9. Annexes

Annex 1: Record of Discussion (R/D)

- 1-1 Master Plan
- 1-2 List of Machinery and Equipment
- 1-3 List of Vietnamese Counterpart and Administrative Personnel
- 1-4 List of Building and Facilities
- 1-5 Joint Coordinating Committee

Annex 2: Minutes of meeting (M/M)

- 2-1 Project Design Matrix (PDM)
- 2-2 Tentative Schedule of Implementation (TSI)

Annex 3: Participatory Planning Workshop Results

- 3-1. Participants
- 3-2. Stakeholders Analysis
- 3-3. Objectives Analysis
- 3-4. Alternatives Analysis
- 3-5. Project Selection

Annex 4: Organizational Chart

- 4-1. Ministry of Health
- 4-2. Hoa Binh Provincial Health Services
- 4-3. Hoa Binh General Hospital

Annex 5: List of training activities by other Projects

- 5-1. ADB-funded Rural Health Project
- 5-2. List of Training in the UNFPA Project

Annex 6: List of Inputs by the ADB

- 6-1. Equipment to District Hospitals
- 6-2. Equipment to Inter-Communal Polyclinics

Annex 7: Project Management Structure of other Projects

- 7-1. Project Management Structure of the ADB Project
- 7-2. Project Management Structure of the UNFPA Project

Annex 8: The Health Care and Protection Strategy for the period of 2001 to 2010 years

Annex 3: Participatory Planning Workshop Results

1-1. Participants

The following staff/organizations were represented in the participatory planning sessions of the PCM Workshop facilitated by the Hoa Binh Provincial Health Service (HBPHS) and the Preparatory Study Team.

Analytical Stage (27~28 August 2003):

- □ Director, HBPHS
- □ Deputy Director (2), HBPHS
- □ Chief, Human Resources and Training, HBPHS
- □ Chief, Medical Professional Department, HBPHS
- □ Deputy Director, Medical Professional Department, HBPHS
- □ Chief, Planning Department, HBPHS
- □ Director, Hoa Binh Provincial Hospital
- □ Deputy Director, Hoa Binh Provincial Hospital
- □ Director, Provincial Preventative Health Center
- □ Expert, Social Diseases Division, Provincial Preventative Health Center
- □ Director, Provincial Medical Secondary School
- □ Project Manager, UNFPA Project
- □ Project Assistant, UNFPA Project
- □ Director (2), Commune Health Center (CHC)
- □ Director, Provincial Health Education and Promotion Center
- □ Representative, Youth Union, Hoa Binh Province
- □ Representative, Peasants Union, Hoa Binh Province
- □ Representative, Women's Union, Hoa Binh Province
- □ JOCVs (2: Rural Development and Public Health), HBPHS

Project Selection Stage (3 September 2003):

- □ Director, HBPHS
- □ Deputy Director, HBPHS
- □ Chief, Human Resources and Training, HBPHS
- □ Expert, Human Resources and Training, HBPHS
- □ Chief, Medical Professional Department, HBPHS
- □ Deputy Chief, Medical Professional Department, HBPHS
- □ Chief, Planning Department, HBPHS
- □ Director, Hoa Binh Provincial Hospital
- □ Deputy Director, Hoa Binh Provincial Hospital
- □ Director, Provincial Health Education and Promotion Center
- □ Director, Bach Mai Hospital
- □ Chief, Direction Office for Healthcare Activities, Bach Mai Hospital
- □ Vice Director, Culture and Social Affairs, HBPPC
- □ Expert, Culture and Social Affairs, HBPPC
- □ Team Leader, Preparatory Study Team
- □ Senior Project Formulation Adviser, JICA Viet Nam Office
- □ Participatory Planning, Preparatory Study Team
- □ JOCV (Rural Development, Public Health), HBPHS

Planning Stage (9~10 September 2003):

- □ Same as the above "Analytical Stage"
- □ Director, International Cooperation Dept., Ministry of Health
- □ Senior Project Formulation Adviser, JICA Viet Nam Office
- □ Program Officer, Medical Cooperation Dept., JICA Hdqrs. (Preparatory Team)
- □ Chief, DOHA, Bach Mai Hospital
- □ DOHA Officers, Bach Mai Hospital

Annex 3: Participatory Planning Workshop Results

1-2. Stakeholders Analysis

In the Stakeholders Analysis session, issues and problems, as they relate to health conditions of the target area, were identified through the analysis of the local residents targeted for assistance, related groups and related organizations and agencies. The framework of the cooperation provided by the Medical Cooperation Department of the JICA Headquarters was presented to the participants, as shown below.

FRAMEWORK FOR THE COOPERATION

1) A pilot project to strengthen healthcare services provision at provincial levels and below, for the purpose of improving health status of residents, especially those who are disadvantaged, in the Northern part of Viet Nam. Thus, this pilot project should:
   - Consider cost implications for replication;
   - Respond to wider situational issues/needs of the health sector applicable to other Provinces; and,
   - Require active involvement of Provincial administration, namely, of the Provincial People's Committee as well as the Provincial Health Service.
2) Cooperation period is within five (5) years.
3) Cooperation with the Bach Mai Hospital is considered if demands for such collaboration are perceived to be efficient and effective.
4) Combinations of different schemes as inputs of the Project can be considered based on the fair assessment of perceived local needs.
5) As there are planned and on-going Projects in the health sector supported by other donor agencies, namely, ADB Rural Health Project and UNFPA Program in Hoa Binh Province, linkage/relationships with those Project, in terms of sharing of objectives, managerial/ operational collaboration and/or coordination need to be clearly defined and agreed upon.

Participants were then asked to enumerate stakeholders in the Province that they thought were related to the planned interventions. Those stakeholders were categorized in accordance with how they relate to the planned Project, into five (5) groups: (1) Beneficiaries of the Project; (2) Implementing Agencies; (3) Decision Makers; (4) Funding Agencies; and, (5) Cooperating Agencies.

Among them, three stakeholders, namely, 1) residents of Hoa Binh Province as Beneficiary; 2) the Hoa Binh Provincial Health Service as Implementer and Beneficiary; and, 3) medical and technical professionals in the Provincial health system as Beneficiary, are suggested as principal items for further analyses (= Detailed Analyses) by the facilitator, which was then agreed upon among the participants.

Results of the Stakeholders Analyses, including the Detailed Analyses for the three principal stakeholders, are provided in the boxes below.

Annex 3: Participatory Planning Workshop Results

RESULT OF THE STAKEHOLDERS ANALYSIS (1)

BENEFICIARIES	IMPLEMENTING AGENCIES	DECISION MAKERS	FUNDING AGENCIES	COOPERATING AGENCIES
Medical Professionals at Different Levels	Hoa Binh Provincial Health Service	Hoa Binh Province People's Committee	JICA	Hoa Binh Health Information and Education Office
Residents of Hoa Binh Province	Hoa Binh Provincial Medical School	Hoa Binh Provincial Health Service	Hoa Binh Province People's Committee	Women's Union
Women and Children	Provincial General Hospital	Ministry of Health		Farmers Union at Each Level
Concerned Agencies at Provincial Level	District Health Centers	Ministry of Planning and Investment		Youth Union
Health Management Staff at Each Level	Commune Health Center	Ministry of Finance		Hoa Binh Department of Finance
Poor Residents in Rural Areas	Preventative Health Center			Hoa Binh Dept. of Planning&Investment
Ethnic Minorities in Hoa Binh Province	Provincial MCH/FP Center			
Children under 5 years old				
Married Women between 15 ~ 49 yrs.				

Annex 3: Participatory Planning Workshop Results

STAKEHOLDERS ANALYSIS [DETAILED ANALYSIS 1]

DETAILED ANALYSIS	Residents in Hoa Binh Province			
BASIC INFORMATION CHARACTERISTICS	40% of farmers in rural areas are poor	Living conditions are difficult.	Residents are hardworking.	85% live in rural areas.
	Maintaining traditional (obsolete) customs.	112 out of 214 communes are especially in difficulty.	Gaps among people in the levels of knowledge.	Population varies from time to time.
	Some are rich while others are poor.	Most of children are thin.	Many women work outside the house.	Households live a bit far from each other.
	Knowledge level is low.	Average income level is low.	Difficult to promote scientific/ technical knowledge in rural	75%(?) not covered by the health insurance scheme.
PROBLEMS	Too busy working to take care of their health matters.	Maternal Mortality Rate is high 100/100,000 live births.	>38% is malnurished among <5 children.	Poor people yet have access to medical/health services.
	Many has to be referred to central-level hospitals.	High abortion rate among women <18 years.	>60% of pregnant women suffer from anemia.	
INTERESTS NEEDS	Stabilisation of population (in number)	Increased knowledge on health and sanitation among residents.	Promotion of scientific/ technical knowledge in rural areas.	Improved living conditions through increased income.
	Health education on pregnancy for under-20s.	Pregnant women receive care before, during and after delivery.	Provision of healthcare services are provided equally to all.	Decrease poverty rate.
	Children receive sufficient care (from family members).	Increase levels of knowledge among residents.		

STAKEHOLDERS ANALYSIS [DETAILED ANALYSIS 2]

DETAILED ANALYSIS	Hoa Binh Provincial Health Service			
BASIC INFORMATION CHARACTERISTICS	Authority of provincial health institutions	Recieves technical advisory from MoH	Responsible for provincial health and medical services	
	Advises People's Committee on matters relating to Health /Medicine	Receives admin. advisory from People's Committee	Resides in mountanous areas where enthnic minority lives	
PROBLEMS	Located alongside with main street (noisy and dustry environ.)	Short in PhD level specialists	Yet to receive training in foreign countries.	50% of the staff in So Y Te yet to receive management training
	Unable to conduct research in specialised topics (due to $)	70% of staff in So Y Te cannot speak foreign language	Shortage in equipment such as projector	
	Weak in capacity among staff	Management and technical knowledge not enough	Shortage in staff (currently 25, need 7~8 more)	
INTERESTS NEEDS	Training in academic degree programme	Foreign Language Education	Training in specialised fields	Managerial staff to be trained abroad
	Structural improvement of organisation for less bureaucratic ...	... requirements and efficient/effective management	Training in management	

Annex 3: Participatory Planning Workshop Results

STAKEHOLDERS ANALYSIS [DETAILED ANALYSIS 3]

DETAILED ANALYSIS	Medical/Technical Professional Staff			
BASIC INFORMATION CHARACTERISTICS	Professional Nurse (Cu Nhan Dieu Duong)	Mid wives	Hamlet Health Workers	Doctors University + (Tien Sy. Tac Sy. BS I. II)
	Shortage of staff	Lacking in Medical Technical Training	Assistant Doctors (Y Sy)	Doctors (Bac Sy)
	Weak in specialised knowledge/skills	Technical skill not up to the level required.	Not adequately distributed at each level.	# of BS not reached the target (4.0/10.000=short 0.5)
PROBLEMS	Current staff not having specialty training.	Lack of opportunities in retraining .	Shortage in medical staff.	Short in management knowledge/skills.
	Infrastructure to villages very weak. difficult to do outreach.	Salary is the second lowest of all the civil servants.	Short in specialised knowledge.	
	Bad working environment at work.	Shortage of necessary medical equipment.	Hoa Binh Department of Planning and Investment	
INTERESTS NEEDS	Training in masters and PhD levels	Foreign Language Education	Training in specialised knowledge	
	Training of Hamlet Health Workers	Specialty Training for Bac Sy and Y Sy (General Doctors)	Continuing Education	

Upon completion of the above analyses, discussion took place to tentatively determine the Project's target group, i.e. "the principal group for which positive changes are intended as a result of the project implementation." A couple of suggestions were raised and discussed, including the HBPHS, medical and technical professionals, the Provincial Medical Schools, and the residents of Hoa Binh Province. Some insisted that the Provincial Hospital should be the target group, as the content of the Request Document was specific enough (i.e. to strengthen the functions of the Hoa Binh Provincial Hospital), while others said that the residents should be selected as the improved services were to benefit them. As consensus was difficult to be reached, the facilitator advised the group not to be too presumptive or narrow in scope at this fist analytical stage, and suggested to take the target group that would enable analyses of the problems of more than one stakeholder. The participants agreed to tentatively select "residents in Hoa Binh Province" as the target group.

1-3. Problems/Objectives/Alternatives Analysis

The next step was the analysis on the existing problems that affect the target group (i.e. the residents) in the target area (i.e. Hoa Binh Province). In this stage, problem statements written in the cards were arranged in the form of a tree that showed the cause and effect relationships among them.

Deciding the Core Problem reached a stalemate and several exchanges of inconclusive statements, basically having repeated the same lines of discussion as when the group had tried selecting the target group. Participants were reminded that they had selected the residents in Hoa Binh Province in the previous session and not a particular group, and that they were to select the problem which overarched different issues and which would allow a scope of analysis wide enough (but within the given framework). After some discussions, "Health status of the residents is low among Hoa Binh residents," was selected as the Core Problem, over many other suggestions, including "MMR is too high," "Children are malnourished," "Injuries due to traffic accidents are increasing," "Residents do not use toilets,"

"Residents do not have knowledge on health matters," "Residents do not have access to healthcare services," "Pregnant women do not come to health facilities," "Home delivery is too high," "TT2 immunization rate is low among women," and, "Medical and technical professionals do not have enough skills." The reasons of why several cards focused on reproductive health issues, or problems of pregnant women and newborns/children, might be explained as sensitization effects from the on-going UNFPA Project in the Province and its preceding planning process.

Selection of the Core Causes also took some time. In the end, consensus was reached with seven (7) causes. Participants did not see cause-effect relationships among the seven statements suggested as Direct Causes despite several attempts to probe into the point. Instead, the whole group seemed quite satisfied with the results. The task to *further develop the Problem Tree* was assigned to the group work: One group consisting mainly of the HBPHS dealt with issues relating to health administration; the second group consisting mainly of medical and technical professionals (doctors, nurses, technicians, and hospital administrative staff) dealt with issues relating to quality of (curative) health services; and the third group, quite mixed group representing the mass organizations, CHCs and DHCs, technical and administrative staff in the preventative health branch, and the UNFPA Project staff, analyzed issues relating to residents' knowledge and behavior.

The Problems Tree was then transformed into the *Objectives Tree*, visualizing the ends and means relationship of each objective. The Result of this analysis (i.e. Objectives Tree) is attached in the following pages.

