# Appendix A

Medical programme schedule and course content for all medical undergraduate programmes

## Medical Programme Schedule

| Number | Course name | Credits |
|---|---|---|
| Semester 1 | | |
| 1 | Mathematics B | 3 |
| 2 | Biology volume | 2 |
| 3 | Practical biology volume | 1 |
| 4 | Chemistry volume 1 | 2 |
| 5 | General psychology | 2 |
| 6 | Physics B | 2 |
| 7 | Basic English 1 | 3 |
| 8 | Basic French 1 | 3 |
| 9 | General information technology | 2 |
| 10 | Physical education 1 | 1 |
| Total, semester 1 | | 18 |
| Semester 2 | | |
| 11 | The NLCB of neo-MLN | 5 |
| 12 | Surgery 1 | 3 |
| 13 | Chemistry volume 2 | 2 |
| 14 | Practical chemistry | 1 |
| 15 | Basic English 2 | 2 |
| 16 | Basic French 2 | 2 |
| 17 | Biophysics | 2 |
| 18 | Biophysics practice | 1 |

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| Number | Course name | Credits |
|---|---|---|
| 19 | Medical genetics | 3 |
| 20 | Physical education 2 | 1 |
| Total, semester 2 | | 20 |
| Semester 3 | | |
| 21 | The military | 2 |
| 22 | Defence work | 2 |
| 23 | General military | 2 |
| 24 | Tactical and technical fire rifles AK | 1 |
| 25 | Basic English 3 | 2 |
| 26 | Basic French 3 | 2 |
| 27 | Anatomy 2 | 4 |
| 28 | Embryonic tissue | 4 |
| 29 | Physiology 1 | 3 |
| 30 | Physical education 3 | 1 |
| 31 | General immunology | 1 |
| 32 | Occupational exposure to HIV/AIDS | 1 |
| Total, semester 3 | | 22 |
| Semester 4 | | |
| 33 | Ho Chi Minh thoughts | 2 |
| 34 | Biochemistry | 4 |
| 35 | Physiology 2 | 3 |
| 36 | Microbiology | 3 |
| 37 | Basic nursing | 2 |
| 38 | Psychological medicine – ethics | 1 |
| 39 | Anatomy 3 | 1 |
| 40 | Physiology 3 | 1 |
| 41 | Skills 1 (communication) | 1 |
| 42 | Skills 2 | 1 |
| Total, semester 4 | | 17 |
| Semester 5 | | |
| 43 | Pathophysiology | 4 |
| 44 | Parasites | 3 |
| 45 | Pathology | 3 |
| 46 | Diagnostic imaging | 2 |
| 47 | Cabinet base LT | 2 |
| 48 | Cabinet base TH | 2 |
| 49 | Foreign establishments LT | 2 |
| 50 | Foreign establishments TH | 1 |
| 51 | Skills 3 (procedure) | 1 |
| 52 | Skills 4 | 1 |
| Total, semester 5 | | 20 |

(continued)

| Number | Course name | Credits |
|---|---|---|
| Semester 6 | | |
| 53 | Pharmacology | 4 |
| 54 | Surgery practice | 2 |
| 55 | LT general cancer | 1 |
| 56 | General cancer TH | 1 |
| 57 | Education and health promotion | 1 |
| 58 | Health organisation | 3 |
| 59 | Sun Y English | 3 |
| 60 | French S Y | 3 |
| 61 | Community practice I | 1 |
| 62 | Haematology basis | 2 |
| 63 | Research methodology sciences | 2 |
| Total, semester 6 | | 18 |
| Semester 7 | | |
| 64 | Internal pathology 1 LT | 2 |
| 65 | Internal pathology 1 TH | 2 |
| 66 | 1 LT foreign pathology | 2 |
| 67 | Foreign pathology 1 TH | 2 |
| 68 | Nutrition – FHS | 1 |
| 69 | Statistics and probability | 2 |
| 70 | Obstetrics 1 LT | 2 |
| 71 | Obstetrics 1 TH | 2 |
| Total, semester 7 | | 15 |
| Semester 8 | | |
| 72 | Epidemiology | 3 |
| 73 | Environmental science and health environment | 3 |
| 74 | Internal pathology 2 LT | 2 |
| 75 | Internal pathology 2 TH | 2 |
| 76 | Children 1 LT | 2 |
| 77 | Children 1 TH | 2 |
| 78 | The DS BVSKBMTE – v.de RH | 1 |
| 79 | Party lines CM C. VN | 3 |
| Total, semester 8 | | 18 |
| Semester 9 | | |
| 80 | 1 LT infectious | 2 |
| 81 | 1 infectious TH | 2 |
| 82 | Lao LT | 1 |
| 83 | Lao TH | 1 |
| 84 | Rehabilitation LT | 1 |
| 85 | Rehabilitation TH | 1 |
| 86 | Neurology LT | 1 |
| 87 | Neurology TH | 1 |

