. Supervising HIV and AIDS infection situation, reporting periodically to Minister, National AIDS Committee, Government and international organizations.

3. Managing and regulating co operative AIDS National Committee and other ministries.

4. Coordinating AIDS prevention activities with National AIDS Committee and other ministries.

5. Guiding and directing the implementation of AIDS prevention activities in the seven specialized sub -Division and provincial AIDS committees under provincial Health Department.

6. Managing and allocating the Government's budget for the Ministry of Health as well as international donations, according to Government policy.

I. AIDS DIVISION ORGANIZATION SYSTEM - MINISTRY OF HEALTH

1.The AIDS Division - Ministry of Health

- **Chairman** :Vice Minister of Health, responsible for hygiene and epidemiology
- **Permanent Vice-Chairman**: Director of Preventive Medicine Department.
- **Vice-Chairman**: Director of Department of Medical treatment.
- **Committee's Member**: Director of Planning Department, Director of Bureau Department, Director of Finance Department, Director of Hygiene and Epidemiology Institute.

Standing office: 10 specialists from Preventive Medicine Department and Department of Medical Treatment.

2. The technical advisory group.

This group has the responsibility of providing the AIDS Division with guidance in AIDS prevention strategies and advising in specialist and technical domains including:

2.1 Strategies for the HIV/AIDS/STD surveillance
2.2 Strategies for providing care and advice for HIV infected person and treatment of AIDS patients.
2.3 Strategies for safe blood transfusion.
2.4 Strategies and techniques for ensuring sterile conditions in all health services.

3.The specialized sub - Divisions:

There are 7 sub-Divisions. Each sub-Division includes the directors of institutes, hospitals and specialist departments belonging to the Ministry of Health and the Central party committee.

Sub-Division for Surveillance: Chairman - Director of Hanoi Institute for Hygiene and Epidemiology.

Sub-Division for Safe Blood Transfusion: Chairman - Director of Institute for Hematology and Blood transfusion.

Sub-Division for Sexual Transmission Disease (STD): Chairman - Director of Institute for Dermatology and V.D.

Sub-Division for Mother and Children care: Chairman - Director of Institute for Mother and Children care.

Sub-Division for HIV care and AIDS Treatment: Chairman - Director of Institute for Tropical clinic.

Sub-Division for Children care: Chairman - Director of Institute for Children care.

Sub-Division for policy and law: Chairman - Leader of Department of Health Legislation MOH.

The seven specialized sub — Divisions of the AIDS Division MOH are responsible for the implementation of specialized tasks following the plans assigned, directing specialized technical measures throughout the lower

levels of the organization, reporting weekly on the progress and result to the AIDS Division and combining reports for the Minister of Health.

4.The AIDS Division - Provincial Health Department.

Assisting Director of Health Department.

Managing and providing guidance to all AIDS prevention activities belonging to the health sector at provincial level, under the direction of the health service, people's committee and AIDS Division Ministry of Health.

This division is comprised of:

Chairman: Director of Health Department or Deputy Director in charge of Hygiene and Epidemiology.
Permanent Vice Chairman: Director of provincial center for Hygiene and Epidemiology.
Members: Director of provincial hospital, center for Dermatology and V.D.

5.AIDS Division organization at district lever

Organizing the AIDS prevention activities at district health centers; depending on each locality's particular situation and needs.

II. OPERATING PROCEDURE AND RELATIONSHIP OF AIDS DIVISION - MOH.

1.The AIDS Division MOH is directly by and accountable to the Ministry of Health in all of the AIDS prevention activities.

2.The AIDS Division MOH operates in accordance to the Ministry's regulations.

3.The relationship between AIDS Division MOH and National AIDS Committee is as following :

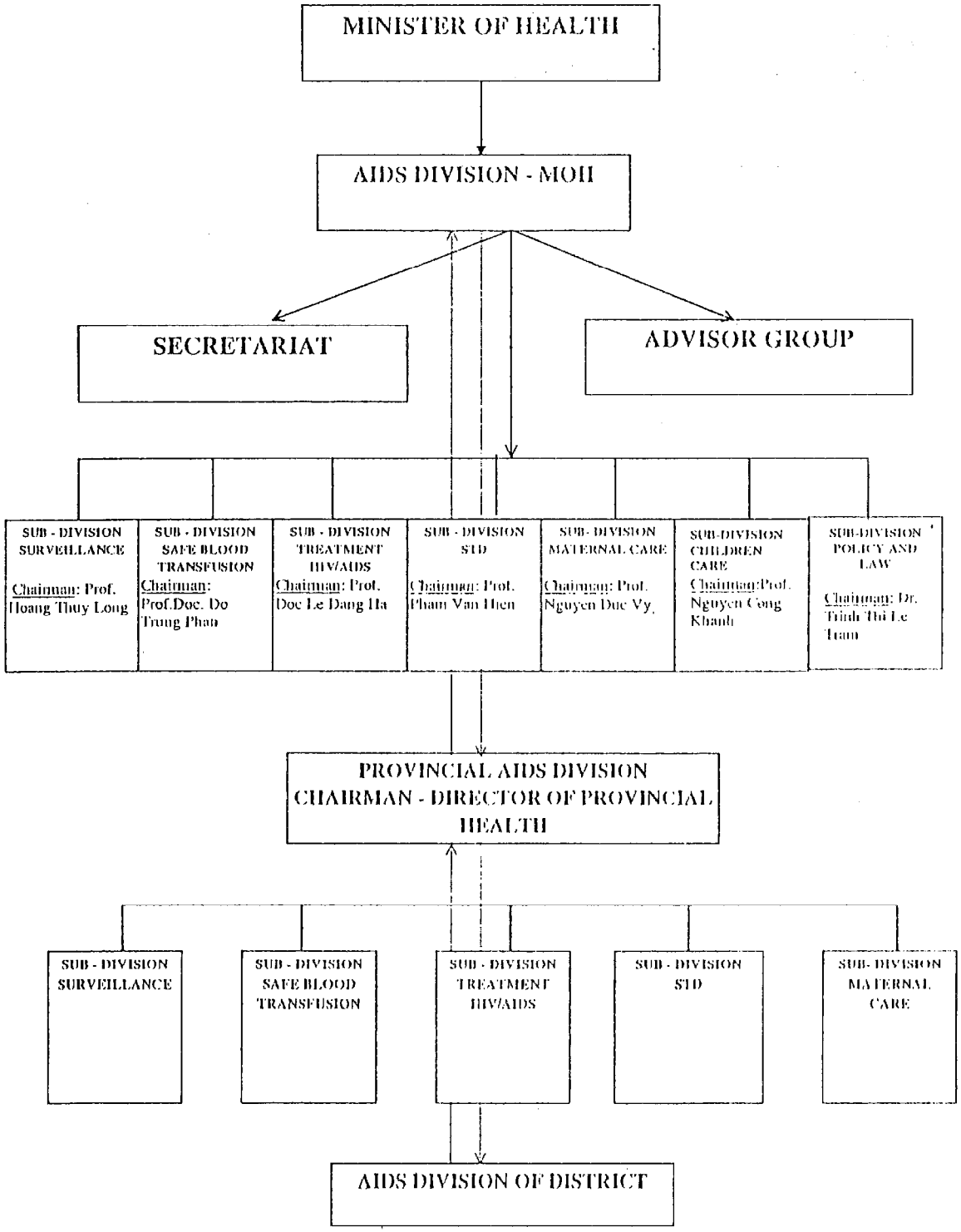
- The implementation of the plans approved by National AIDS Committee.
- The AIDS Division MOH, together with sections of the Department of Planning and Department Finance and Economic, is responsible for the management of the entire AIDS prevention budget granted by the Government and international organization (including budget for AIDS prevention activities in all areas, including the executive committee and expenditure granted directly by MOH). It reports periodically on progress and results to the National AIDS Committee.