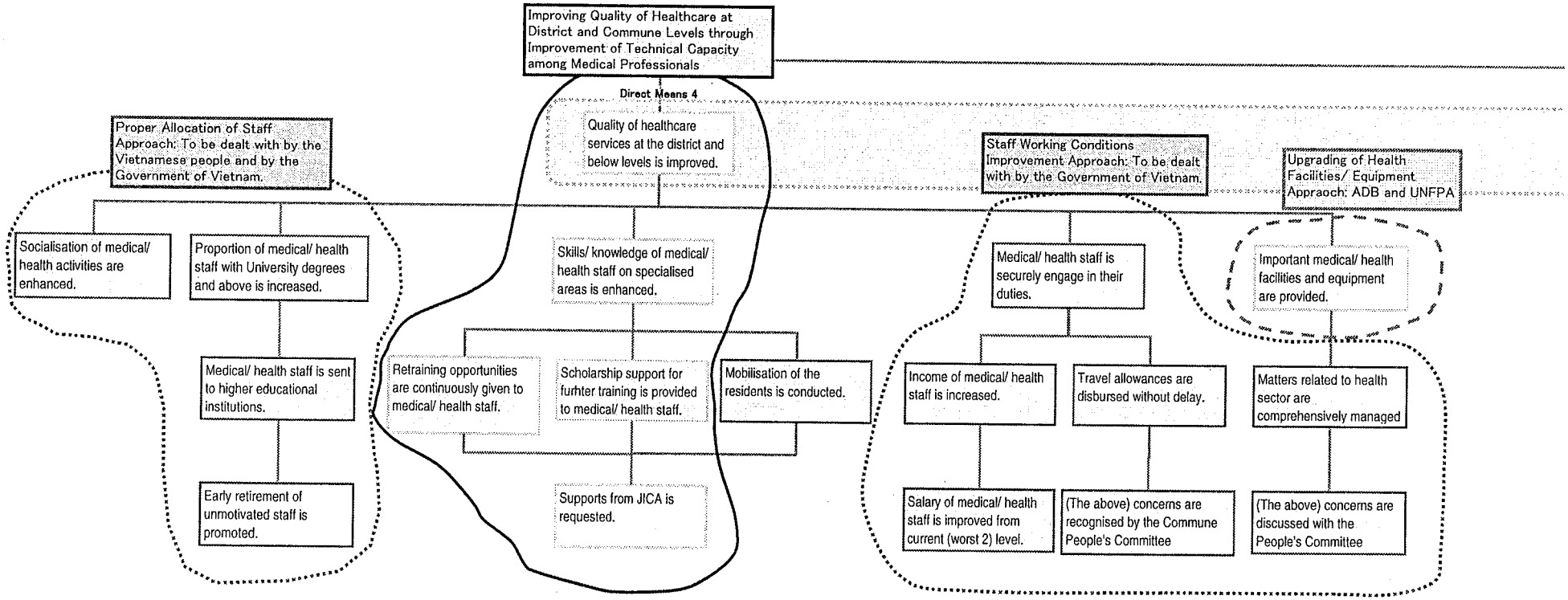
1-4. Alternatives Analysis

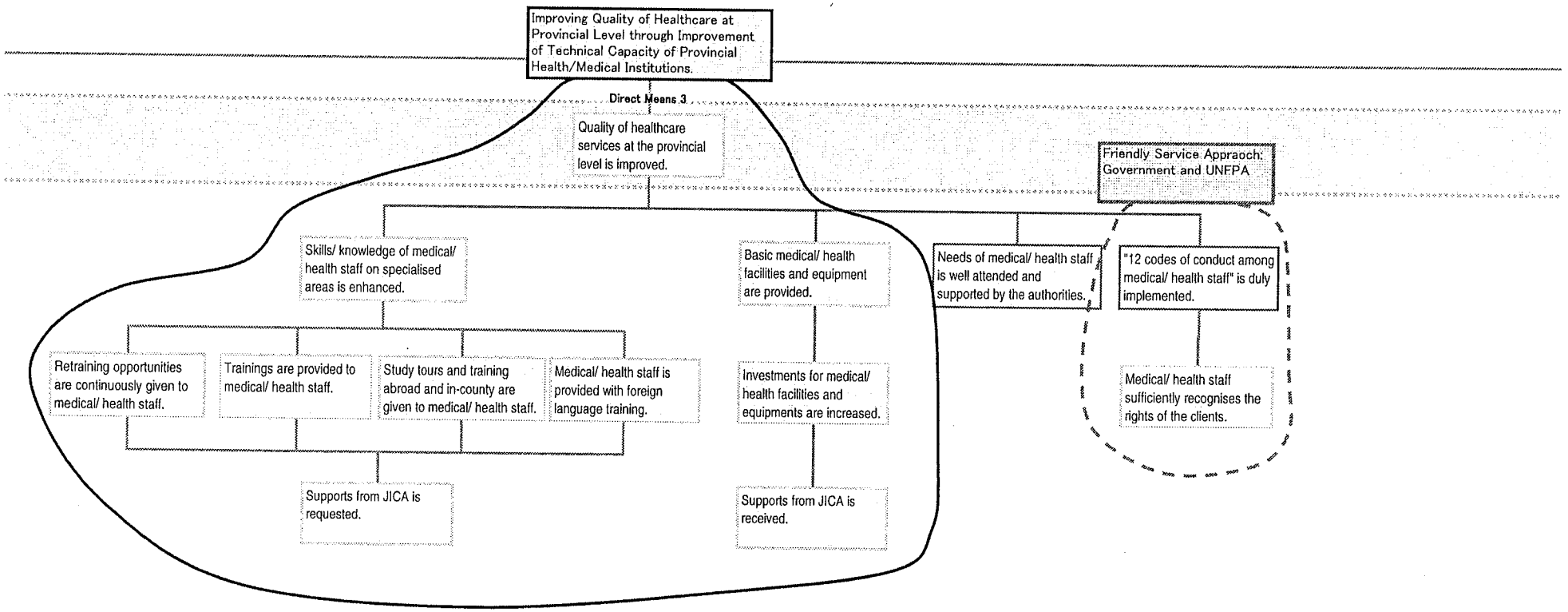
Alternative Analysis is a process in which specific project strategies, or approaches are identified among objectives and means raised in Objectives Analysis. Different strategies are then scrutinized in reference to selection criteria, to provide the information base for subsequent decision-making process, i.e. the Project Selection session.

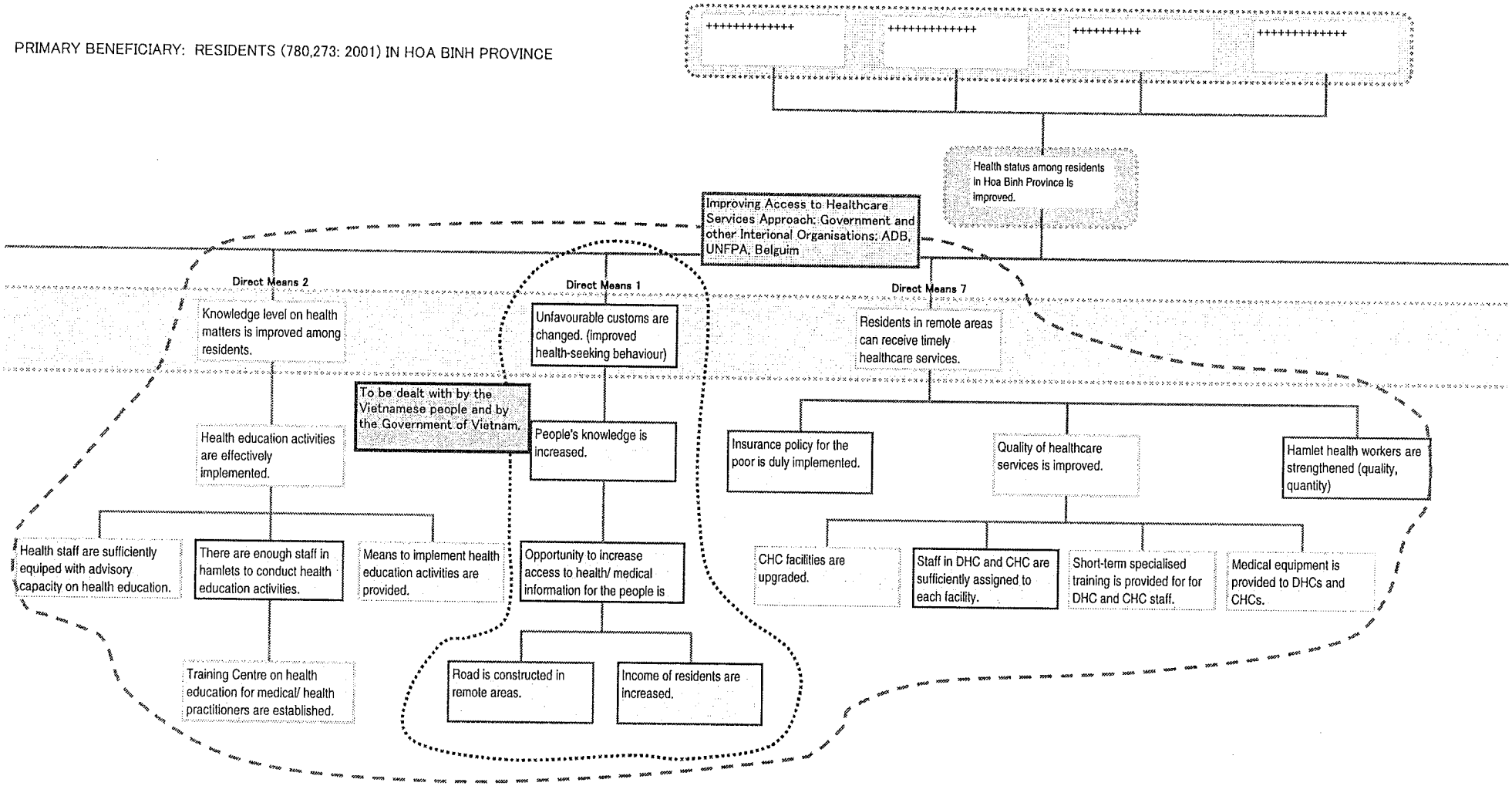
Participants were first asked to *identify the branch(es) of the Tree that have been and/or will be covered by the Projects supported by other donor agencies*, including the ones of UNFPA and ADB (Circled with green, rough-broken lines in the Tree Diagram). In this process, participants took initiative in also identifying some of the issues that were beyond the responsibility of foreign agencies, and/or the issues that were already taken up by GOV (Circled with red, fine-broken lines in the Tree Diagram, or cards marked with the red siege).

The participants also circled the branches that they wished to be covered by JICA (Circled with blue, solid lines in the Tree Diagram). They were: 1) Provincial Medical and Technical Capacity Enhancement Approach; 2) DHC/CHC Technical Capacity Enhancement Approach; and, 3) Management Capacity Building of Health Leaders Approach. Participants claimed that other Direct Means were covered either by GOV and by UNFPA, ADB and potentially the Belgium Technical Cooperation, while quality improvement of curative care services, both at the provincial levels and below, left unattended and undermined. Strengthening of the health administration was also raised as an essential and necessary component to improve the health system as a whole.

The above process proceeded without delay or incongruities. The group was then divided into the same three sub-groups and performed the further analyses of the three selected approaches, in order to clarify the contents and its characteristics of each approach for subsequent assessment of its feasibility. The result of the analysis, although with limited scrutiny due to the lack of time, was summarized in a table format attached in the following pages.


Improving Quality of Healthcare at District and Commune Levels through Improvement of Technical Capacity among Medical Professionals
Direct Means 4
Quality of healthcare services at the district and below levels is improved.
Proper Allocation of Staff Approach: To be dealt with by the Vietnamese people and by the Government of Vietnam.
Staff Working Conditions Improvement Approach: To be dealt with by the Government of Vietnam.
Upgrading of Health Facilities/ Equipment Appraoch: ADB and UNFPA
Socialisation of medical/ health activities are enhanced.
Proportion of medical/ health staff with University degrees and above is increased.
Medical/ health staff is sent to higher educational institutions.
Early retirement of unmotivated staff is promoted.
Skills/ knowledge of medical/ health staff on specialised areas is enhanced.
Retraining opportunities are continuously given to medical/ health staff.
Scholarship support for furhter training is provided to medical/ health staff.
Mobilisation of the residents is conducted.
Supports from JICA is requested.
Medical/ health staff is securely engage in their duties.
Important medical/ health facilities and equipment are provided.
Income of medical/ health staff is increased.
Travel allowances are disbursed without delay.
Matters related to health sector are comprehensively managed
Salary of medical/ health staff is improved from current (worst 2) level.
(The above) concerns are recognised by the Commune People's Committee
(The above) concerns are discussed with the People's Committee


Improving Quality of Healthcare at Provincial Level through Improvement of Technical Capacity of Provincial Health/Medical Institutions.
Direct Means 3
Quality of healthcare services at the provincial level is improved.
Friendly Service Appraoch: Government and UNFPA
Skills/ knowledge of medical/ health staff on specialised areas is enhanced.
Basic medical/ health facilities and equipment are provided.
Needs of medical/ health staff is well attended and supported by the authorities.
"12 codes of conduct among medical/ health staff" is duly implemented.
Retraining opportunities are continuously given to medical/ health staff.
Trainings are provided to medical/ health staff.
Study tours and training abroad and in-county are given to medical/ health staff.
Medical/ health staff is provided with foreign language training.
Investments for medical/ health facilities and equipments are increased.
Medical/ health staff sufficiently recognises the rights of the clients.
Supports from JICA is requested.
Supports from JICA is received.


PRIMARY BENEFICIARY: RESIDENTS (780,273: 2001) IN HOA BINH PROVINCE
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++++++++++++
++++++++++
++++++++++++
Health status among residents in Hoa Binh Province is improved.
Improving Access to Healthcare Services Approach: Government and other Interional Organisations: ADB, UNFPA, Belguim
Direct Means 2
Direct Means 1
Direct Means 7
Knowledge level on health matters is improved among residents.
Unfavourable customs are changed. (improved health-seeking behaviour)
Residents in remote areas can receive timely healthcare services.
To be dealt with by the Vietnamese people and by the Government of Vietnam.
Health education activities are effectively implemented.
People's knowledge is increased.
Insurance policy for the poor is duly implemented.
Quality of healthcare services is improved.
Hamlet health workers are strengthened (quality, quantity)
Health staff are sufficiently equiped with advisory capacity on health education.
There are enough staff in hamlets to conduct health education activities.
Means to implement health education activities are provided.
Opportunity to increase access to health/ medical information for the people is
CHC facilities are upgraded.
Staff in DHC and CHC are sufficiently assigned to each facility.
Short-term specialised training is provided for for DHC and CHC staff.
Medical equipment is provided to DHCs and CHCs.
Training Centre on health education for medical/ health practitioners are established.
Road is constructed in remote areas.
Income of residents are increased.