(continued)

| Number | Course name | Credits |
|---|---|---|
| 88 | Mental LT | 1 |
| 89 | Mental TH | 1 |
| 90 | Traditional medicine 1 LT | 2 |
| 91 | Traditional medicine 1 TH | 2 |
| 92 | 2 LT infectious | 1 |
| 93 | 2 TH infectious | 1 |
| 94 | Traditional medicine 2 LT | 1 |
| 95 | Traditional medicine 2 TH | 1 |
| 96 | Clinical pharmacology LT | 1 |
| 97 | TH clinical pharmacology | 1 |
| Total, semester 9 | | 18 |
| Semester 10 | | |
| 98 | National health programme | 1 |
| 99 | Health economics – health insurance | 1 |
| 100 | LT allergies | 1 |
| 101 | Allergy TH | 1 |
| 102 | Oral and maxillofacial LT | 1 |
| 103 | Oral and maxillofacial TH | 1 |
| 104 | Otolaryngology LT | 1 |
| 105 | ENT TH | 1 |
| 106 | Eye LT | 1 |
| 107 | Eyes TH | 1 |
| 108 | LT dermatology | 1 |
| 109 | TH dermatology | 1 |
| 110 | Forensic medicine | 2 |
| 111 | Military medicine | 1 |
| 112 | Community practice II | 1 |
| Total, semester 10 | | 16 |
| Semester 11 | | |
| 113 | Internal pathology 3 LT | 2 |
| 114 | Internal pathology 3 TH | 2 |
| 115 | 2 LT foreign pathology | 2 |
| 116 | Foreign pathology 2 TH | 2 |
| 117 | Obstetric 2 LT | 2 |
| 118 | Obstetric 2 TH | 2 |
| 119 | Children 2 LT | 2 |
| 120 | Children 2 TH | 2 |
| Total, semester 11 | | 16 |
| Semester 12 | | |
| 121 | Thesis | 10 |
| 122 | The final thematic cabinet LT | 1 |
| 123 | The final thematic foreign LT | 1 |
| 124 | The final thematic LT | 1 |

(continued)

| Number | Course name | Credits |
|---|---|---|
| 125 | The final thematic paediatric LT | 1 |
| 126 | The final internal TH | 4 |
| 127 | The final foreign TH | 4 |
| 128 | The final product TH | 4 |
| 129 | The final children TH | 4 |
| 130 | The disease is spread through colleges | 1 |
| 131 | Topic LCK secretary | 1 |
| 132 | Topical parasite | 1 |
| 133 | Epidemiology symposium | 1 |
| 134 | Sanitation symposium | 1 |
| Total, semester 12 | | 10 |

*LT* theory study proportion
*LH* practical study proportion

## Course Content and Level

9.1. KC211005. Mathematics B (3TC, 3-0,0-4). Basic knowledge of limits, continuity and integral calculus functions of one variable; matrix determinants and systems of linear equations; limits, continuity and calculus functions of several variables and integral two layers, three layers, series, functions and differential equations.

9.2. KC211022. Biological CG (2TC, 2-0,0-4). Fundamental characteristic of life and structure and function of the basic units of living cells; processes occurring in living organisms: nutrition, metabolism and transport of material circulation and activity of the endocrine and nervous system, and breeding and genetics.

9.3. KC211023. Practical biology volume (1TC, 0-1,0-2). Principles using a microscope and some forms of cell organelles of animals, plants and microorganisms; water transport across the cell membrane; contractures and reflex contraction of the cytoskeleton; a survey of the phenomenon through the process of cell metabolism and chromosome morphology, the number of chromosomes of an organism.

9.4. KC211018. Chemistry volume 1 (2TC, 2-0,0-4). Knowledge of atomic structure, molecular structure, physical state of aggregation, chemical thermodynamics, kinetic contact effects, chemical reactions and electrical lines.

9.5. SP211014. General psychology (2TC, 2-0,0-2). General psychology presents an overview of the psychological phenomenon; the origin and nature of psychological phenomena and factors affecting the formation and expression of psychological phenomena.

