I. Project Context

Country Context

Vietnam has achieved an impressive record of economic growth and poverty reduction in the past twenty years. Ongoing political and economic reforms launched at the end of the 1980s have transformed Vietnam from one of the poorest countries in the world to a lower middle income country with a per capita income estimated at US$1,374 at the end of 2011. Economic growth averaged 8 percent per annum for many years, but slowed to 5-6 percent beginning in late 2008. The poverty headcount ratio has fallen steadily over time, from 58 percent in 1993 to 20.7 percent in 2010, and 17.2 percent in 2012 based on an updated poverty line applied to the 2010 Vietnam Household Living Standards Survey (VHLSS). Despite this progress, poverty is increasingly concentrated among Vietnam's ethnic minority populations, also in more isolated rural areas and smaller cities and towns. Although minorities make up only 15 percent of population, they account for nearly half of Vietnam's remaining poor (World Bank, 2012).

In line with national socio-economic development and government’s investments to develop access to health care, health outcomes in Vietnam have been improving remarkably throughout the country. The average life expectancy of the Vietnamese people has increased from 65.5 years to 75
years in the last decade. Both maternal and child mortality has been rapidly decreasing: infant mortality rate is 17.3 per 1000 births in 2011 compared to 36.1 in 1990; maternal mortality rate is 59 per 100,000 births in 2010 compared to 240 in 1990. Although aggregate outcomes have been improving, the equity of distribution of improved outcomes remains a problem. Maternal and child mortality remains high in remote and disadvantaged areas. There are three-fold differences in under-five mortality rates between the lowest economic quintiles and the highest quintiles, and the inequalities have increased over time. Vietnam is an aging country with the population over the age of 60 growing at the fastest rate. Non-communicable diseases (NCDs) account for almost two-thirds of mortality, followed by accident, injury and poisonings (more than 20%).

**Sectoral and institutional Context**

Vietnam’s rapid economic growth has provided substantial additional resources for all sectors, including the health sector. At the same time, the Government of Vietnam has shown strong political commitment towards universal health coverage over the last two decades, making it a national goal for 2014. In 2009, Vietnam passed the Law on Social Health Insurance to create a national Social Health Insurance (SHI) program, making SHI the primary mechanism for achieving universal coverage. By 2011, coverage as measured by enrollment rates has increased significantly, reaching more than 64% of the population. The recent expansion of coverage has been financed largely through tax subsidies to cover insurance premiums for the poor, near-poor and other vulnerable groups. A major challenge lies now in the expansion of coverage to the remaining 40% of the population while addressing the large out-of-pocket (OOP) share of total health spending, the range of system inefficiencies and financial sustainability.

In order to respond to increased coverage of health insurance, the government has to improve the supply of health services, including their availability, financial accessibility as well as quality. The most prominent and politically taxing issue in the health sector is the problem of hospital overcrowding: occupancy rates are especially high in central and provincial specialty hospitals with sometimes 2-3 patients per bed. Outpatient departments in those hospitals are also suffering from long queues. Self-referral by patients is common with rates as high as 93% in specialist hospitals. Co-payments or other financial mechanisms to dissuade self-referrals have proved to be insufficient to address this problem.

A number of underlying reasons for overcrowding have been advanced as follows: (i) increase in demand because of the aging of the population, increasing NCD morbidity, increased health insurance coverage and general economic development as well as inappropriate use of hospitals for basic health care; (ii) revenue enhancing incentives (and consequent behaviors) resulting from hospital autonomy policy, payment mechanisms and private investments in medical equipment for profit in public hospitals; (iii) deficient hospital infrastructure; (iv) Low quality supply at lower levels, including the perception of poor quality by users; and (v) inefficient referral, clinical, and patient flow management.

Clearly, a major factor contributing to overcrowding is that patients skip lower levels of care and go straight to higher level for examination and treatment. A recent analysis of a sample of patient records shows a high rate of self-referrals, about 42% in provincial hospitals, 59% in general central hospitals and 93.5% at the specialist hospitals. Patients indicated “trust to provide proper diagnosis and quality of care” as the main reason for the self-referral. The lack of technical capacity of the lower levels facilities is one part of the trust equation as they are perceived to be unable to provide
functions stipulated by the Government mandate.

However, there are signs of progress. The MOH has recently developed and is about to launch a quality monitoring and benchmarking system focused on improving patient satisfaction with the overall experience - a start to a more comprehensive quality system. As the 2012 Joint Annual Health Review – which had a particular focus on quality – pointed out, the MOH and related institutions have developed hundreds if not thousands of technical guidelines, protocols, and patient safety related circulars but there has not been a system in place to monitor, enforce or support implementation.