DIRECT ENDS

CORE OBJECTIVE

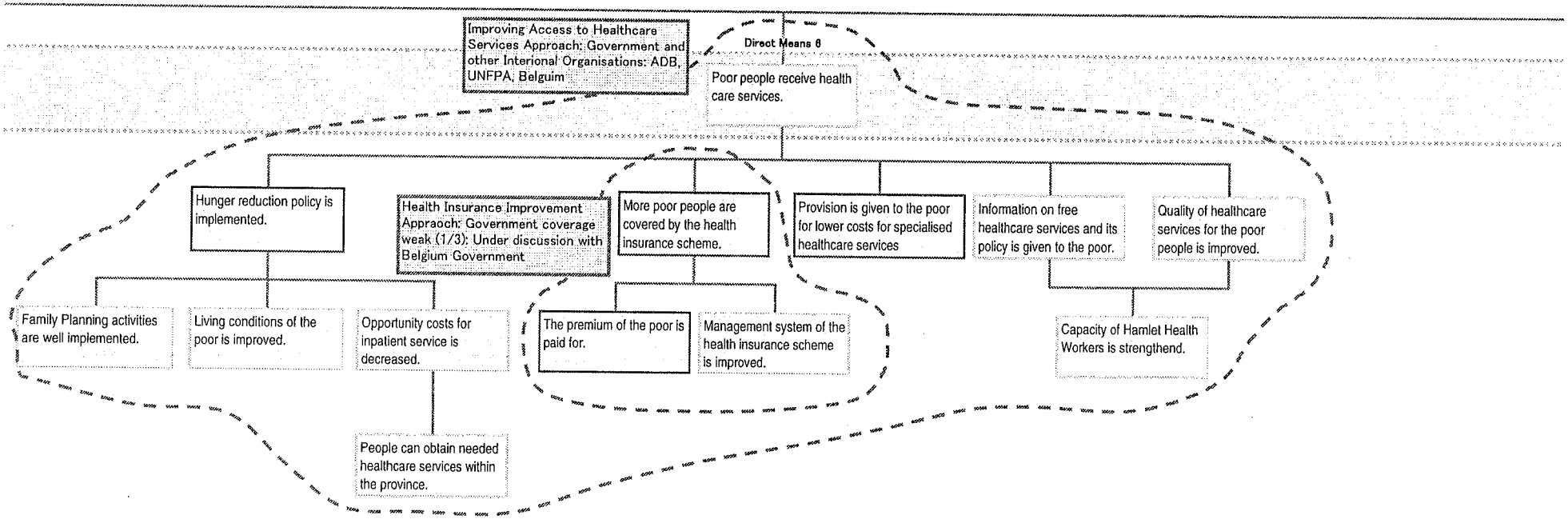
DIRECT MEANS

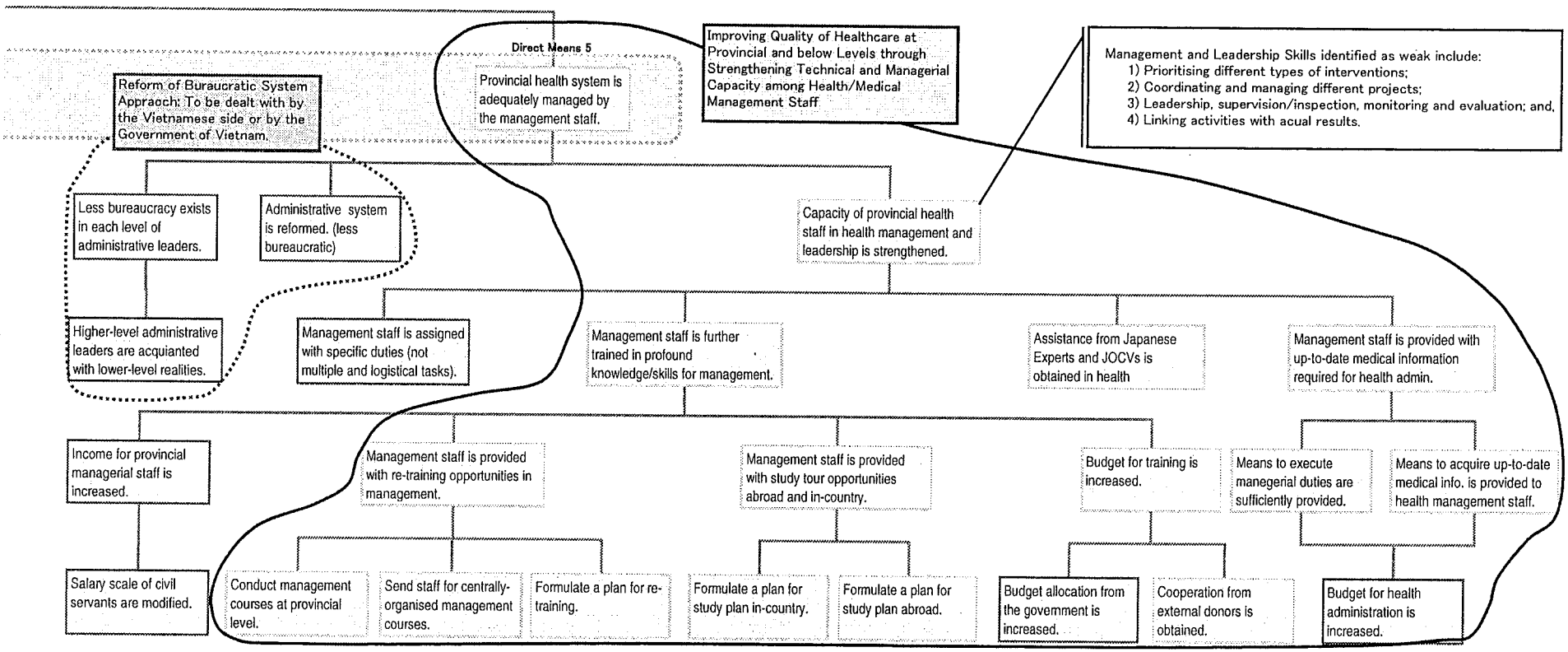
Matters identified to be dealt with by Vietnamese Side, or Vietnamese Government. +++++++

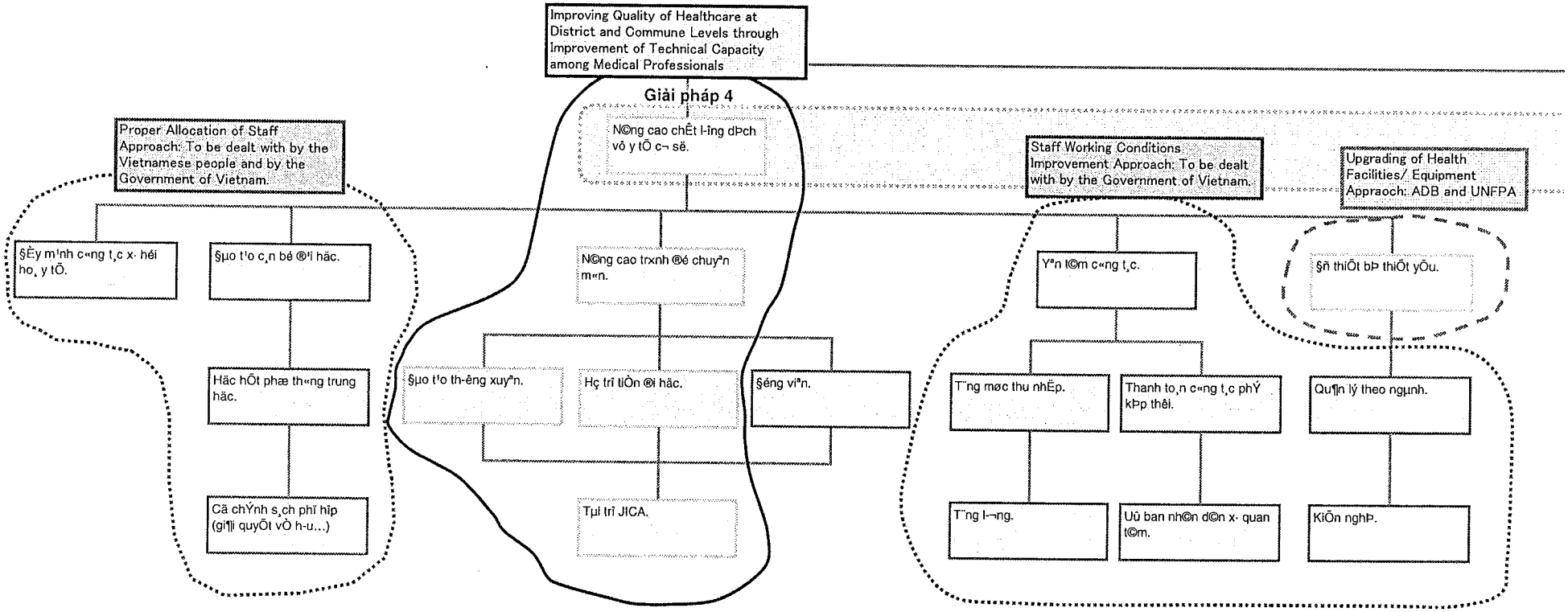
Approach(es) identified to be dealt with by ADB, UNFPA or Belgium government. +++++++

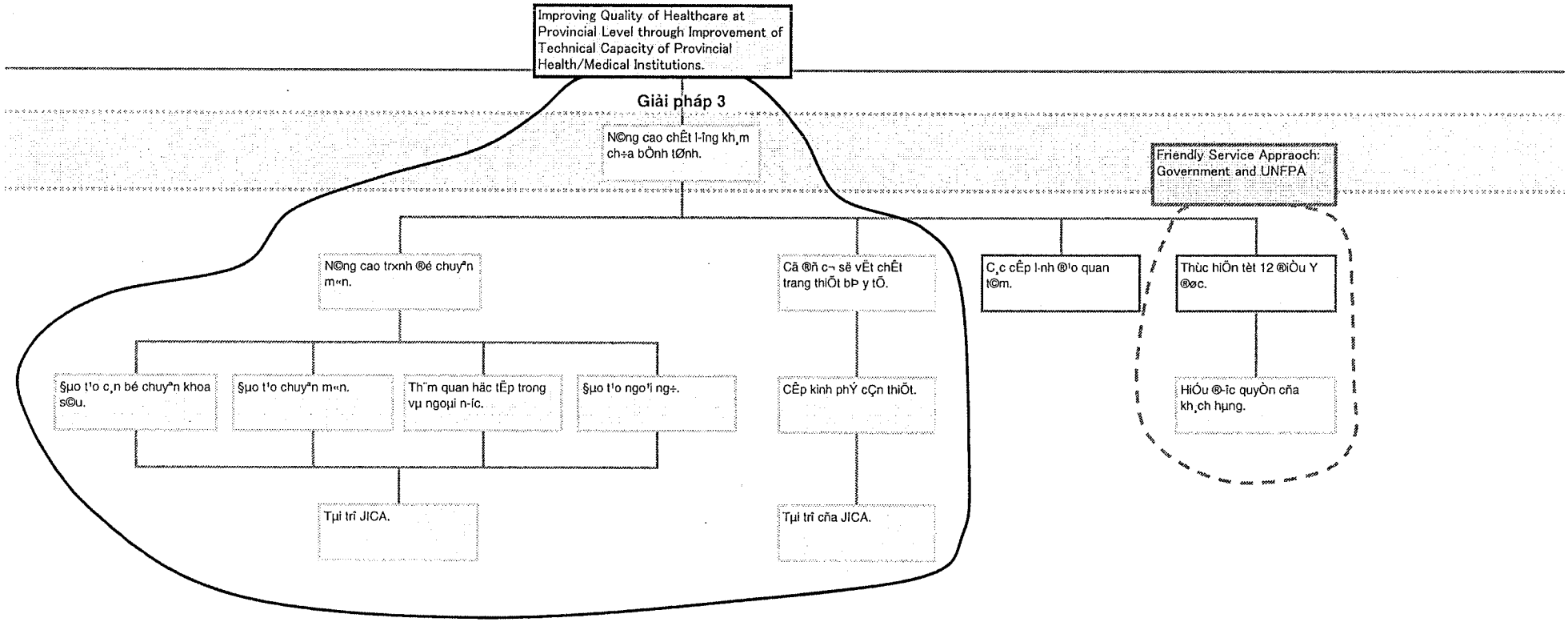
Approach(es) identified to be dealt with by Vietnamese Side, or Vietnamese Government. +++++++