4.The relationship between AIDS Division MOH and National Committee for AIDS Prevention.

- Reports weekly on the situation of HIV/AIDS nationally.
- Reports on the progress of AIDS prevention activities managed by the Ministry of Health.
- Appraises the Government 's and international donor"s expenditure on AIDS prevention activities.

5.The AIDS Division MOH directly manages all AIDS prevention Committees at provincial health department.

CHART ORGANIZATION
AIDS DIVISION MINISTRY OF HEALTH



PART II

HIV/AIDS SITUATION IN VIETNAM

I. EXECUTIVE SUMMARY

Vietnam has already experienced extensive HIV spread among IDUs but is still at the early phase of a heterosexual HIV epidemic, with the low prevalence among CSWs and STDs and very low among general population.

By 11 January, 1999, 11 681 HIV positive cases had been reported by 61 of the 61 provinces in Vietnam with 65.2% of reported HIV infections are among injecting drug users and mainly among males. A total of 2 231 AIDS cases had been reported including 1 180 died.

In Vietnam HIV infection has predominantly and rapidly been transmitted among injecting drug users, through sharing needles and syringes. HIV infection among CSWs and STD patients has been low except in some southern provinces, especially in the Mekong Delta area and at the border with Cambodia. Sexual transmission of HIV in the South thus appears to be more extensive than in the North. HIV prevalence rates among prenatal attendees and army conscripts are still rather low, ranging from zero to less than 1.2%.

By the end of 1997, in Vietnam 64,000 to 78,000 HIV infection were estimated cumulatively, among them 3,000 - 5,000 have developed AIDS and 2,000-4,000 have died of AIDS. It is projected that by the year 2000, the cumulative number of HIV infections will reach about 135,000 - 160,000, among them 14,000 - 21,000 have developed AIDS and 10,000- 15,000 have died of AIDS

II. HIV REPORTED INFECTION.

In December 1990, the first case of HIV infection in Vietnam was detected.

As of January 1999, HIV cumulative cases was 11681.

HIV/AIDS has been reported from 61 out 61 provinces/cities. Before 1995 almost HIV cases were identified in the southern provinces, but recently the epidemic exploded in some northern provinces. 65,3% of reported HIV infections are among IDUs, followed by CSWs (4.5%) and STD patients(2.9%). HIV infection has so far been reported mainly among males,

who account for 84.7% of cases. HIV infection is mainly occurring in young adults: 37.8% are 20-29 years old, 30.3 % are 30-39 and 19.6 % are 40-49 years old. By gender, female HIV infected people are younger than male. The proportion of female and younger age - groups is increasing.

III. AIDS REPORTED CASES

In 1993, first case was defined in Vietnam

As January 1999, AIDS cumulative cases as 2 231 including 1 180 deaths.

Opportunistic infection among AIDS reported cases

TB	31.6%	PCP	2.2%
Weight loss	16.9%	dementia	2.2%
Chronic diarrhea	16.0%	Herpes Zoster	0.9%
Persistent fever	14.0%	Other	14.0%
Candidiasis	2.2%		

Distribution of AIDS cases by target groups

IDUs	46.45%
Heterosexual	12.59%
Mother to infant	0.32%
Other/unknown	40.63%

IV. HIV/AIDS SENTINEL SURVEILLANCE

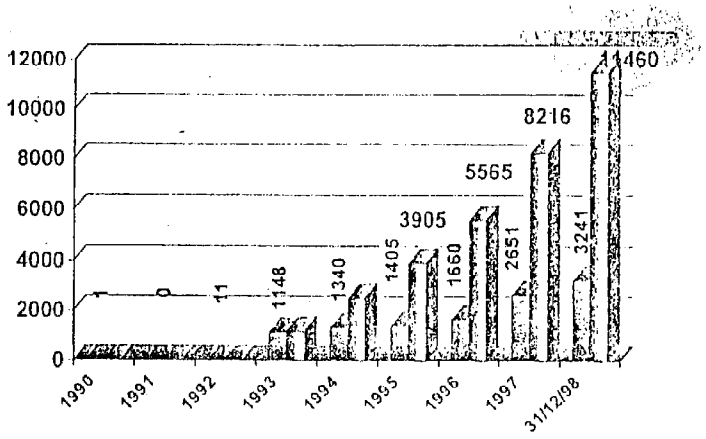
HIV/AIDS sentinel surveillance system was established in 1994.

Number of sentinel provinces	1994 in 10 provinces
	1995 in 12 provinces
	1996 and now in 20 provinces

Number of target group: 6 including IDU, CSWs, STD patient, TB patient, (representing hi - risk group), pregnant women, military recruit (representing low risk- group).