The government policy to increase the number of physicians and nurses in order to improve access to care has led to an increase in the number of medical and nursing schools and an increase in the number of students admitted to the schools. The number of medical schools has increased from nine schools in 1997 to 14 schools to date. Admission to medical schools has almost tripled during the last 10 years. Graduates in general medicine were increased by around 60% from 1,550 in 2006 to 2,450 in 2012. The number of nursing schools is increasing even more rapidly. There are currently 14 undergraduate nursing programs (four year training) and 29 nursing colleges (three year training). Three of the 14 undergraduate nursing programs were established by the private sector indicating a growing interest of the private sector to invest in health professionals’ education. The undergraduate nursing program currently enrolls around 1,430 students each year, or a 10-fold increase during the last 10 years.

Increase in the number of schools, and students, was not accompanied with needed investment. Clinical practice sites are limited to central and some provincial hospitals that cannot absorb the growing number of students. Investment in medical/nursing skill laboratories – essential teaching sites – is still limited. Although Vietnam has produced the Knowledge, Attitude, and Practice book as the basis for standardizing medical curriculum in the country, the quality of curriculum implementation varies with the schools. The situation is similar for nursing education.

Vietnam has gradually shifted medical teaching from conventional to more active teaching methods although the level of progress varies among the schools. Medical education is six years consisting of two years of basic medical sciences with introduction of clinical theory during the third and fourth year and clinical practice during the last two years. Medical training was hospital based but moved gradually in the last 10 years towards a combination of hospital and community based health care. Some universities have received assistance from international partners to apply more active teaching methods such as problem based learning and case scenarios, and to introduce Objective Structured Clinical Examinations (OSCEs) as a part of student assessment. Vietnam has also benefited from the findings of the recent Lancet Independent Commission report on 21st century health professionals which calls for transforming education to strengthen health systems in an interdependent world.

The Ministry of Education and Training (MOET) introduced institutional accreditation in 2005. MOET Decision No 65/2007 refers to ten standards and 61 criteria for accreditation of higher education institutions, while Decision 76/2007 explains the accreditation procedures, starting with an internal assessment by an internal assessment committee. By the end of 2012, all medical and nursing schools have completed the internal assessment and are waiting for an external review by an independent body which is to be established.
There is a consensus that the accreditation criteria developed by MOET are too general for medical/nursing teaching that requires specific facilities, equipment and clinical practice, and that a specific quality assurance system should be established. In collaboration with the medical and nursing schools, the Administration of Science, Technology and Training (ASTT) at the Ministry of Health (MOH), is in the process of developing the specific standards of education for medicine and nursing as the basis for developing instruments that can be used in an education quality assessment process. Nevertheless, Vietnam will need support in establishing the system as knowledge on quality assurance among the MOH staff and medical/nursing schools is limited.

Vietnam is committed to improving the quality of student assessment prior to graduation as part of the quality assurance system for medical and nursing education. Currently, student assessment at the end of medical and nursing education is conducted by individual schools and not guided by national standards. The examination methodology adopted by each school has never been reviewed and there has never been an evaluation of the competencies of graduates who pass the school examination. Standards of competencies for nurses and draft standards for physicians are available. The next step will be to improve the examination methodology and introduce a nationally standardized examination system.

There is recognition that in order to provide quality health services in a cost-effective and efficient way and ensure the fiscal affordability of universal health coverage, particularly for the bottom 40% of the population, there is a need to strategically strengthen policies, institutions, incentives and key service delivery inputs. For that, particularly in a highly decentralized system, the management capacity of health officers at various levels will need to be strengthened. According to a 2013 MOH survey, there is a large gap between need and current management capacity. Only 30% of hospital administrators are trained in management and although they have been working as managers for many years, more than 95% of health managers expressed a lack of management skills. The MOH has a master plan for health human resource development which calls for improving management capacity at all levels.

While the country has slowly embarked in a process of improving the quality of the medical and nursing graduates (the “flow” to the health care system), there is an existing “stock” of health professionals that are ill-prepared to respond to the dramatic epidemiologic and demographic change that the country is facing. In general, medical training is hospital-based and there is little preparation and incentive to practice at the primary care level and in the grass-roots health care network, especially at the commune level.