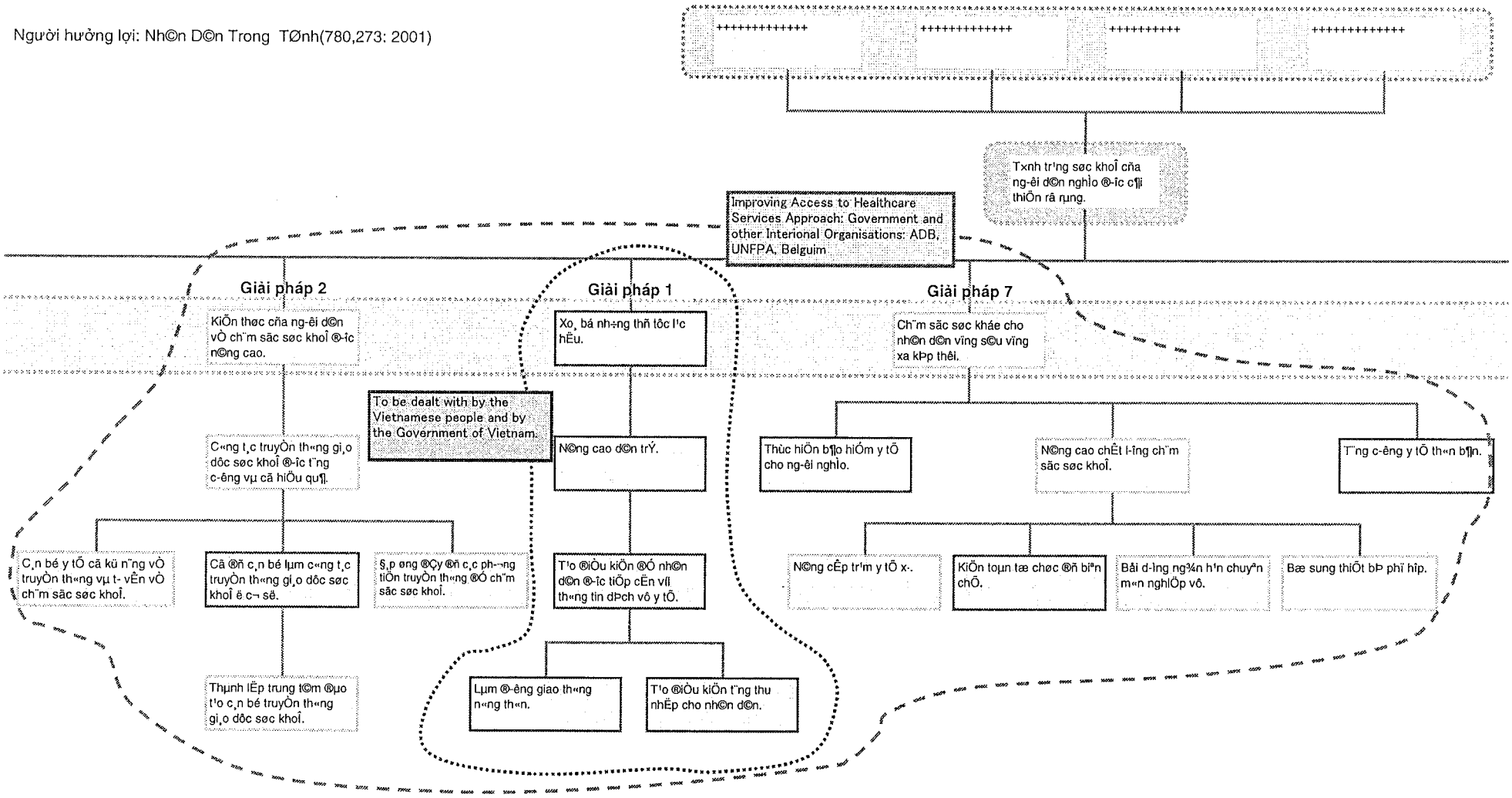
Approach(es) identified as not being dealt with as yet and thus to be analysed its feasibility to be assisted by JICA.. +++++++




Direct Means 5
Improving Quality of Healthcare at Provincial and below Levels through Strengthening Technical and Managerial Capacity among Health/Medical Management Staff
Management and Leadership Skills identified as weak include:
1) Prioritising different types of interventions;
2) Coordinating and managing different projects;
3) Leadership, supervision/inspection, monitoring and evaluation; and,
4) Linking activities with acual results.
Reform of Buraucratic System Appraoch: To be dealt with by the Vietnamese side or by the Government of Vietnam.
Provincial health system is adequately managed by the management staff.
Less bureaucracy exists in each level of administrative leaders.
Administrative system is reformed. (less bureaucratic)
Capacity of provincial health staff in health management and leadership is strengthened.
Higher-level administrative leaders are acquianted with lower-level realities.
Management staff is assigned with specific duties (not multiple and logistical tasks).
Management staff is further trained in profound knowledge/skills for management.
Assistance from Japanese Experts and JOCVs is obtained in health
Management staff is provided with up-to-date medical information required for health admin.
Income for provincial managerial staff is increased.
Management staff is provided with re-training opportunities in management.
Management staff is provided with study tour opportunities abroad and in-country.
Budget for training is increased.
Means to execute managerial duties are sufficiently provided.
Means to acquire up-to-date medical info. is provided to health management staff.
Salary scale of civil servants are modified.
Conduct management courses at provincial level.
Send staff for centrally-organised management courses.
Formulate a plan for re-training.
Formulate a plan for study plan in-country.
Formulate a plan for study plan abroad.
Budget allocation from the government is increased.
Cooperation from external donors is obtained.
Budget for health administration is increased.


Improving Quality of Healthcare at District and Commune Levels through Improvement of Technical Capacity among Medical Professionals
Giải pháp 4
Proper Allocation of Staff Approach: To be dealt with by the Vietnamese people and by the Government of Vietnam.
N©ng cao chÊt l-îng dÞch vô y tÕ c¬ së.
Staff Working Conditions Improvement Approach: To be dealt with by the Government of Vietnam.
Upgrading of Health Facilities/ Equipment Appraoch: ADB and UNFPA
§Èy m¹nh c«ng t¸c x· héi ho¸ y tÕ.
§µo t¹o c¸n bé ®¹i häc.
N©ng cao trxnh ®é chuy³n m«n.
Y³n t©m c«ng t¸c.
§ñ thiÕt bÞ thiÕt yÕu.
Häc hÕt phæ th«ng trung häc.
§µo t¹o th-êng xuy³n.
Hç trî tiÕn ®i häc.
§éng vi³n.
T¨ng møc thu nhËp.
Thanh to¸n c«ng t¸c phÝ kÞp thêi.
Qu¶n lý theo ngµnh.
Cã chÝnh s¸ch phï hîp (gi¶i quyÕt vÒ h-u...)
Tµi trî JICA.
T¨ng l-¬ng.
Uû ban nh©n d©n x· quan t©m.
KiÕn nghÞ.


Improving Quality of Healthcare at Provincial Level through Improvement of Technical Capacity of Provincial Health/Medical Institutions.
Giải pháp 3
N©ng cao chÊt l-îng kh¸m ch÷a bÖnh tØnh.
Friendly Service Appraoch: Government and UNFPA
N©ng cao trxnh ®é chuy¶n m«n.
Cã ®ñ c¬ së vËt chÊt trang thiÕt bÞ y tÕ.
C¸c cÊp l-nh ®¹o quan t©m.
Thùc hiÖn tèt 12 ®iÒu Y ®øc.
§µo t¹o c¸n bé chuy¶n khoa s©u.
§µo t¹o chuy¶n m«n.
Th¨m quan häc tÊp trong vµ ngoµi n-íc.
§µo t¹o ngo¹i ng÷.
CÊp kinh phÝ cÇn thiÕt.
HiÓu ®-îc quyÒn cña kh¸ch hµng.
Tµi trî JICA.
Tµi trî cña JICA.


Người hưởng lợi: Nh©n D©n Trong TØnh(780,273: 2001)
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Txnh tr¹ng søc khoÎ cña ng-êi d©n nghÌo ®-îc c¶i thiÖn rã rµng.
Improving Access to Healthcare Services Approach: Government and other Interional Organisations: ADB, UNFPA, Belguim
Giải pháp 2
Giải pháp 1
Giải pháp 7
KiÖn thøc cña ng-êi d©n vÒ ch¨m sãc søc khoÎ ®-îc n©ng cao.
Xo¸ bá nh÷ng thñ tôc l¹c hËu.
Ch¨m sãc søc khác cho nh©n d©n vïng s©u vïng xa kÞp thêi.
To be dealt with by the Vietnamese people and by the Government of Vietnam.
C«ng t¸c truyÒn th«ng gi¸o dôc søc khoÎ ®-îc t¨ng c-êng vµ cã hiÖu qu¶.
N©ng cao d©n trÝ.
Thùc hiÖn b¶o hiÓm y tÕ cho ng-êi nghÌo.
N©ng cao chÊt l-îng ch¨m sãc søc khoÎ.
T¨ng c-êng y tÕ th«n b¶n.
C¸n bé y tÕ cã kü n¨ng vÒ truyÒn th«ng vµ t- vÊn vÒ ch¨m sãc søc khoÎ.
Cã ®ñ c¸n bé lµm c«ng t¸c truyÒn th«ng gi¸o dôc søc khoÎ ë c¬ së.
§¸p øng ®Çy ®ñ c¸c ph¬ng tiÖn truyÒn th«ng ®Ó ch¨m sãc søc khoÎ.
T¹o ®iÒu kiÖn ®Ó nh©n d©n ®-îc tiÕp cËn víi th«ng tin dÞch vô y tÕ.
N©ng cÊp tr¹m y tÕ x·.
KiÖn toµn tæ chøc ®ñ bi¤n chÕ.
Bải d-ìng ng¾n h¹n chuy¤n m«n nghiÖp vô.
Bæ sung thiÕt bÞ phï hîp.
Thµnh lËp trung t©m ®µo t¹o c¸n bé truyÒn th«ng gi¸o dôc søc khoÎ.
Lµm ®-êng giao th«ng n«ng th«n.
T¹o ®iÒu kiÖn t¨ng thu nhËp cho nh©n d©n.

DIRECT ENDS

CORE OBJECTIVE

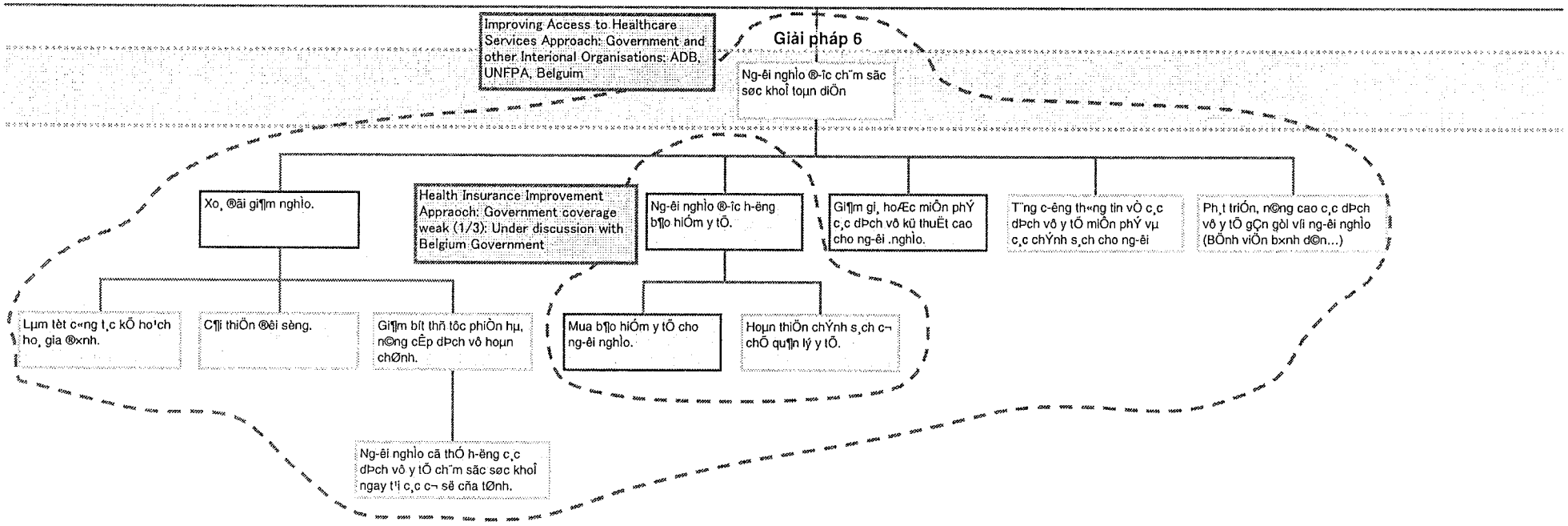
DIRECT MEANS

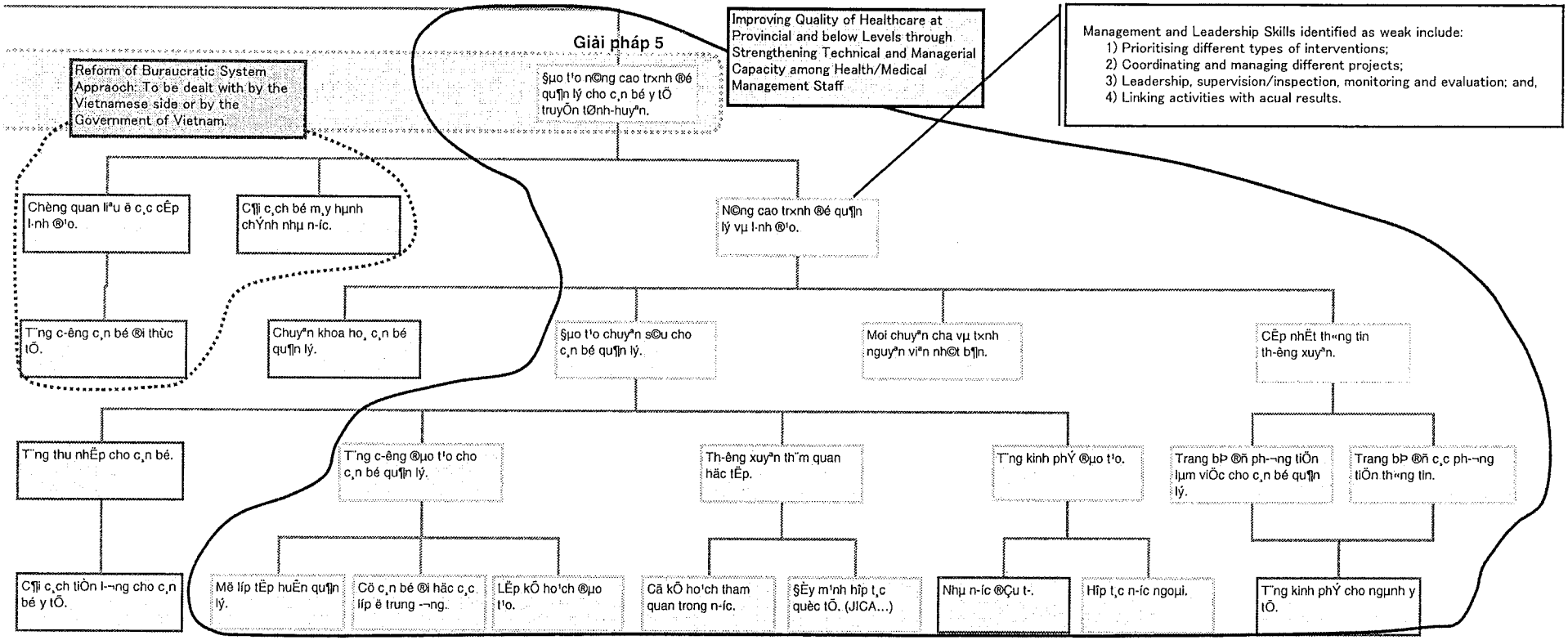
Matters identified to be dealt with by Vietnamese Side, or Vietnamese Government.