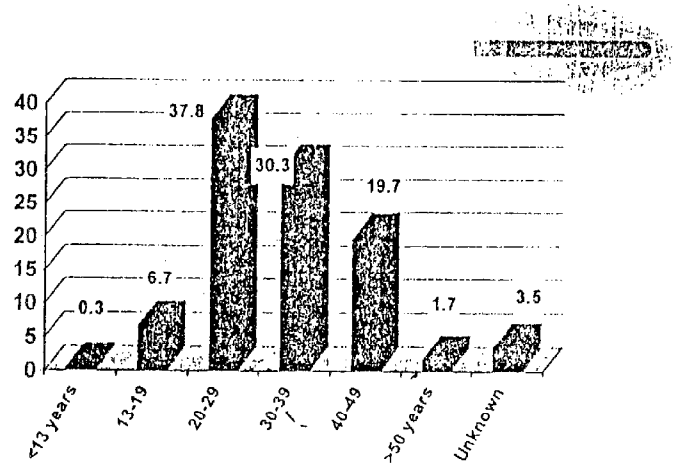
Result of sentinel surveillance (see attach annex)

CUMMULATIVE OF HIV INFECTION BY YEAR



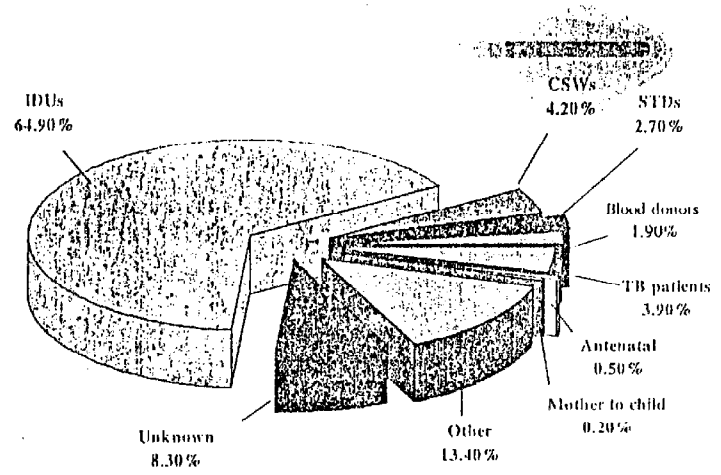
Source: AIDS Division - MOH

HIV INFECTION BY AGE



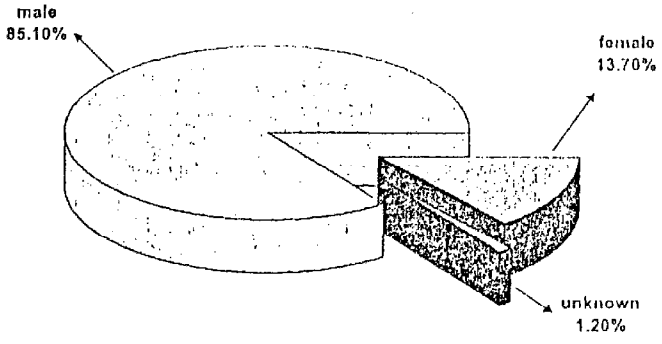
Source: AIDS Division - MOH

HIV INFECTION BY TARGET GROUPS



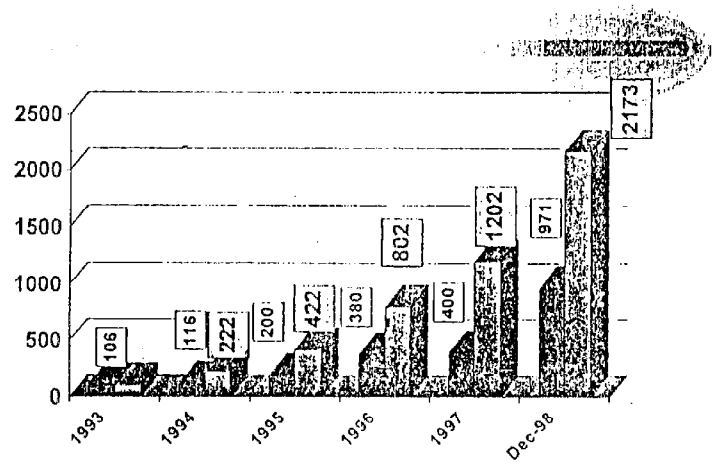
Source: AIDS Division - MOH

DISTRIBUTION OF HIV INFECTION BY GENDER



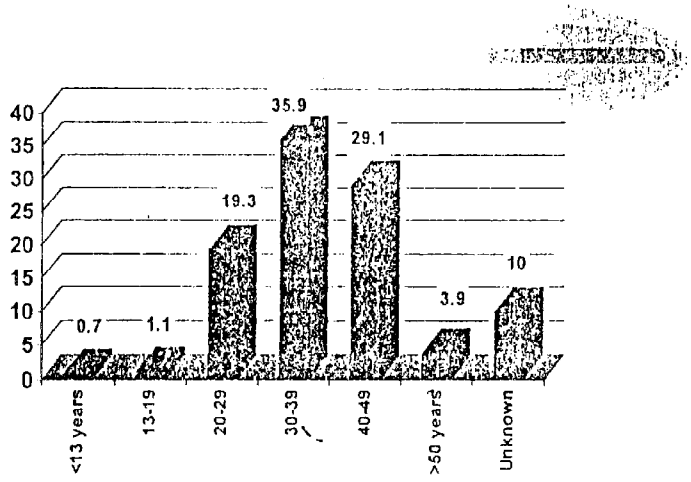
Source: AIDS Division - MOH

CUMULATIVE OF AIDS CASES BY YEARS



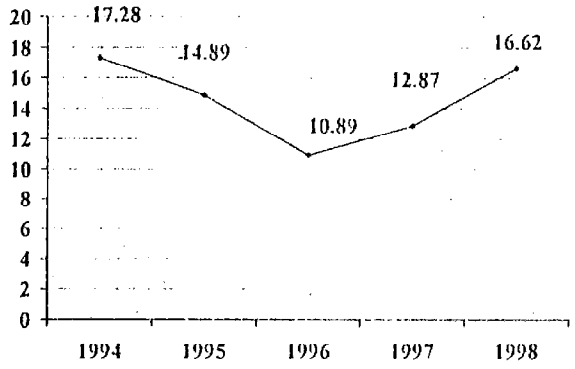
Source: AIDS Division - MOH

DISTRIBUTION OF AIDS CASES BY AGE

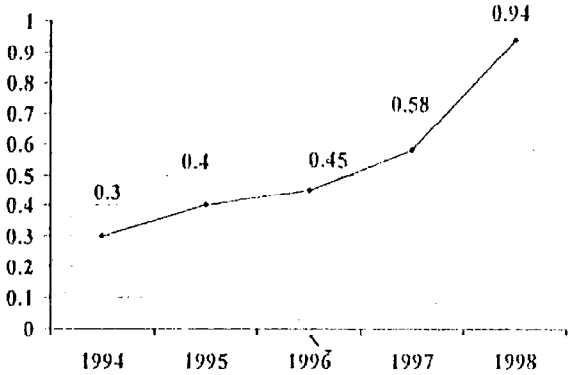


Source: AIDS Division - MOH

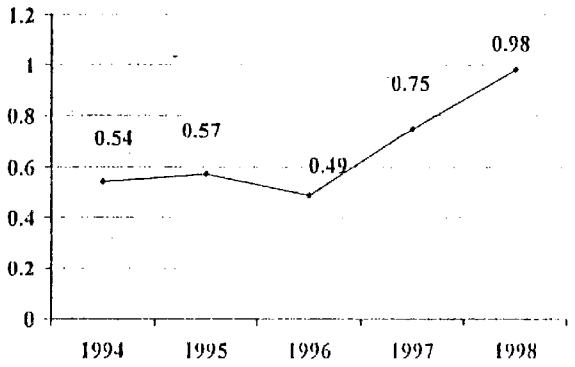
TREND OF HIV INFECTION AMONG IDUs
(VIETNAM NATIONAL SENTINEL SURVEY 1994-1998)