There is a severe shortage of health professionals at the grass-roots level, especially in disadvantaged areas. Less than 18% of the total workforce is currently working at the commune level, and about a third of the Commune Health Stations (CHS) are without a physician. The shortage of physicians is most severe in the poorest 62 districts where on average 30% of CHSs have a physician compared to 70% nationwide. The government has set a target of 80% of the communes staffed with a physician, yet it is difficult to attract qualified physicians to work in rural areas. About 53% are concentrated in urban areas where only 28% of the population lives.

Even when an adequate number of health staff works in CHSs, they often lack the competencies to perform designated services and deal with emerging health problems - to identify, manage, refer and coordinate patients. They also have limited decision rights to prescribe and do medical interventions. A recent 5C study shows that despite the number of training programs delivered with
the support of international organizations, PHC teams are unable to provide most PHC services such as early detection of risk factors and management of most common NCDs, provision of prevention and counseling services, organization of medical care for the elderly with chronic conditions, Maternal and Child Health services, etc. An evaluation of professional competency at commune level found that physicians and assistant physicians gave the wrong answer to more than 50% of the questions on cardiovascular and internal medicine problems.

To address the health sector issues presented above, Vietnam has embarked in a program of policy changes, regulation, enforcement and public persuasion in many areas including among others, health financing and health insurance, service delivery organization and pharmaceuticals, and human resources for health. The Joint Annual Health Review (JAHR) of September 2013 describes in detail the 2013 major tasks Vietnam has embarked on, some of them well-underway and others just initiated. In Health Financing/Health Insurance, reform is underway in the following areas: strengthening purchasing capacity and leverage of the Vietnam Social Security, raising the breadth and depth of HI coverage, and provider payment reform while improving payroll tax compliance. In Service Delivery, priorities that are defined by Government, with work underway, aim to address hospital overcrowding, strengthen PHC and Care coordination across levels, and improve quality of care. In the area of pharmaceuticals, Vietnam is working to ensure supply of essential medicines at affordable prices, particularly as it relates to the VSS norms and rational use of drugs/benefit package. In the area of Human Resources for Health (HRH), there has been a major effort to raise the production of physicians and other health professionals. At the same time, there are efforts aimed at improving quality of HRH and their distribution through policies and legislation. However, as the JAHR notes, they have remained limited.

The GOV has recently adopted several important directives which set government policies for strengthening grass-roots health network. Directive 06-CT/TW of the Central Party Committee emphasized the importance of investing in human resources, infrastructure and stable financing for recurrent activities at grass-roots level. The National Strategy for People’s Health Care and Protection focuses on health workforce development, particularly at the grass-roots level. Moreover, the National Assembly Resolution No11/2011/QH13 calls to: (i) strengthen the Health Sector at the district and grass-roots level to reduce hospital overcrowding; and (ii) implement reforms in human resource development. Similarly, the government’s National Benchmarks for Commune Health Care (2011-2020) aims to ensure that “all CHS have adequate number of health workers with staff continuously trained”.

Rationale for Bank Involvement: This project fits within the comprehensive health services strengthening strategy, as part of the universal health coverage agenda and is part of the larger program that the Government is engaged in, with Bank’s support. This project is based on the strong political interest in reforming medical training institutions, and on improving quality of the country’s health workforce. Given all the reforms underway in the health sector, this project focuses on the health workforce education and training agenda that has received major political support as evidenced by the laws and policies recently introduced.

The Bank is able to bring its global and regional experience to the fore and support Government in addressing these issues. The most recent investment credit provided by the Bank in the health sector aims at increasing efficiency and equity in the use of hospital services in selected provinces of the NE and Red River Delta provinces. The Bank is also providing analytical and advisory support to improve the performance of the health insurance system and expand the coverage in a fiscally
sustainable way. Unlike other development partners, the Bank is in a unique position to provide the breadth of this support through a combination of investment credit and advisory and analytical services. The project is specifically oriented towards addressing quality of care and primary health care issues through: (i) improving basic health professionals’ education with a focus on nursing and medicine; (ii) improving management competencies in the health sector; and (iii) training of PHC teams at the grass-roots level through a combination of long-term and short-term modular courses and on-the-job training. In this effort, the Bank is coordinating closely with other development partners, particularly ADB, the Global Fund, GAVI, and EU, to ensure complementarity of efforts and avoid duplication.

II. Proposed Development Objectives
The PDO are to improve the quality of health professionals’ education, strengthen management competencies in the health sector, and improve the competencies of Primary Health Care Teams at the grass-roots level.