Approach(es) identified to be dealt with by ADB, UNFPA or Belgium government.

Approach(es) identified to be dealt with by Vietnamese Side, or Vietnamese Government.

Approach(es) identified as not being dealt with as yet and thus to be analysed its feasibility to be assisted by JICA..




Giải pháp 5
Improving Quality of Healthcare at Provincial and below Levels through Strengthening Technical and Managerial Capacity among Health/Medical Management Staff
Management and Leadership Skills identified as weak include:
1) Prioritising different types of interventions;
2) Coordinating and managing different projects;
3) Leadership, supervision/inspection, monitoring and evaluation; and,
4) Linking activities with acual results.
Reform of Buraucratic System Appraoch: To be dealt with by the Vietnamese side or by the Government of Vietnam.
§µo t¹o n©ng cao trxnh ®é qu¶n lý cho c¸n bé y tÕ truyÒn tØnh-huyÖn.
Chèng quan liªu ë c¸c cÊp l·nh ®¹o.
C¶i c¸ch bé m¸y hµnh chÝnh nhµ n-íc.
N©ng cao trxnh ®é qu¶n lý vµ l·nh ®¹o.
T¨ng c-êng c¸n bé ®i thùc tÕ.
Chuyªn khoa ho¸ c¸n bé qu¶n lý.
§µo t¹o chuyªn s©u cho c¸n bé qu¶n lý.
Moi chuyªn cha vµ txnh nguyªn viªn nh©t b¶n.
CÊp nhËt th«ng tin th-êng xuyªn.
T¨ng thu nhËp cho c¸n bé.
T¨ng c-êng ®µo t¹o cho c¸n bé qu¶n lý.
Th-êng xuyªn th¨m quan häc tËp.
T¨ng kinh phÝ ®µo t¹o.
Trang bÞ ®ñ ph-¬ng tiÖn lµm viÖc cho c¸n bé qu¶n lý.
Trang bÞ ®ñ c¸c ph-¬ng tiÖn th«ng tin.
C¶i c¸ch tiÒn l-¬ng cho c¸n bé y tÕ.
Më líp tËp huÊn qu¶n lý.
Cö c¸n bé ®i häc c¸c líp ë trung -¬ng.
LËp kÕ ho¹ch ®µo t¹o.
Cã kÕ ho¹ch tham quan trong n-íc.
§Èy m¹nh hîp t¸c quèc tÕ. (JICA...)
Nhµ n-íc ®Çu t-.
Hîp t¸c n-íc ngoµi.
T¨ng kinh phÝ cho ngµnh y tÕ.

ANNEX 3: Participatory Planning Workshop Results
1-4. Alternatives Analysis

Selection Criteria	Basic Information for Discussion		
	1) Provincial Medical/Technical Capacity Enhancement Approach	2) DCH/CHC Technical Capacity Enhancement Approach	3) Management Capacity Building of Health Leaders Approach
Target Group	Instructors and Medical Technical Staff - Medical Technical School (28) - Provincial Hospital (30 + 30) - MCH/FP Centre (20) - Preventative Health Centre (15) **TOTAL (123)**	Medical staff at District and Commume levels - DHC (10x11=110) - PKDK (2x26=52) - CHC (1x214=214) **TOTAL (374)**	Managerial staff at Provincial and District levels - Provincial People's Committee (02) - Provincial Health Service (15) - District Health Centre (33) - Other Health-related institutions @ provincial level (39) **TOTAL (90)**
Target Area(s)	Hoa Binh Province	- 11 Districts, 214 Communes in Hoa Binh	Provincial and District levels in Hoa Binh Province
Core Activities	-Re-training of Lecturers in Medical Schools - Specialised training on technical skills/ knowledge - Training in Monitoring activities - Technical Training on Pediatrics - Training in Information Technology	- Medical/Technical Training (eg. Prescribing right drugs, Intensive Care and Emergency, Nursing, Surgery, Anestetics, X-Ray)	- Enhanced training activities on management
Main Implementers	- Medical Technical Schools - Medical/ Health Personnel - Mother and Child Hospital - Staff in MCH/FP Centre	- Provincial Health Service - Medical Technical School	- Training Department of Provincial Health Service
Capacity of Implementing Agency **Possibility for Cooperation**	- Ministry of Health - Provincial Health Service - Medical Universities - Medical Technical Schools - Health-related institutions in Hoa Binh - JICA - Bach Mai Hospital - Viet Duc Hospital - Mother and Child Hospital	- Cooperation from Medical Universities and Pharmaceutical Schools - Cooperation from Bach Mai Hospital - Educational capacity of Medical Technical School not sufficient, lecturers requires training	- College of Public Health - National University of Public Administration
Likelihood of Achieving Objectives	- Possibility high	- High	- Efficient Management
Sustainability	- Possibility High, will sustain longer	- High	- Likelihood for the results to sustain is high.
Policy Priorities	- High	- Very High	- Possibly high.
Inputs	- Equipment (Ultrasound, Computer, Motercycle, other medical equipment) - Medical Technical Experts - Demo Kit of human body - Equipment for training	- Costs for training - Fees for Lecturers and Experts - Costs for study tours and visits	- Training costs - Fee for Instructors - Japanese and Vietnamese Experts - Costs for National Educational Programme - Other expenses for activities

ANNEX 3: Participatory Planning Workshop Results
1-4. Alternatives Analysis [Vietnamese]

Ti[a]u chÝ lùa chän	1) Gi¶i ph¸p N©ng cao chuy[a]n m«n tuyÕn tØnh	2) Gi¶i ph¸p N©ng cao chuy[a]n m«n tuyÕn huyÖn-x·	3) Gi¶i ph¸p N©ng cao trxnh ®é qu¶n lý l·nh ®¹o HuyÖn-TØnh
§Æc ®iÓm, Sè l-îng nhãm ®èi t-îng	123 ng-êi Gi¸o vi[a]n: 28 ng-êi; BÖnh viÖn tØnh: 30 B¸c sÜ + 30 ®iÒu d-ìng; Trung t©m Bµ mÑ trÎ em: 20 ng-êi; Trung t©m y tÕ dù phßng: 15 ng-êi **(Tæng sè: 123)**	Nh©n vi[a]n y tÕ tuyÕn huyÖn-x·: 376 ng-êi -HuyÖn : 11huyÖn x 10 ng-êi = 110 ng-êi -Phßng kh¸m khu vùc: 2 x 26 ng-êi=52ng-êi -Tr¹m x¸ x·: 214 x 1 ng-êi= 214 ng-êi **(Tæng sè: 374)**	Lµ c¸n bé qu¶n lý HuyÖn-TØnh; 90 ng-êi - Uû ban nh©n d©n tØnh: 2 ng-êi - Së y tÕ: 15 ng-êi - Trung t©m y tÕ huyÖn: 33 ng-êi - C¸c ®¬n vÞ trùc thuéc: 39 ng-êi **(Tæng sè: 90)**
Khu vùc ®èi t-îng	TuyÕn TØnh	11 huyÖn vµ 214 x·	TØnh huyÖn
Néi dung c¸c ho¹t déng chÝnh	§µo t¹o l¹i gi¸o vi[a]n: -§µo t¹o n©ng cao n¨ng lùc gi¸m s¸t -§µo t¹o nhi khoa -C¸n bé Trung t©m b¶o vÖ søc khoÎ bµ mÑ trÎ em, KÕ ho¹ch ho¸ gia ®xnh -§µo t¹o tin häc T¨ng c-êng trang thiÕt bÞ y tÕ, m« hxnh d¹y häc	§µo t¹o nh©n vi[a]n y tÕ tuyÕn huyÖn-x·: - §µo t¹o kü thuËt håi søc cÊp cøu - §µo t¹o ®iÒu d-ìng vi[a]n - §µo t¹o g©y m[a] håi søc - X-quang, xÐt nghiÖm - Sö dông thuèc an toµn, hîp lý - §µo t¹o ngo¹i ng÷	§µo t¹o n©ng cao n¨ng lùc qu¶n lý
Chñ thÓ ho¹t ®éng chÝnh	C¸c tæ bé m«n Nh©n vi[a]n y tÕ	Phßng Tæ chøc hµnh chÝnh Së y tÕ Tr-êng trung häc y tÕ	Phßng §µo t¹o Së y tÕ
Hîp t¸c víi c¸c c¬ quan chøc n¨ng, ®oµn thÓ	Bé y tÕ Së y tÕ C¸c tr-êng §¹i häc vµ tr-êng nghiÖp vô C¸c bÖnh viÖn: B¹ch Mai, ViÖt §øc, BV Nhi, 103...	C¸c tr-êng §¹i häc Y D-îc BÖnh viÖn B¹ch mai	Tr-êng §¹i häc Y tÕ c«ng céng Häc viÖn hµnh chÝnh quèc gia
Kh¶ n¨ng hoµn thµnh môc ti[a]u	Cao, tèt.	Cao	§iÒu hµnh cã hiÖu qu¶ cao
Kh¶ n¨ng ph¸t triÓn ®éc lËp	Kh¶ n¨ng cao, l©u dµi. Ngµy cµng sö dông cã hiÖu qu¶	Cao	Cã kh¶ n¨ng ph¸t triÓn bÒn v÷ng
Møc ®é -u ti[a]n vÒ mÆt chÝnh s¸ch	Cao	RÊt cao	Cao
Chñng lo¹i, Sè l-îng, ChÊt l-îng ®Çu vµo	M« hxnh gi¶i phÉu sinh lý M« hxnh ch¨m sãc toµn diÖn ThiÕt bÞ d¹y häc	C¸c trang thiÕt bÞ y tÕ Chi phÝ ®µo t¹o PhÝ c«ng t¸c Chi phÝ chuy[a]n gia Chi phÝ gi¸m s¸t	Kinh phÝ Gi¶ng vi[a]n Chuy[a]n gia Gi¸o trxnh chuÈn quèc gia C«ng t¸c phÝ

1-5. Project Selection

Upon completion of the analytical stages which came up with three potential approaches for selection, the core stakeholders and the Preparatory Study Team held several discussion sessions, following the below basic principles set by the Team.

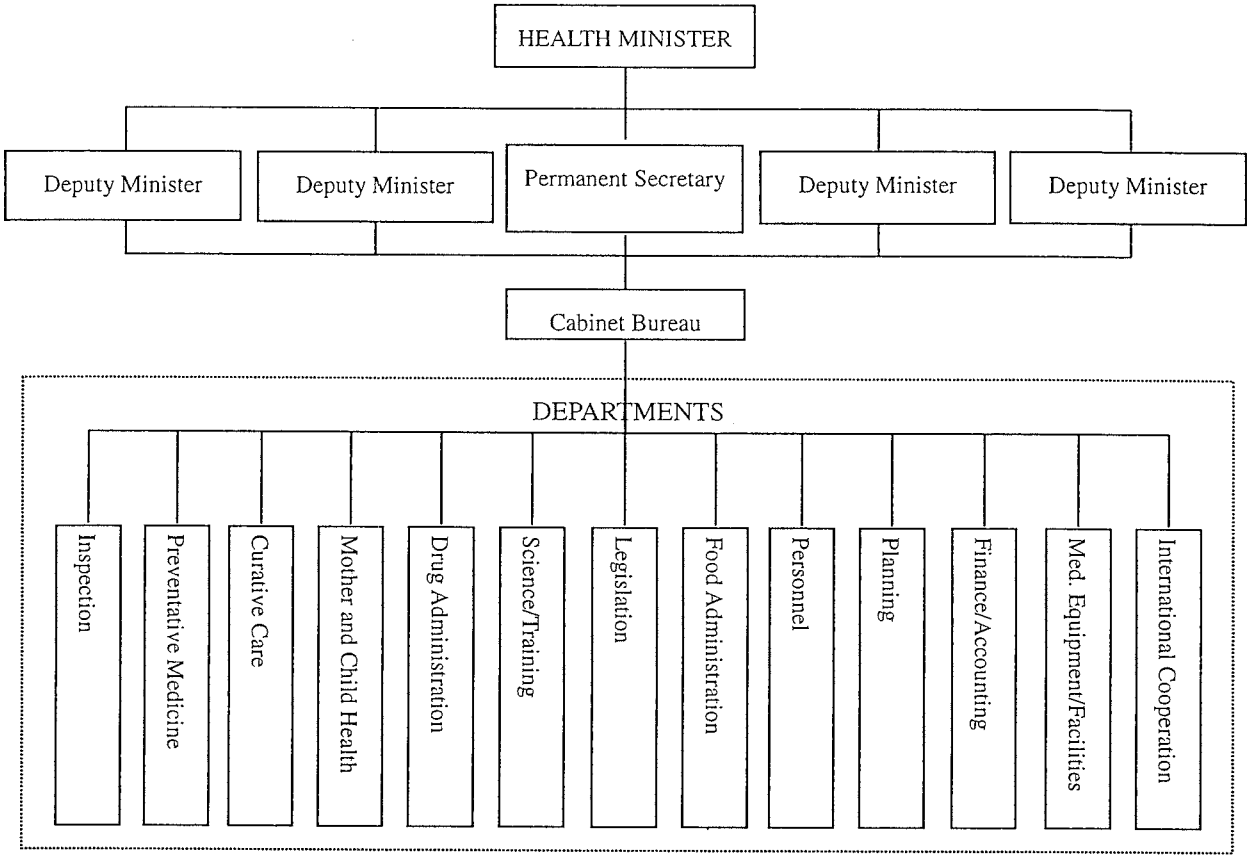
- Project duration is within five (5) years
- Project places its core on human resources development for enhancing technical capacity of institutions, and does not include large-scale investments into facilities and medical equipment
- Scope of benefits should not be limited merely to the provincial institutions, but should also include institutions under the province, i.e., district, commune and villages.
- The Vietnamese and Japanese sides jointly own the Project, building on the spirit of collaboration and mutual trust. Commitments from the national and local authorities to this Project are of great importance.
- The main components of the Project will be enhancement of medical technical capacity of curative services providers at provincial and below levels.
- The Project will pay due attention to the collaboration and coordination with other donor agencies rendering supports to the health sector, in order for the interventions to benefit the whole residents.
- The Project will restrict its technical support to essential medical services and will not extend its support to highly advanced medical technology, with the aim to focus on high-demand areas and thus to benefit larger population.
- To the extent possible, the Project will encourage utilization of local institutions and resource persons to carry out capacity building activities. Among them, technical assistance and guidance from the Bach Mai Hospital will form the large part.
- Three approaches selected in the Workshop, namely, 1) improving technical capacity of Provincial Hospital, 2) improving technical capacity of District and below levels, and, 3) improving managerial and leadership capacity of HBPHS, can all be dealt with by the Project. Weight of each approach needs to be considered to form more efficient and effective design of the Project.