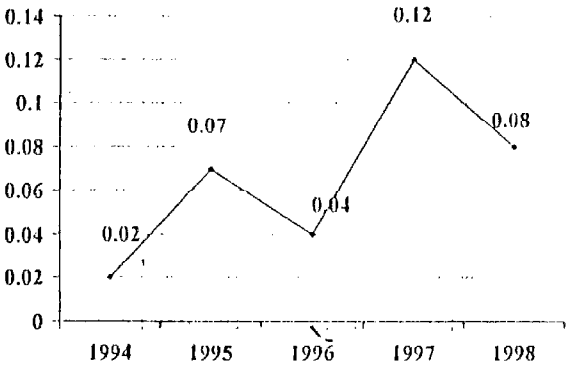
TREND OF HIV INFECTION AMONG STDs
(VIETNAM NATIONAL SENTINEL SURVEY 1994 -1998)



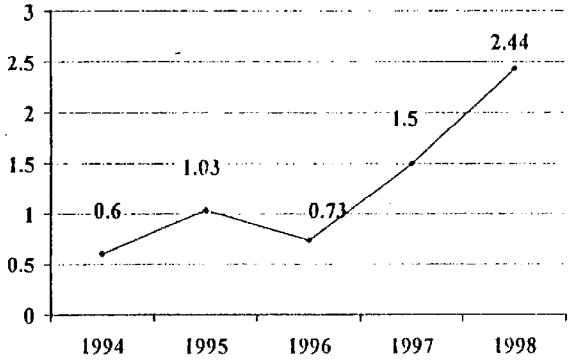
TREND OF HIV INFECTION AMONG GROUP TB PATIENT
(VIETNAM NATIONAL SENTINEL SURVEY 1994-1998)



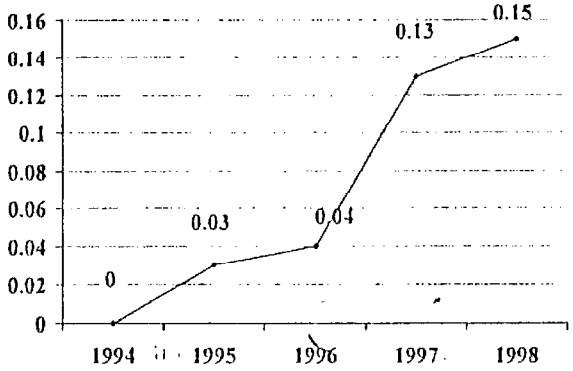
TREND OF HIV INFECTION AMONG GROUP ANCs
(VIETNAM NATIONAL SENTINEL SURVEY 1994-1998)



TREND OF HIV INFECTION AMONG CSWs
VIETNAM NATIONAL SENTINEL SURVEY 1994-1998)



TREND OF HIV INFECTION AMONG MILITARY RECRUITS
(VIETNAM NATIONAL SENTINEL SURVEY 1994-1998)



OFFICIAL HIV AND AIDS CASE REPORT

Updated report includes cases cumulative to: 3 AUGUST 1999

Name of reporter: *Sub-Committee of HIV/AIDS Surveillance*
Address: *National Institute of Hygiene and Epidemiology*
1 Yersin Street, Hanoi, Vietnam.
Tel: *84.4.8211501* Fax: *84.4.8210853*
E-mail : *niheaids@netnam.org.vn.*

Country: Vietnam

AGE GROUP, BY SEX

	1998						1999						CUMULATIVE TOTAL					
	HIV			AIDS			HIV			AIDS			HIV			AIDS		
	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown
Less than 5 years	7	10	0				3	3	0				22	25	0			
5 to 9 years	2	0	0				0	0	0				3	1	0			
10 to 14 years	3	0	0				2	0	0				12	2	0			
15 to 19 years	437	51	0				154	13	0				854	216	3			
20 to 24 years	1257	174	0				604	91	0				2816	643	5			
25 to 29 years	950	97	0				439	65	0				2302	382	7			
30 to 34 years	434	43	0				186	32	0				1573	230	6			
35 to 39 years	278	43	0				114	16	0				2030	193	6			
40 to 44 years	258	28	0				92	9	0				1821	142	12			
45 to 49 years	85	1	0				31	4	0				493	19	3			
50 years and older	32	8	0				15	6	0				196	33	2			
Unknown age	55	7	11				30	4	3				293	74	90			
Totals: Number	**3798**	**462**	**11**	**460**	**119**	**356**	**1670**	**243**	**3**	**248**	**55**	**16**	**12415**	**1960**	**134**	**1638**	**319**	**779**
AIDS Deaths						**488**						**129**						**1414**

NOTE: Totals for HIV cases include AIDS cases as well as asymptomatic HIV infections.

In case of multiple risks, case(s) would be assigned hierarchically, following the order of the categories, as stated above.

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E-mail : *niheaids@netnam.org.vn.*

MODE OF TRANSMISSION, BY SEX

	1998						1999						CUMULATIVE TOTAL					
	HIV			AIDS			HIV			AIDS			HIV			AIDS		
	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown	Male	Female	Unknown
Mother to child transmission	2	3	0			3	0	1	0			2	10	12	0			11
Infecting drug use	2679	51	4			329	1132	15	2			135	8960	303	19			1284
Homosexual/Bisexual transmission	0	0	0			0	0	0	0			0	0	0	0			0
Blood or blood product recipients	0	0	0			1	0	0	0			0	0	0	0			1
Heterosexual transmission	134	184	2			111	55	97	0			95	341	916	6			423
Other known mode of transmission	0	0	0			36	0	0	0			13	0	0	0			80
Unknown mode of transmission	980	227	5			455	483	130	1			74	3094	739	109			937
Totals: Number	**3795**	**465**	**11**			**935**	**1670**	**243**	**3**			**319**	**12405**	**1970**	**134**			**2736**

NOTE: Totals for HIV cases include AIDS cases as well as asymptomatic HIV infections.

In case of multiple risks, case(s) would be assigned hierarchically, following the order of the categories, as stated above.