III. Project Description

Component Name
Improve the quality of health professionals education
Comments (optional)

Component Name
Strengthen Management Competencies in the Health Sector
Comments (optional)

Component Name
Improve Competencies of Primary Health Care Teams at the Grass-roots Level
Comments (optional)

Component Name
Project implementation support and coordination
Comments (optional)

IV. Financing (in USD Million)

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For Loans/Credits/Others

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V. Implementation

The implementing agency will be the MOH. As per its common practice, the MOH will establish a Project Steering Committee (PSC) which will largely be a consultation body for discussing issues related to project implementation. It will be chaired by the Minister of Health who has approved the following proposed composition: Vice-minister for human resources as Vice-Chair, directors/vice directors of ASTT, DOM, DPF, Department of International Cooperation, Administration of Preventive Medicine, Administration of Medical Services, Administration of Drug Control, and representatives of the following ministries: Planning and Investment, Finance, Education and Training, and Internal Affairs.

Project management has been streamlined to some extent as the CPMU has been approved by the Minister of Health as part of the ASTT with the Director of ASTT as the CPMU director. It will be staffed to carry out the following functions: project management, procurement, financial management, disbursements, audit (internal and external), and monitoring and evaluation. Details in terms of roles and responsibilities will be described in the POM. In addition to the director and three deputy directors (from ASTT, DOM and DPF respectively), CPMU staff will include a chief accountant, a financial management (FM) specialist, a procurement officer, a project officer, and a project coordinator.

Other stakeholders that are critical to project implementation are the universities/schools/colleges and provincial and district authorities. Universities/colleges will be implementing the grants under sub-component 1.2, and the training programs under sub-components 2.1 and 2.2 and subcomponent 3.1. Under sub-component 1.2, training institutions may establish a Project Implementation Unit (PIU) to support the implementation and administration of the grant funds. In that case, they will be responsible for allocating their own resources for the cost of the PIU, and those costs will be considered as the matching fund from the schools. The Minister of Health will sign a grant agreement with the Dean of each university/college for the grant implementation. The primary responsibility for supervision and monitoring of the grants implementation under sub-component 1.2 lies with the ASTT. The CPMU director will sign off on the release of the six-monthly payment to each school. The specific details of the procedures for development, implementation, and funding of the grants (under subcomponent 1.2) will be detailed in the Project Operations Manual (POM).

Under component 2, CPMU will sign an MOU with the two management training centers who will be responsible to implement sub-component 2.1. There will be two types of MOUs. The first MOU is input-based and includes minor renovations, procurement of office equipment and technical assistance to revise/develop curricula. The second type of MOU is output-based and includes training of managers and health inspectors at central, provincial, district and facility levels. Training costs have been estimated and the centers will be paid on the basis of people trained. With respect to subcomponent 2.2 which includes the Young Volunteer Physicians Program, CPMU will sign an MOU with training institutions and central and provincial level hospitals. The MOH will include in the POM the modalities for disbursing the relocation benefits to the young Physicians who will relocate to the disadvantaged districts. Monthly allowances will be paid by the recruiting hospital and will be included in the unit cost.

Under component 3, CPMU will sign an MOU with training institutions who will implement subcomponent 3.1 and who will be paid on the basis of number of staff trained according to an agreed curriculum. The CPMU will be responsible to manage all contracts with the training institutions. A PHC Training Coordination Committee will be established to review and approve a
unified curriculum for training of PHC providers at the commune level. In addition to relevant
departments of the MOH, the Committee will also include representatives of medical and nursing
programs and professional associations. Province health authorities have prepared and submitted to
the MOH the province PHC staff development plans and inventory of available equipment at CHS.
The MOH is reviewing the Provincial PHC staff development plans which, once endorsed by the
MOH, will serve as the basis for the MOUs between the MOH and training institutions. Similarly,
the MOH is reviewing the equipment development plans prepared by the participating provinces to
assess the equipment gap at each CHS as compared with approved MOH standard list. These will
serve as the basis for the procurement of CHS equipment.

As part of their submission of the training and equipment plan, the Central and Provincial authorities
commit to ensure that trained PHC staff will be in a position to apply their newly acquired skills in
their work environment at grass-roots level. For this, barriers presently existing, and preventing a
large number of CHS to perform a wide range of services, should be removed in these particular
CHSs (VSS accreditation, equipment, medicines, authorisation from DOH, etc.). This will require
on-going dialogue among stakeholders, during project supervision, and beyond this project.
Experience has shown that in provinces where similar PHC/FM training has taken place, newly-
trained CHC staff has seen a positive change in their ability to apply their newly-acquired skills.

VI. Safeguard Policies (including public consultation)

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Comments (optional)

VII. Contact point

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