Drawing from the results of the Workshop (ANNEX 1-4. Alternatives Analysis), and in line with the above basic principles, the meeting decided to include all the three approaches in the Project, albeit with differentiated emphasis. Approach (1) will obtain the most investments and training inputs, while the Approach (2) would be obtained as an outcome of Approach (1). Approach (3) is to support the Approach (1) and (2). The reasons of why all the approaches are selected draw much from the analyses conducted in the PCM Workshop. Through the Stakeholders and Problems/Objectives Analyses, the access to the health services are perceived as limited and having quality services provided at the district level and below are considered to be of great importance to the residents. Through the Problems/Objectives Analyses, interventions to strengthen the leadership and management capacity of the HBPHS are revealed crucial for the enhancement of provincial-level institutions.

Furthermore, the issue of considering health education component to be part of the Project was discussed, as the gravity of the problem, "lack of knowledge and unfavorable health-seeking behavior" pointed out in the Workshop, seemed too large to exclude. The meeting agreed that some health education components be incorporated within the selected Approaches, and collaboration with the JOCV will be sought in pursuit of the issue. To be added, in the subsequent PDM Formulation Workshop, this issue has been taken up as an independent Output of the Project.

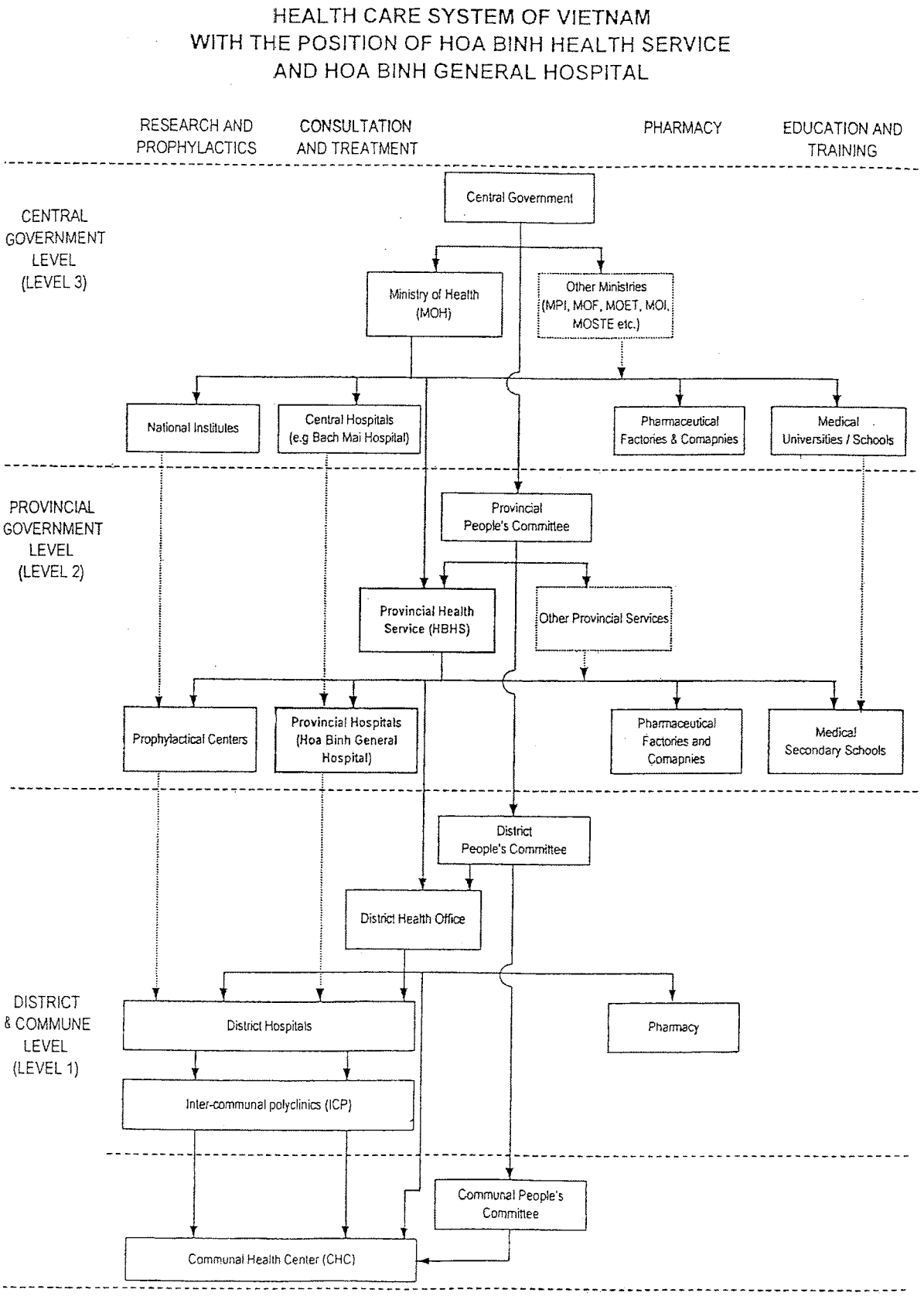
Annex 4: Organizational Chart

2-1. Ministry of Health



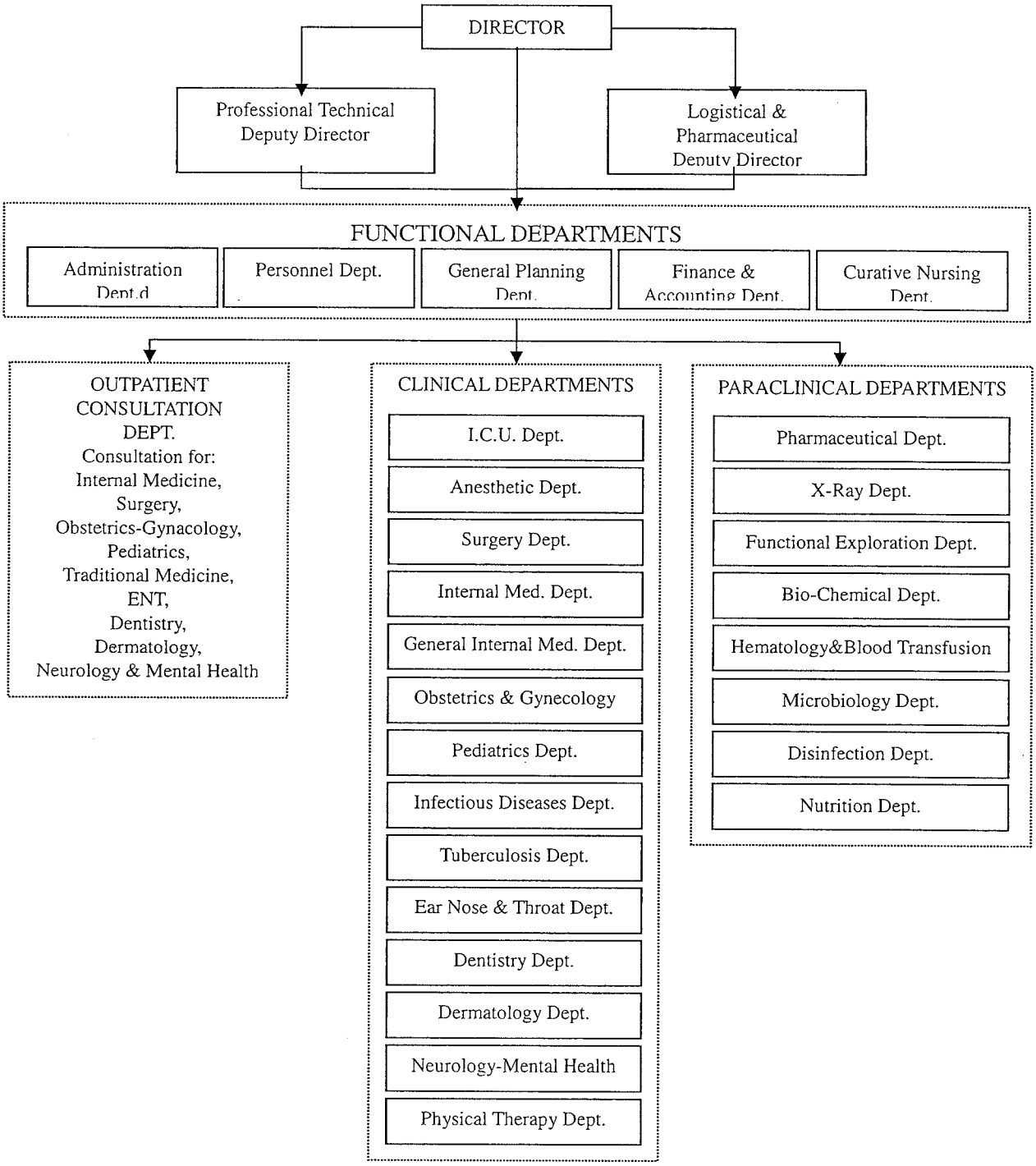
Annex 4: Organizational Chart

2-2. Hoa Binh Health Care System



Annex 4: Organizational Chart

2-3. Hoa Binh General Hospital



Source: Application for Japan Grant Aid: The Project for Improvement of Hoa Binh General Hospital, HBPPC/HBPHS, November 2002

Annex 5: List of training activities by other Projects

3-1. ADB-funded Rural Health Project

No.	Training Course	Number	Duration	Participants	Objective/Outputs	Location	Unit Cost
1.	Provincial training planning workshop (A. 4.2.1)[a]	13x5 years	3 days	40 persons (provincial staff, project staff, training district)	Annual provincial training plans	Project province	$25x3
2.	Epidemiology and food safety at provincial level (c. 1 .3) [a]	5	1 week	10-1 5 persons (5 health staff from/ each provincial center for medical prevention)	65 health staff trained to improve the management of food safety	NIHE Pasteur Inst. in Ho Chi Minh City (HCMC) & Nha Trang	$25x5
3.	Food safety and management at district level (c. 1 .3) [a]	13	3 days	20 persons (2 health staff from each district health center [DHC])	200 health staff trained to improve the management of food safety	Project provinces	$25x3
4.	Behavior change communication (BCC) capacity. training at provincial level (c.2) [a]	13x2 years	4 days	20 persons (from health education, medical prevention of province)	400 health staff trained for planning and implementing BCC	Project province or Can Tho	$25x4
5.	Project management course (B.3.2) [a]	13	3 days	30 persons (provincial staff, district staff)	400 project staff trained for implementing, monitoring, evaluating the Project	Project province	$25x3
6.	District health management (B 2.2) [a]	13	5 days	30 persons (district health managers, project staff, head of epidemiology team)	400 health staff trained to strengthen district health management	Project province (secondary medical school [SMS])	$25x5
7.	Health financial management at district level (B.2 2) [a]	13	4 days	30 persons (district health managers, project staff head of epidemiology team)	400 health staff trained to improve the health financial management	Project province	$25x4
8.	Management of health insurance pilots (B.2) [a]	4	5 days	25 persons (from DHC, project staff)	100 health staff trained to implement health insurance pilot	Project provinces and Hai Phong	$25x5
9.	Health statistics at district level (including monitoring analysis) (B.2. 1.)[a]	13	4 days	30 persons (district health managers, project staff head of epidemiology team)	250 health staff trained to improve the quality of health statistics and management	Project province (SMS)	$25x4
10.	Medical skills for medical doctors at district level (special courses) (A. 4.2.1)[a]	7x5 years	4 weeks	15 persons (5 medical doctors from each DHC)	500 medical doctors trained to improve the quality of emergency, surgical and diagnostic services	Good selected hospitals in HCMC, Hanoi, Can Tho, Da Nang	

Annex 5: List of training activities by other Projects

No.	Training Course	Number	Duration	Participants	Objective/Outputs	Location	Unit Cost
11.	Management of obstetric emergency cases (A.4.2.1) [a]	13x5 years	1 week	15 persons (5 health workers from Dept. of Emergency of each	500 health workers trained to improve the quality of essential obstetric emergency service	Good selected provincial hospitals	$30x5
12.	Nursing care for health workers in the hospital (A.4.2.1) [a]	13x2 years	4 days	20 persons (7 nurses per DHC)	700 nurses trained to improve the quality of total nursing care in th DHC	Project provinces (SMS)	$25x4
13.	Management of medical equipment (C. 1 .3) [a]	13x2 years	3 days	20 persons (2 medical technicians per district)	200 technicians trained to improve use/maintenance of medical equipment in the DHC	Project province or (subcontract with the supplier)	$25x3
14.	Interpersonal communication skills for health workers at district level (C.2) [a]	13x2 years	4days	20 persons (4 selected health workers per district)	400 health workers trained to work as health counselor in their district (counseling)	Project provinces (SMS)/ non-government organization (NGO)	$25x4
15.	Integrated Care for commune health center (CHC) workers (A.4. 1 .2) [a]	103x5	3 days	10-30 persons (3 from each CHC)	6000 CHWs trained for primary health care (PHC)	District health center	$10x3
16.	PHC in the community for village health worker (VHW) (C.3)[a]	103x5 years	2 days	30 persons (1 selected VHW or traditional birth attendants [TBA] per village)	14500 VHW or TBA trained to improve the community involvement in PHC	Project district/ NGO	$7x2

[a] Notation within brackets represents the component and subcomponents of the Project.