SOME DOMAINS NEED TO SUPPORT TO HIV/AIDS PREVENTION STAGE 1999 - 2000 - 2005

1.Surveillance activity:

- Supply laboratoy equipment (ELISA) for Highland and Middle provinces.
- Training surveillance staffs
- Establishing behavioral surveillance system

2.Sexual transmissive Diseases Services:

- STD surveillance
- Training staff
- Supply equipments for STD diagnosis and treatment
- Promotion of condom.

3.HIV/AIDS Treatment:

- AIDS Treatment for pregnant women and children infected by HIV
- Establishing counselling network
- Training staffs on care and counselling.

4.Information - Education - Communication:(IEC)

- HIV/AIDS prevention at workplace
- HIV/AIDS prevention in countryside.
- HIV/AIDS prevention in minority regions
- HIV/AIDS prevention in border regions
- HIV/AIDS prevention for special groups as pupil, student and other(CSWs, IDUs, Prisoner)
- Training staffs on IEC and research..

5. Safe blood supply:

- Supply HIV screening equipment
- Produce blood components
- Build national blood bank

6.Program management:

- Evaluate HIV/AIDS program effectiveness in Vietnam (inside and outside)

- Formulate stratergy for HIV/AIDS in Vietnam stage 2000-2005.
- Training on programme management.

7.Research:

7.1.Bio medical researchs:

- Type and subtype of HIV in Vietnam
- Natural history of HIV infection in Vietnam
- Clinical manifestations of HIV/AIDS infection in Vietnam
- HIV/AIDS Treatmnet trials.
- Trend of HIV/AIDS infection and predict HIV/AIDS epidemic in Vietnam.

7.2.Intervention researchs:

- Change behavior in population groups.
- Legal Impact to HIV/AIDS epidemic
- Socio-economic impact of HIV/AIDS epidemic in Vietnam
- HIV/AIDS Prevention and care in Community
- Role of NGOs in HIV/AJDS prevention.

⑦ 都市保健関連

DÂN SỐ 1998

POPULATION 1998

TT No.	TỈNH & THÀNH PHỐ *PROVINCES & CITIES*	Tổng dân số *Population (1000)*	Nữ - *Female* Số lượng *Number (1000)*	Nữ - *Female* Tỷ lệ *Rate (%)*	Thành thị - *Urban* Số lượng *Number (1000)*	Thành thị - *Urban* Tỷ lệ *Rate (%)*
	Tổng số - *Total*	78 059,1	39 825,3			
	Dân số thường trú- *Resident population*	**77 046,4**	**39 669,1**	**51,49**	**16 245,2**	**21,08**
	Miền núi trung du Bắc bộ - *North hightland*	**13 245,7**	**6 766,6**	**51,09**	**1 960,5**	**14,80**
1	Hà giang	577,4	300,0	51,96	**53,6**	9,28
2	Tuyên quang	688,9	349,9	50,79	78,7	11,42
3	Cao bằng	568,7	279,9	49,22	58,8	10,34
4	Lạng sơn	743,8	384,8	51,73	112,4	15,11
5	Lai châu	565,3	291,0	51,48	79,5	14,06
6	Lao cai	597,7	303,6	50,79	95,7	16,01
7	Yên bái	705,4	360,4	51,09	135,5	19,21
8	Thái nguyên	1 020,3	528,1	51,76	240,3	23,55
9	Bắc kạn	318,8	157,7	49,47	40,9	12,83
10	Sơn la	868,1	449,6	51,79	112,4	12,95
11	Hoà bình	779,3	391,3	50,21	125,7	16,13
12	Phú thọ	1 302,8	655,7	50,33	150,6	11,56
13	Vĩnh phúc	1 103,7	570,6	51,70	105,6	9,57
14	Bắc giang	1 496,0	777,4	51,97	88,2	5,90
15	Bắc ninh	950,3	491,6	51,73	65,9	6,93
16	Quảng ninh	959,2	475,0	49,52	416,7	43,44
	Đồng bằng sông Hồng - *Red river delta*	**14 935,1**	**7 691,7**	**51,50**	**2 962,5**	**19,84**
17	Hà nội	2 420,2	1 240,1	51,24	**1 370,5**	56,63
18	Hải phòng	1 719,0	881,9	51,30	582,6	33,89
19	Hà tây	2 387,7	1 240,0	51,93	210,4	8,81
20	Hải dương	1 731,7	898,1	51,86	150,1	8,67
21	Hưng yên	1 110,0	570,9	51,43	80,5	7,25
22	Thái bình	1 865,5	960,2	51,47	114,7	6,15
23	Nam định	1 950,5	999,9	51,26	260,0	13,33
24	Hà nam	835,3	432,7	51,80	88,5	10,59
25	Ninh bình	915,2	467,9	51,13	105,2	11,49
	Bắc trung bộ - *North central coast*	**10 323,3**	**5 291,2**	**51,25**	**1 204,0**	**11,66**
26	Thanh hoá	3 613,4	1 876,8	51,94	**341,7**	9,46
27	Nghệ an	2 899,4	1 483,4	51,16	268,7	9,27
28	Hà tĩnh	1 365,9	677,0	49,56	104,9	7,68
29	Quảng bình	814,7	413,7	50,78	95,9	11,77
30	Quảng trị	568,7	292,0	51,35	112,3	19,75
31	Thừa thiên huế	1 061,2	548,3	51,67	280,5	26,43

TÌNH HÌNH CÁN BỘ Y TẾ PHÂN THEO TUYẾN 1998

HEALTH PERSONNEL BY LEVEL - 1998

Phân loại cán bộ *Categories*	Tổng số *Total*	Trong đó - *Of which* Trung ương *Central*	Địa phương *Local*	Các ngành khác *Other branches*
TỔNG SỐ - *TOTAL*	**230 029**	**24 765**	**185 386**	**10 324**
Tiến sỹ và PTS y - *Medical PhDs*	665	584	75	6
Thạc sỹ - *Medical master sciences*	306	137	169	-
Tiến sỹ và PTS Dược - *Pharm. PhDs*	146	143	3	-
Bác sỹ - *Medical doctors*	36 487	5 826	28 837	1 824
Dược sỹ ĐH - *Pharmacists*	5 465	1 504	3 735	226
Y tá ĐH - *Hight degree nurses*	326	45	281	-
Y sỹ - *Assistant doctors*	50 201	379	47 860	1 962
KTV Y - *2nd degree medical technicians*	6 880	1 582	5 148	150
Dược sỹ TH - *Assistant pharmacists*	7 255	595	6 457	203
KTV Dược - *2nd degree pharm. technicians*	1 655	529	984	142
Y tá TH - *2nd degree nurses*	23 997	2 882	17 839	3 276
Nữ HS TH - *2nd degree midwives*	9 553	471	8 934	148
Y tá SH - *Elementary nurses*	19 399	546	17 990	863
Nữ HS SH - *Elementary midwives*	4 173	9	4 082	82
XNV - *Lab. technicians*	2 278	86	2 066	126
Lương y - *Traditional medicine practitioners*	423	94	302	27
Dược tá - *Elementary pharmacists*	8 096	631	7 183	282
ĐH khác - *Other bachelor degrees*	4 444	1 777	2 535	132
TH khác - *Other 2nd degree level*	6 780	1 810	4 865	105
Cán bộ khác - *Others*	41 500	5 135	26 041	770

KẾT QUẢ TIÊM CHỦNG CHO TRẺ EM < 1 TUỔI

IMMUNIZATION COVERAGE AMONG CHILDREN <1 YEAR OF AGE

STT *No.*	Vaccine	1996	1997	1998
I	***BCG***			
1	**Số trẻ em được tiêm** *No of Immunized children*	1 814 502	1 728 069	1 591 660
2	**Tỷ lệ được tiêm** *% of Coverage*	95,4	96,4	93,5
II	***Bại liệt*** - *Poliomyelitis*			
1	**Số trẻ em được uống** *No of Immunized children*	1 797 264	1 706 147	1 597 379
2	**Tỷ lệ được uống** *% of Coverage*	94,5	95,2	93,8
III	***Bạch hầu - Ho gà - Uốn ván*** *Diptheria - Pertusis - Tetanus*			
1	**Số trẻ em được tiêm** *No of Immunized children*	1 796 523	1 701 920	1 594 914
2	**Tỷ lệ được tiêm** *% of Coverage*	94,4	94,9	93,7
IV	***Sởi*** - *Measles*			
1	**Số trẻ em được tiêm** *No of Immunized children*	1 826 216	1 721 675	1 638 517
2	**Tỷ lệ được tiêm** *% of Coverage*	96,0	96,0	96,2
V	***Tiêm đầy đủ*** - *Fully Vaccinated*			
1	**Số trẻ em được tiêm** *No of Immunized children*	1 809 781	1 710 203	1 626 342
2	**Tỷ lệ được tiêm** *% of Coverage*	95,1	95,4	95,5

Nguồn: Chương trình tiêm chủng mở rộng Quốc Gia

Source: National expand program of Immunization

TÌNH HÌNH MẮC LAO 1998

TUBERCULOSIS DISEASE IN 1998

TT No.	TỈNH & THÀNH PHỐ *PROVINCES & CITIES*	Tổng số BN *Prevalence*	Lao phổi - *Lung TB patients*			Lao ngoài phổi - *Other*
			AFB + (Mới) *Incidence*	Tái phát AFB + *Relapse*	Âm tính AFB -	
	Toàn quốc - *Whole country*	**142 487**	**90 263**	**10 378**	**34 354**	**20 432**
	Zone A	**32 471**	**19 531**	**1 733**	**7 861**	**3 346**
1	Hà nội	1 885	1 301	112	170	302
2	Hải phòng	1 392	1 012	78	198	104
3	Hải dương	1 701	1 037	62	510	92
4	Hưng yên	885	681	36	160	8
5	Thái bình	1 820	1 072	101	482	165
6	Hà nam	882	596	36	142	108
7	Nam định	1 685	1 128	67	262	228
8	Ninh bình	613	472	27	80	34
9	Thanh hoá	3 064	2 022	228	623	191
10	Nghệ an	2 127	1 363	89	420	255
11	Hà tĩnh	1 234	690	34	420	90
12	Phú thọ	1 477	693	37	654	93
13	Vĩnh phúc	637	462	25	64	86
14	Bắc ninh	845	595	54	142	54
15	Bắc giang	1 321	993	77	191	60
16	Hà tây	1 480	990	76	185	229
17	Hoà bình	489	268	45	118	58
18	Yên bái	440	241	20	100	79
19	Lao cai	197	135	12	32	18
20	Thái nguyên	1 022	436	55	336	195
21	Bắc kạn	79	29	4	30	16
22	Quảng ninh	1 102	567	77	241	217
23	Lạng sơn	658	349	54	129	126
24	Cao bằng	272	167	22	51	32
25	Hà giang	178	86	17	53	22
26	Tuyên quang	214	135	13	33	33
27	Lai châu	246	114	6	40	86
28	Sơn la	316	233	17	31	35
29	TB - Hospital	4 210	1 664	252	1 964	330

KẾT QUẢ ĐIỀU TRỊ BỆNH NHÂN AFB (+) MỚI BẰNG CÔNG THỨC

RESULT OF AFB(+) TREATMENT BY NEW METHOD

2SHRZ/6HE - 1998

TT No.	TỈNH & THÀNH PHỐ *PROVINCES & CITIES*	Tổng cộng *Total*	Số khỏi - *No. recovered*		Chết - *Deaths*	
			Số lượng *No.*	Tỷ lệ khỏi *Rate (%)*	Số lượng *No.*	Tỷ lệ *Rate (%)*
	Toàn quốc - *Whole country*	**76 850**	**67 945**	**88,1**	**2 312**	**2,9**
	Zone A	**15 956**	**13 831**	**86,7**	**386**	**2,4**
1	Hà nội	1 165	1 088	93,4	22	1,9
2	Hải phòng	1 016	921	90,1	24	2,4
3	Hải dương	944	886	93,9	23	2,4
4	Hưng yên	589	565	95,9	8	1,4
5	Thái bình	938	864	92,1	43	4,6
6	Hà nam	565	508	89,9	12	2,1
7	Nam định	1 095	930	84,9	43	3,9
8	Ninh bình	523	468	89,5	8	1,5
9	Thanh hoá	1 368	1 105	80,8	26	1,9
10	Nghệ an	1 116	986	88,4	52	4,7
11	Hà tĩnh	666	612	91,9	9	1,4
12	Phú thọ	399	350	87,7	4	1,0
13	Vĩnh phúc	206	186	90,3	3	1,5
14	Bắc ninh	444	405	91,2	5	1,1
15	Bắc giang	450	391	86,9	8	1,8
16	Hà tây	876	781	89,2	23	2,6
17	Hoà bình	261	226	86,6	14	5,4
18	Yên bái	86	79	91,9	4	4,7
19	Lao cai	67	53	79,1	2	3,0
20	Thái nguyên	380	345	90,8	4	1,1
21	Bắc kạn	17	2	11,8	3	17,6
22	Quảng ninh	498	452	90,8	7	1,4
23	Lạng sơn	259	197	76,1	9	3,5
24	Cao bằng	128	110	85,9	6	4,7
25	Hà giang	64	44	68,8	2	3,1
26	Tuyên quang	149	79	53,0	8	5,4
27	Lai châu	139	109	78,4	3	2,2
28	Sơn la	244	189	77,5	8	3,3
29	TB Hospital	1 304	900	69,0	3	0,2
	Zone B1	**7 822**	**6 750**	**86,3**	**194**	**2,5**
30	Quảng bình	590	493	83,6	9	1,5
31	Quảng trị	382	355	92,9	6	1,6
32	Thừa thiên huế	622	567	91,2	12	1,9