3-2. List of Training in the UNFPA Project

Training/Workshop	Participants	Objectively Verifiable Indicators	Timing
Training on Advocacy skill on RH and Population	HMs at Provincial, District and Commune levels	☐ 6 core trainers trained ☐ 10 provincial, 33 district HMs and 241 heads of ICPs and CHCs	2003
Training on BCC skills	HMs at Provincial, District and Commune levels	☐ 6 core trainers trained ☐ 10 provincial, 33 district HMs and 241 heads of ICPs and CHCs	2003
Workshop on advocacy on RH	HWs	☐ 56 health staff at provincial and district levels trained, annually	2002-2005
Training on Advocacy and BCC and its follow-up	Core trainers of PCPFC and mass organizations	☐ 34 core trainers, 79 cadres trained ☐ 95% of trainers in follow-up training	2003, 2005
Training on advocacy and BCC skills and its follow-up	Provincial and district level cadres, commune population workers, person in-charge of Culture and Information activities	☐ 15 provincial, 66 district level cadres trained ☐ 85% of trainees in follow-up training	2003, 2005
Training on BCC skills and its follow-up	VHWs, Population Collaborators	☐ 3,305 communicators trained ☐ 85% of trainees in follow-up training	2003, 2005
Advocacy workshops on ARH education and curricula	Representatives of DOET, Provincial YU, the deans or vice deans, school YU secretaries	☐ 98 participants in 2 workshops	2002, 2004
Training on National Standards/Guidelines for RH Services and its supplementary training	Core trainers, HWs in CHCs, ICPs, DHCs, provincial institutions, dermatologists and private HWs	☐ 12 core trainers, 430 CHC HWs, 78 ICP HWs, 110 DHC HWs, 27 provincial HWs, 20 dermatologists, 20 private HWs trained ☐ 95% of trainees receive supplementary training	2002-2003, 2004
Training on client-oriented management and its M&E skills	HMs at all levels	☐ 241 heads of CHC/ICPs, 20 provincial HMs, 33 district HMs trained ☐ 95% of trainees trained on M&E skills	2002-2003, 2004
Training on Logistics management	Staff in-charge of logistic management	☐ 2 core trainers trained ☐ 267 staff trained	2004
Training on Safe Motherhood	General practitioners	☐ 25 general practitioners trained	2002, 2004
Training on basic utilization of medical equipment	HWs directly in-charge of operating medical equipment	☐ Some relevant HWs trained	2003-2004
Training on laboratory skills	Laboratory technicians	☐ 28 laboratory technicians trained	2003
Dissemination Workshops on HMIS	HMs at provincial, district and commune levels	☐ 327 HMs participated	2003
Training on operation and utilization of the unified HMIS system	Provincial and district HMIS unit staff	☐ 2 provincial and 22 district staff trained	2003-2004
Training on use of new forms and books	Health staff at provincial, district and commune levels	☐ 50 provincial, 275 district and 241 CHC/ICP staff trained	2003-2004
Training on managing the system and using data in	HMs at all levels	☐ 2 core trainers trained ☐ 20 provincial, 33 district and	2003-2004

Annex 5: List of training activities by other Projects

Training/Workshop	Participants	Objectively Verifiable Indicators	Timing
planning		241 CHC/ICP HMs trained	
Overseas short-term training/conference	Staff/cadres involved directly with the implementation	□ 10 staff/cadres participated	2002-2005

Source: Compiled based on data in the UNFPA Project Document (VIE/01/P05), 2002

4-1. Equipment to District Hospitals

No.	Item	Qty	No.	Item	Qty
A.	*Basic Equipment*				
1.	Electrocardiograph	1	6.	Electrophoresis apparatus	1
2.	Respirator	1	7.	Oxygen en Concentrator	1
3.	Colorimeter photoelectric	1	8.	X ray machine (accessories)	1
4.	Ultrasound	1	9.	X ray film autoprocessing apparatus	1
5.	Laparoscope	1	10.	Fluorescent film illuminator	1
B.	**Laboratory Equipment**				
11.	Balance double beam triple clamp 2 kg	1	15.	Haemacytometer set complete	2
12.	Balance semi-analysis 250g with weight	1	16.	Incubator oven lab. 400 x400 x 300mm	1
13.	Centrifuge angle head 220v	1	17.	Microscope binocular	2
14.	Centrifuge micro hematocrite 24 tubes	1	18.	Urine analyser	1
C.	**Surgical Equipment**				
19.	Light operating	1	29.	Endotracheal	2
20.	Operating table	1	30.	Tracheotomy kit	1
21.	Electric suction unit	3	31.	Surgical Instrument major kit	2
22.	Gypsum cutter	1	32.	Surgical instrument minor kit	2
23.	Oxygen flow meter & humidifier	5	33.	Table adjustable Mayo type with tray	4
24.	Oxygen's bag	5	34.	Table instrument on wheels	4
25.	Pumps aspirating surgical 220V/50Hz	2	35.	Tray instrument covered 225 x 125mm	20
26.	Resuscitator - hand operated	2	36.	Tray Instrument shallow 343 x 247 x 16mm	8
27.	Ventory Set for I V	2	37.	Ultra violet lamp for sterilizer	1
28.	Anaesthesia portable	1	38.	Light examining floor stand type	2
D.	**Other Specialty Equipment**				
39.	Adenoidectomy Instrument set	2	46.	Ophthalmic examining lamp (Hammer lamp)	2
40.	Head light specialist	1	47.	Retinoscope	1
41.	Ophthalmic examination set	2	48.	Dental hand Instrument set	1
42.	Chalazion instrument set	2	49.	Oesophagoscope forceps and instrument set	2
43.	Enucleation instrument	2	50.	Infrared therapy lamp	2
44.	Etropian instrument set	2	51.	Microwave therapy apparatus	1
45.	Ophthalmic foreign body Instrument set	1	52.	Nebulizer	2
E.	**Hospital Furniture**				
53.	Instrument & drug cabinet (VN)	3	58.	Stretcher army type – folding	2
54.	Bed patient stationary mattress	50	59.	Stretcher combination wheel	2
55.	Patient cupboard	50	60.	Wheelchair invalid folding	2
56.	Syringe rectal Infant rubber bulb	10	61.	Stool (adjusted revolving)	2
57.	Syringe hypodermic 20ml-Luer	10	62.	Electric generator 2.5 VA	1

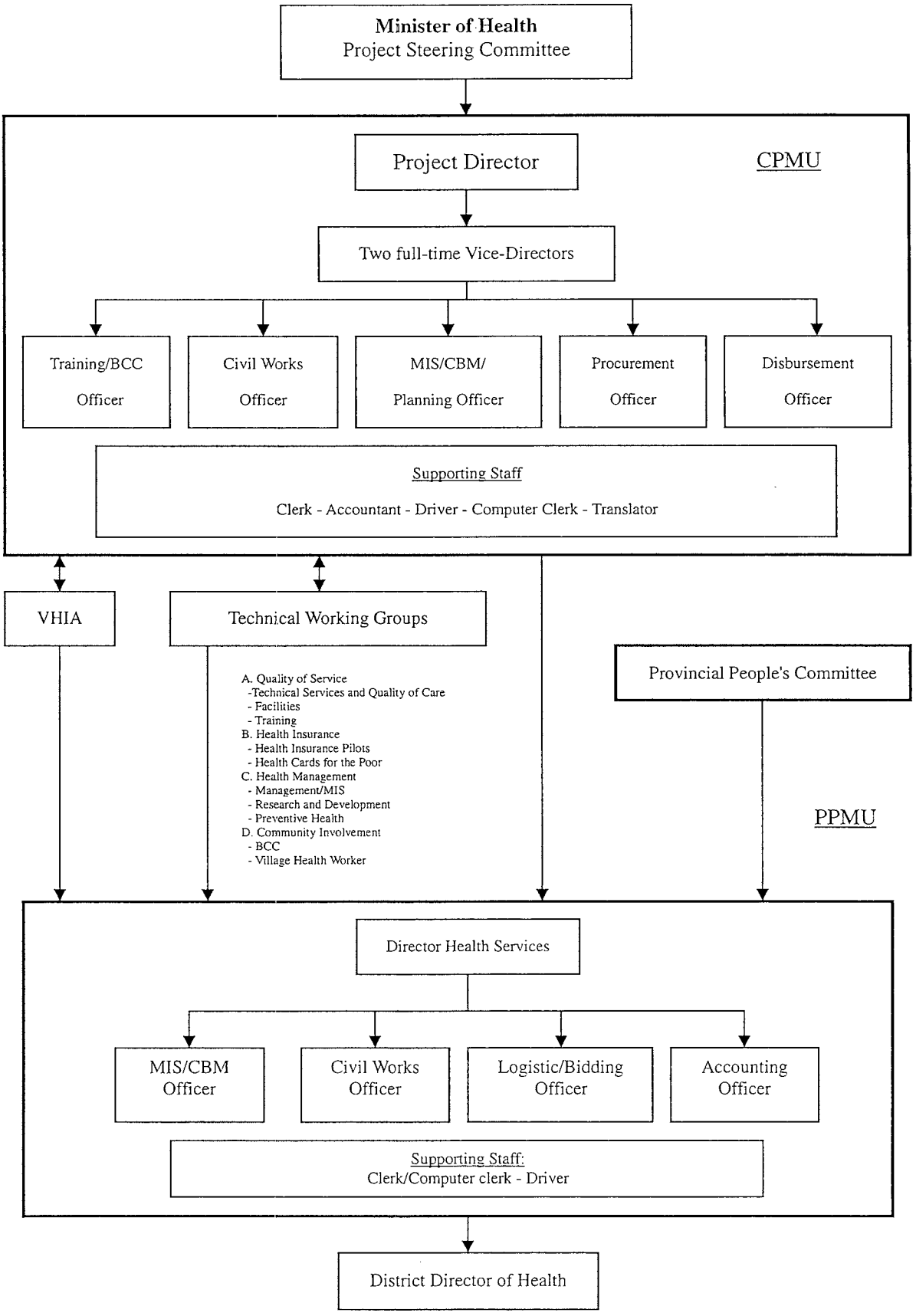
4-2. Equipment to Inter-Communal Polyclinics

No.	Item	Qty	No.	Item	Qty
1.	Ambulance	1	24.	IUD removal forceps	5
2.	Gasoline Generator 2 5 VA	1	25.	IUD insertion kit	10
3.	Adenoidectomy instrument set	2	26.	Karmann syringe single valve	5
4.	Balance double beam triple clamp 2 kg	1	27.	Karmann syringe double valve	2
5.	Balance semi-analysis 250 with weight	1	28.	Light examining floor stand type	2
6.	Bed labor and delivery	1	29.	Microscope binocular	2
7.	Bed patient stationary mattress	15	30.	Oesophagoscope forceps and Instrument set	2
8.	Patient cupboard	15	31.	Ophthalmic examining lamp (Hammer lamp)	2
9.	Chalazion instrument set	2	32.	Ophthalmic foreign body instrument set	1
10.	Diagnostic set	1	33.	Oxygen cylinder 40 lit-150 atm	2
11.	Dental hand instrument set	1	34.	Oxygen flow meter & humidifier	5
12.	Dressing sterilizer pressure electric, 50-70 litters	1	35.	Oxygen s bag	5
13.	Drum sterilizing d=340mm	10	36.	Resuscitator hand-operated	2
14.	Electric water bath	1	37.	Scale infant clinic metric 15.5 X 0.005 kg	2
15.	Electric suction unit	3	38.	Scale physical adult metric (140 kgs x 100g)	2
16.	Etropian instrument set	2	39.	Sphygmomanometer aneroid 300mm/Hg with cuff Spare cuff for child size	2
17.	Fluorescent film illuminator	1	40.	Sterilizer boiling type 600 x 400 x 400	1
18.	Gynecological examining table	2	41.	Sterilizer for syringe/needle - boiling 220 V/50Hz	1
19.	Gypsum cutter	1	42.	Station water filter chlorination Stretcher army type – folding	1
20.	Haemacytometer set complete	2	43.	Stretcher combination wheel	1
21.	Head light specialist	1	44.	Stool adjusted revolving	1
22.	Infrared therapy lamp	1	45.		1
23.	Instrument & drug cabinet (VN)	3	46.		1

Annex 7: Project Management Structure of other Projects

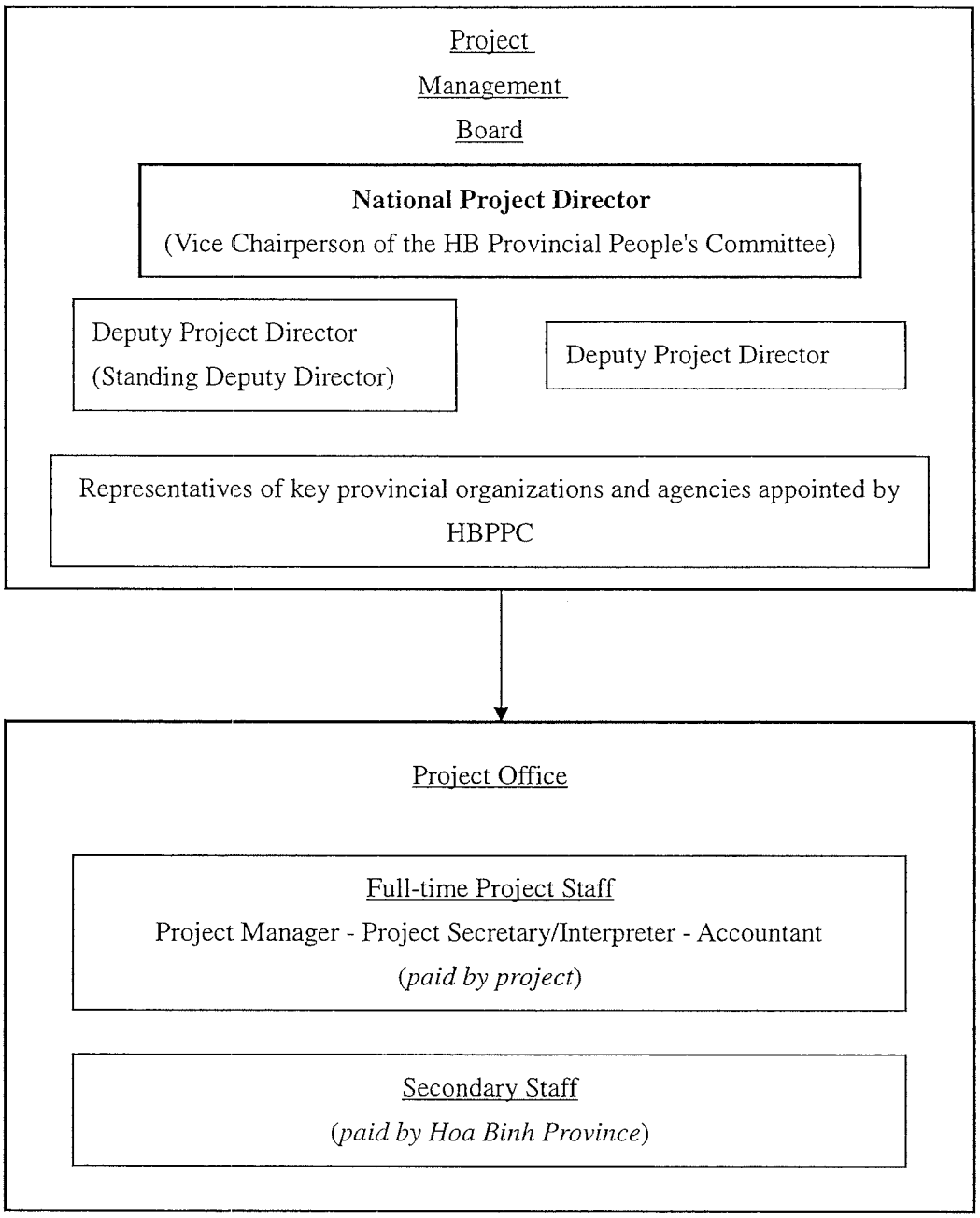
5-1. Project Management Structure of the ADB Project

Note: CPMU, the Central Project Management Unit is located within MoH (HaNoi), while PPMU, the Provincial Project Management Unit structure applies to 16 Project Provinces including Hoa Binh Province.