MẮC CHẾT DO SỐT RÉT 1998

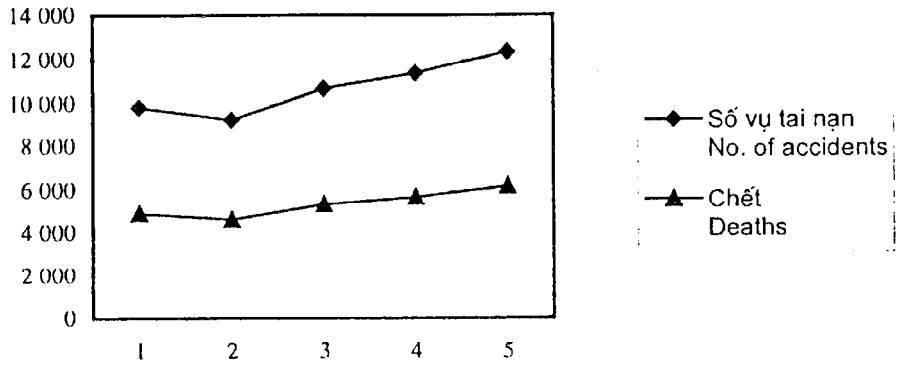
MALARIA MORBIDITY AND MORTALITY 1998

TT *No.*	Tỉnh & Thành phố *Provinces & Cities*	Tổng số người bị SR *Case*	Trong đó *Of which* Ác tính *Malignant*	Chết *Deaths*	Tỷ lệ/100.000 dân *Rate per/ 100.000 inhab.* Mắc *Cases*	Chết *Deaths*
	Tổng số - *Total*	***383 341***	***1 447***	***183***	***491,1***	***0,23***
	Miền núi phía Bắc - *Northern Highlands*	**101 779**	**43**	**3**	***768,4***	***0,02***
1	Hà Giang	13 669	12	-	2367,3	-
2	Tuyên Quang	4 248	-	-	616,6	-
3	Cao Bằng	8 523	-	-	1498,7	-
4	Lạng Sơn	1 722	-	-	231,5	-
5	Lai Châu	13 507	-	-	2389,4	-
6	Lào Cai	12 022	12	1	2011,4	0,17
7	Yên Bái	9 421	-	-	1335,6	-
8	Thái Nguyên	2 460	-	-	241,1	-
9	Bắc Cạn	5 874	3	-	1842,5	-
10	Sơn La	8 655	5	2	997,0	0,23
11	Hoà Bình	5 439	10	-	697,9	-
12	Phú Thọ	8 631	-	-	662,5	-
13	Vĩnh Phúc	2 139	1	-	193,8	-
14	Bắc Giang	2 799	-	-	187,1	-
15	Bắc Ninh	1 317	-	-	138,6	-
16	Quảng Ninh	1 353	-	-	141,1	-
	Đồng bằng sông Hồng - *Red River Delta*	**20 180**	**11**	**1**	***135,1***	***0,01***
17	Hà Nội	195	1	-	8,1	-
18	Hải Phòng	1 374	-	-	79,9	-
19	Hà Tây	931	1	1	39,0	0,04
20	Hải Dương	1 206	6	-	69,6	-
21	Hưng Yên	5 372	-	-	484,0	-
22	Thái Bình	1 132	-	-	60,7	-
23	Nam Định	4 454	-	-	228,4	-
24	Hà Nam	2 651	3	-	317,4	-
25	Ninh Bình	2 865	-	-	313,0	-
	Khu Bốn cũ - *North Central Coast*	**56 994**	**230**	**23**	***552,1***	***0,22***
26	Thanh Hoá	13 752	11	-	380,6	-
27	Nghệ An	13 700	20	2	472,5	0,07
28	Hà Tĩnh	8 923	21	-	653,3	-
29	Quảng Bình	11 053	85	4	1356,7	0,49
30	Quảng Trị	5 811	80	9	1021,8	1,58
31	Thừa Thiên Huế	3 755	13	8	353,8	0,75

TAI NẠN GIAO THÔNG
TRAFFIC ACCIDENT

Năm *Year*	Số vụ *No. of accidents.*	Bị thương *Injuries*	Chết *Deaths*
1994	13 760	14 174	4 907
1995	14 328	18 234	4 625
1996	17 582	19 410	5 342
1997	19 159	21 905	5 680
1998	20 246	22 882	6 189

SỐ VỤ TAI NẠN GIAO THÔNG
NO. OF ACCIDENTS



	Tỷ lệ % - *Percentage*
Nguyên nhân gây tai nạn - Cause of traffic accident	
- Người tham gia tai nạn - *Pedestrian involved*	78%
- Phương tiện không an toàn - *Unsafe traffic means*	1,6%
- Khác - *Other*	20,4%
Đối tượng gây tai nạn - Traffic accident by	
- Lái ôtô - *Car driver*	27,2%
- Lái mô tô - *Motor driver*	62,3%
- Khác - *Other*	10,5%
Nơi xảy ra tai nạn - Accident places	
- Quốc lộ - *National routes*	53%
- Tỉnh lộ - *Provincial routes*	15,7%
- Đường thành phố - *Urban streets*	27,5%

NHỮNG BỆNH MẮC, CHẾT CAO NHẤT

LEADING CAUSES OF MORBIDITY AND MORTALITY

TOAN QUOC - ALL PROVINCES

	Tên bệnh Diseases	Số mắc Cases	Mắc Cases /100000	Tên bệnh Diseases	Số chết Deaths	Chết Deaths /100000
1	Iả chảy do nhiễm trùng *Diarrhoea and gastroenteritis of presumed in fectious origin*	250337	330.8	Xuất huyết não *Intracerebral haemorrhage.*	1419	1.8
2	Viêm phổi *Pneumonia*	238127	314.7	Viêm phổi *Pneumonia*	1313	1.7
3	Viêm phế quản cấp *Acute bronchitis and acute bronchiolitis*	209434	276.7	Lao hô hấp *Respiratory tuberculosis*	882	1.1
4	Sốt xuất huyết *Dengue fever*	186573	246.5	Thai phát triển chậm, suy dinh dưỡng và các bệnh do thai thiếu tháng *Slow fetal growth ,fetal malnutrition and disorders related to short gestation and low birth weight*	685	0.9
5	Nạo hút thai *Medical abortion*	154909	204.7	Nhồi máu cơ tim cấp *Acute myocardial infarction*	536	0.7
6	Cao huyết áp *Essential (primary) hypertension*	93294	123.3	Cao huyết áp *Essential (primary) hypertension*	482	0.6
7	Sốt rét *Malaria*	87944	116.2	Sốt xuất huyết *Dengue fever*	472	0.6
8	Loét dạ dày, tá tràng *Gastric and duodenal ulcer*	67815	89.6	Suy tim *Heart failure*	376	0.5
9	Lao hô hấp *Respiratory tuberculosis*	66223	87.5	Viêm não siêu vi trùng *Viral encephalitis*	374	0.4
10	Viêm ruột thừa *Diseases of appendix*	59928	79.2	Tự tử *Suicide*	371	0.4

BTTV- 12 - 98

NHỮNG BỆNH MẮC, CHẾT CAO NHẤT

LEADING CAUSES OF MORBIDITY AND MORTALITY

HA NOI

	Tên bệnh Diseases	Số mắc Cases	Mắc Cases /100000	Tên bệnh Diseases	Số chết Deaths	Chết Deaths /100000
1	Viêm phế quản cấp *Acute bronchitis and acute bronchiolitis*	7074	300.1	Viêm phổi *Pneumonia*	60	2.5
2	Viêm phổi *Pneumonia*	4986	211.5	Xuất huyết não *Intracerebral haemorrhage*	44	1.8
3	Sốt xuất huyết *Dengue fever*	4674	198.3	Thai phát triển chậm, suy dinh dưỡng và các bệnh do thai thiếu tháng *Slow fetal growth ,fetal malnutrition and disorders related to short gestation and low birth weight*	38	1.6
4	Iả chảy do nhiễm trùng *Diarrhoea and gastroenteritis of presumed in fectious origin*	3596	152.6	U lành tính *Benign neoplasm*	32	1.3
5	Viêm ruột thừa *Diseases of appendix*	1763	74.8	Lao hô hấp *Respiratory tuberculosis*	23	0.9
6	Loét dạ dày, tá tràng *Gastric and duodenal ulcer*	1669	70.8	Sởi *Measles*	12	0.5
7	Rối loạn hành vi tâm thần *Mental and behavioural disorders*	1646	69.8	Thiếu o xy và ngạt khi đẻ *Intrauterine hypoxia and birth asphyxia*	8	0.3
8	Đục thuỷ tinh thể và các bệnh khác của nhãn cầu *Cataract and other disorders of lens*	1646	69.8	Bỏng *Burns*	8	0.3
9	Hen phế quản *Asthma*	1546	65.6	Ung thư khí phế quản, phổi *Malignant neoplasm of trachea , bronchus and lung*	6	0.2
10	Cao huyết áp *Essential (primary) hypertension*	1209	51.3	Ung thư gan, đường mật *Malignant neoplasm of liver and and bile ducts*	5	0.2

BTTV- 12 - 98

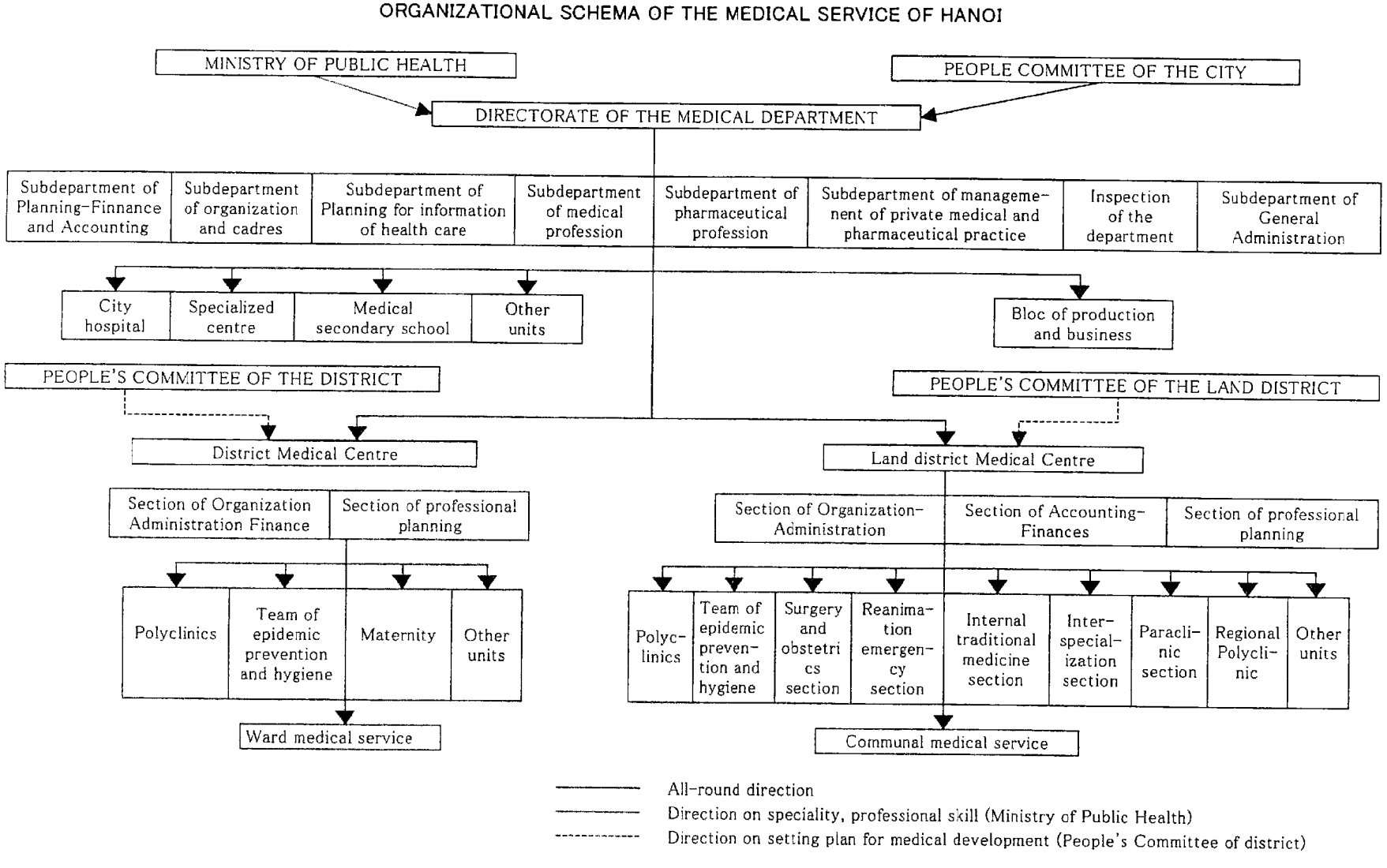


図４－１　ハノイ市保健医療システム