Annex 7: Project Management Structure of other Projects

5-2. Project Management Structure of the UNFPA Project Structure in Hoa Binh Province



Annex 8: The Health Care and Protection Strategy for the period of 2001 to 2010 years

GOVERNMENT
No. 35/2001/QD-TTg

Social Republic of Vietnam
Independence-Freedom-Happiness
Hanoi. March 19, 2001.

Decision of Prime Minister

(Ob: Approval of Health Care and Protection Strategy for the period of 2001 to 2010 years)

PRIME MINISTER

* Based on the Organizational Structure Law of Government dated on September 30, 1992
* Based on the Health Protection Law promulgated on June 30,1989
* Regarding the request of Health Minister No. 3769/TTr-BYT dated on June 1, 2000

DECIDES

Article 1 - To approve the Health Care and Protection Strategy for the period of 2001 to 2010 year with the following main contents:

1. Objectives

a. Overall objectives

To strive for all the people to receive primary health care, access and use the qualified health services and live in a safe society to develop their physical conditions and soul. To reduce morbidity rate, improve physical strength, increase average life of expectancy and develop the human being

b. Specific objectives

- The indicators to be achieved by the year 2010
  - Average life expectancy is 75 years.
  - Maternal mortality rate is reduced to 70/100,000 deliveries.
  - Infant mortality rate is reduced to less than 25/1,000 live births.
  - Mortality rate of under-five children is reduced to less than 32/1,000.
  - Low birth weight rate is reduced to less than 6%.
  - Malnutrition rate of under-five children is reduced to less than 20%.
  - Average height of the youth is increased to equal or over 1.60 meters.
  - There are 4.5 doctors and 1 university pharmacist/10,000 people.

- To reduce mortality and morbidity rates of communicable diseases. To prevent serious epidemics and to control the mortality and morbidity rates of cholera, salmonella, Dengue fever, malaria, plague, hepatitis B, Japanese cerebritis and STDs.... To maintain the situation of polio and neonatal tetanus elimination and to control the increasing speed of incidence of HIV/AIDS
- To prevent and manage non-communicable diseases, e.g. cardio-vascular diseases, cancers, accidents and injuries, diabetes, occupational diseases, mental disorders, poisons, suicide and the diseases caused by the unhealthy living style such as drug or alcohol addicts and obesity...
- To ensure the fairness in accessing and using health services, especially the examination and treatment services
- To improve quality of health care at all levels in all the terms e.g. prevention, treatment rehabilitation and health promotion. To apply the advanced scientific technologies to the heath activities in order to catch up the developed countries in the region

2. Main solutions

a) Investment

The investment for health includes State investment, contribution by the community people and making use of international donation... of which the State investment is main. To increase the proportion of health budget in the State expenditure step by step. To give a high priority of investment for the poor, mountainous, remote areas, particularly in the fields of disease prevention, traditional medicine, primary health care at grass-root level, examination and treatment for the poor and favorable policy recipients, maternal and child health activities

To implement new financial mechanism and policy in some pilot hospitals in the big cities, step by step transferring to the mechanism of self income-expenditure balance by using health insurance and hospital fees. To adjust hospital fees to correspond with the service costs, including technical investment cost at a specific level and affordable by the community people in different areas and strata

To expand voluntary health insurance; to consolidate compulsory insurance, step aiming to implement compulsory health insurance for all of community people

To mobilize and coordinate the donations, especially the ODAs for technical supports and favorable loans for the increased investment

b) Consolidation of organizational structure

- To consolidate and complete the organizational system of health sector, particularly to set up and strengthen the prevention, examination and treatment and pharmaceutical systems in the line of reducing procedures and increasing the effectiveness
- To develop the regional or inter-districts hospitals which are located far away from the central area of province. To consolidate and improve the quality of activities of inter-communal polyclinics in mountainous and remote areas
- To increase the capacity of disease prevention system from central-administered to grass-root levels, especially for-the provincial centers, epidemic prevention and sanitation teams of the districts and wards. To strengthen the labor health departments and to establish examination rooms of occupational diseases at the industrial cities and provinces. To complete the quality management network of food sanitation
- To strengthen the health inspection system
- To rearrange the network and upgrade facilities of the medical training centers. To innovate contents and improve quality of training and to promote the trainer resources at the secondary medical schools in order to develop those schools to colleges

c) Promotion of management

- To train health managerial and organizational staffs at various levels and define the management roles for the health facilities at particular levels in different local areas
- To improve capacity for long and short-term planning in different terms of health activities; Regularly monitor and evaluate the results of planning and implementation of the set plans
- To implement well the policy on mobilization of professional personnel for the mountainous and remote areas; To coordinate between army and civil medicine in health care, especially in the areas where there are difficulties in epidemic prevention and settlement of natural disaster consequences
- To continue to complete the health legislative system; To set up and promulgate Pharmaceutical Law, Food Law and Revised and Supplementary Law of Private Medicine; To promulgate technical regulations and standardized list of facilities and equipment for each specific field; To elaborate the favorable policies for the health staffs working in the mountainous and remote areas
- To improve knowledge on management for the health staffs; set up and consolidate the health inspection system that is capable to carry out its tasks as stipulated in the State Health Inspection Regulations
- To implement democratic regulations at all of the health facilities and develop the emulation movements, especially the advanced agencies and individuals

d) Health personnel development

- To standardize training courses for particular subjects at various levels
- To train health personnel in various fields in order to achieve the target of sufficient number of health staffs per capita with the balance among the different specialties; To promote training of master, ph. Dr., first and second-graded doctors for provincial and district levels, especially of the department leaders and to provide international training courses of specialists that are impossible to organize locally
- To rearrange personnel structure in the health facilities at provincial and district levels in order to alternatively mobilize the doctors to work at grass-root level; To upgrade the professional qualification, promote the implementation of labor regulations and improve health moral of the health staffs
- To implement the regulation step by step on the task force of working in mountainous and remote areas for the newly graduates

e)Grass-root health development

- To ensure that 100% of CHC have facilities that are adaptable to the particular conditions of regional economy, geography, environment and peoples' needs on health examination and treatment
- The aim by the year of 2005 is that 100% of the inter-communal policlinics in mountainous and remote areas are constructed strongly and provided with doctors; 65% of the CHCs. including 50% of mountainous ones have doctors; 100% of CHC have midwives, including 60% of secondary level
- The aim by the year of 2010 is that 80% of CHC, including 60% of mountainous ones have doctors; 80% of CHCs have secondary midwives; all of the CHC have at least primary pharmacist to manage the drug-related activities and staffs who are trained on traditional medicine; 100% of the hamlets have at least primary health workers and health volunteers networks are developed at hamlet levels in plain areas

f) Disease prevention and health promotion

- To continue implementing the National programs to eliminate some social and dangerous communicable diseases and to start carrying out the programs to prevent non- communicable diseases e.g. cardio-vascular diseases, cancers, diabetes, genetic diseases, birth anomalies and drug addiction
- To take initiative in disease and epidemic prevention in order to control the serious epidemics; To consolidate the systems of reporting and epidemiological monitoring and to modernize the HMIS
- To elaborate the projects on prevention and settlement of the consequences of disasters, prevention of accidents and injuries, especially of traffic and labor accidents and occupational diseases
- To implement the regulations on health protection and labor environment in the enterprises; To give priority to monitor and treat the wastes e. g. hospital wastes and chemicals that pollute the environment and badly affect the health condition.
- To promote food quality and hygiene control activities; To study and take initiative in monitoring food pollution in order to prevent food poisons and food-related diseases; To develop human resources for inspection of food hygiene at all levels
- To implement the programs of reproductive health care, motherhood, essential obstetric care and FP services and to strive to reduce rapidly the maternal mortality rate, abortion rate and the rate of women suffering gynecological diseases
- To implement the child health care programs e.g. prevention of malnutrition, adolescent health, school dentistry, prevention of diarrhea, acute respiratory infection, rheumatic heart diseases and parasites
- To encourage the movements of sport playing and athletics practice in order to promote health and increase physical build of Vietnamese

g) Examination and treatment

- To invest for upgrading synchronously the system of examination and treatment to meet the needs and be suitable to the social and economical conditions of particular regions; To define the technical levels and promulgate the strict regulations on patient referral; To early complete the scheme of examination and treatment network, increase number of patient beds for the provinces that have low rate of patient bed per capita; To standardize the list of essential equipment and regular techniques, utilize effectively and exploit maximum capacity of medical equipment for diagnosis and treatment; Based on the demands of hospitals to prepare list of drugs, with a high priority given for local products; To struggle with squandering and abusing expensive drugs and high technologies in diagnosis and treatment; To continue and promote rehabilitation and prevention of
sequels of diseases.
- To implement the hospital regulations and reform the administrative procedures in examination and treatment; To ensure the best conditions for the patients at health examination and treatment facilities, especially for the essential requirements e.g. foods, clothes and hygiene
- To diversify the services of examination and treatment, including State, occupational sector, private and international invested clinics

h) Development of traditional medicine
- To continue to implement the Guidance of Prime Minister No. 25/1999/CT-TTg dated on August 30, 1999 with the object of traditional medicine promotion

i) Drug and medical equipment
- To continue to implement the "National Policy on Drug" with the main objectives as follows: to ensure the regular and sufficient supply of the qualified drug; to use drugs safely, properly and effectively and to consolidate and strengthen the State management system of drug from central-administered to local levels
- To scheme and re-organize the drug industrial sector with the line of focused, effective investment and specialization. The aim by the year of 2010 is that all of the drug production agencies are standardized with GMP standard. To modernize the drug distribution network, paying attention to the rural mountainous and remote areas
- To complete the legislative documents on medical equipment, to consolidate the organizational structure and build up the technical services. To invest and equip the modern equipment in accordance with the technical grades of prevention, examination and treatment systems and to develop the medical equipment industry in Vietnam

k) Development of technologies and health information
- To step by step modernize the image, biochemical, biophysical, immunization, genetic and molecular biology diagnosis; To apply the advanced technologies of cardiology, scopes, orthopedics, microtomy, organ replacement and joining. To build up standardized laboratories and three specialized centers for inspection of food quality and safety in the Northern, Central and Southern areas.
- To develop the biological technologies, especially genetic, multiplicative and tissue growing technologies to be applied for production of drugs, vaccines and biological materials that are used for diagnosis and treatment. To develop the automatic technologies in production of major medical equipment, treatment of hospital wastes and hospital management
- To continue to complete and increase effectiveness of two specialized centers in Hanoi and Ho Chi Minh cities and to early construct the specialized centers in Hue, DaNang and other regions
- To consolidate the systems of statistics, information management in order to provide timely with reliable data and information

l) Socialization of health activity

- To promote the implementation of the Government' s Decision No. 90/CP dated on August 21, 1997 that defined *"The Direction and Policy on Socialization of Education, Health and Culture Activities "* . To integrate the requirements of health protection and promotion into the macro economic policies, programs and projects on production, poverty reduction and hunger elimination.
- To diversify the types of health cares, to look for and exploit the investments for health e.g. voluntary heath insurance and international donation. To develop the models of environmental sanitation and community safety.
- To continue consolidating and developing the IEC centers in provinces and cities; To develop and strengthen the IEC collaborator network to the commune level; To adapt the appropriate IEC methods in order for all of the social strata and organizations to participate and contribute in health protection for oneself and entire community.

3. Budget

a) Every year, based on the assigned tasks of implementing the 2001-2010 Health Care and Protection Strategy, the Ministry of Health shall prepare the annual budget proposal and submit it to the Ministry of Finance and Ministry of Planning and Investment for consideration and making balance with the total required budget. The National Assembly shall examine and approve the budget proposal later.

b) The People's Committees of Provinces and Central-administered Cities shall allocate annual local budget for health activities in the area.

4. Duration of strategy implementation: From the year 2001 to 2010

Article 2 - The Ministry of Health is mainly responsible for the implementation of Strategy. Besides, the Ministry shall cooperate with the other line Ministries and sectors e.g. the Ministry of Science, Technology and Environment, MPI, Ministry of Finance, Ministry of Fishery, Ministry of Agriculture and Rural Development, Ministry of Industry, Ministry of Trade, Ministry of Training and Education, Ministry of Culture and Information, Ministry of Police to elaborate annual plans of implementation, inspection and monitoring, to sum up the activities and report to Prime Minister the results of-implementation. The partial and total summary conferences shall be organized by the year of 2005 and 2010 respectively.

Article 3 - The Decision shall be effective 15 days after signature.

Article 4 - The Ministers and Directors of ministerial level-administered organizations and related agencies, Chairpersons of People's Committees of Provinces and Central-administered Cities are responsible for implementing this Decision.

Prime Minister
Phan Van Khai

Source : Decision of Prime Minister: Government No.35/2001/QD-TTg, Hanoi, March 19, 2001 (Unofficial Translation)