9.6. KC211014. Physics B (2TC, 2-0,0-4). Basic knowledge of mechanical, thermal, electrical, optical and nuclear physics; the law of motion of objects often gawoj in engineering and everyday life; application of laws, the laws of physics to explore and study the interaction between the simple system.

9.7. FL211005. English CB 1 (3TC, 3-0,0-6). To provide a range of vocabulary, structure, grammar and communication skills training at the basic level on topics of normal activities of daily life such as humans and career, job, hobby, transportation, travel, fashion, health and experience. These themes are described and expressed through the medium grammar, language structure and function from categories such as the present form, present continuous, present perfect and past simple, nouns (singular/plural, countable/uncountable, possessive), adverbs, prepositions, adjectives, etc.

9.8. FL211008. French CB 1 (3TC, 3-0,0-6). To provide a range of vocabulary, structure, grammar and communication skills training at the basic level on topics of normal activities of daily life such as humans and career, job, hobby, transportation, travel, fashion, health and experience. These themes are described and expressed through the medium grammar and structure and from categories such as same and, in the present form, present continuous, present perfect and past simple, nouns (singular/plural, countable/uncountable, possessive), adverbs, prepositions, adjectives, etc.

9.9. KC211027. Informatics general (2TC, 1-1). Fundamental concepts of information processing and computers, Internet access operations, the skills used to manipulate the operating system on computers and exploit some application software and storage preparation and serving documents of clerical work. System administrators use database for scientific computing and problem-solving expertise.

9:10. SP211011. Physical education 1(1TC). Course content promulgated in Decision No. 3244/2002/Education and Training and Decision No. 1262/ Education and Training of Ministers dated December 4, 1997 of the Ministry of Education and Training.

9:11. ML211001. The basic principles of Marxism-Leninism (5TC, 3,5-1,5-10). Contents issued Decision No. 52/2008/QD-MoET, dated September 18, 2008, of the Ministry of Education and Training requires political theory to be taught to all students of universities and colleges.

9:12. YD212001. Anatomy 1 (3TC, 2-1). Content covers basic human anatomy, details of organs and systems through theory, models, paintings and other representations of the human body.

9:13. KC211019. Chemistry volume 2 (2TC, 2-0,0-4). Knowledge of the typical non-metals (types of single substances and compounds), the typical metals (pure form and compounds) and the transition metals and structure of organic compounds, hydrocarbons, hydrocarbon derivatives and the derivatives of hydrocarbons.

9:14. KC211021. Practising chemical CG (1TC, 0-1,0-2). Consists of two parts: theory includes qualitative analysis system elements, weight analysis, volumetric analysis and analytical tools and practice includes qualitative analysis of cations, anions, neutral approach, redox method, precipitation method to create complex, determining pH and photometric method.

9:15. FL211006. English CB 2 (2TC, 2 – 0-4). Provides a range of vocabulary, structure, grammar and communication skills training at the basic-level advanced

topics such as everyday life, describing appearance, including biography, predicting the future, comparison, etc. These themes are expressed through the medium vocabulary grammatical structures such as verb tenses present/past tense, present/past continuous and present perfect; conditional sentences 1; comparative adjectives; etc.

9:16. FL211009. French CB 2 (2TC, 2 – 0-4). Provides a range of vocabulary, structure, grammar and communication skills training at the basic-level advanced topics such as everyday life, describing appearance, including biography, predicting the future, comparison, etc. These themes are expressed through the medium vocabulary grammar structure as varieties and from the present/past tense, present/past continuous and present perfect, the article event type 1, comparative adjectives, etc.

9:17. KC211016 Biophysics (2TC: 2 – 0.0 to 4). Basic knowledge of physical laws occurring in the organism: the law of carriage of the body material, the potential formation mechanism of biological effects of light and radiation on biological organisms and biophysical processes in a number of specific organs in the organism.

9:18. KC211017. Practice biophysics (1TC: 0 – 1.0 to 2). Testing the learned knowledge of specific experiments, consisting of nine exercises; determination of activation energy of the frog heart contractions; permeability of cells and tissues; durability of the membrane of red blood cells; mobile phones; power authority; and viscosity.

9:19. KC211043. Medical Genetics (3TC, 2-1). Classifications of the human chromosome, the method and genetic research, the research methodology of human chromosomes, the characteristics and mechanisms of common inherited diseases in humans, and the pathology of human chromosomes. The congenital malformations, mechanisms of molecular pathology, significance of genetic pharmacology studies, and principles of diagnosis, treatment, and preventive advice genetics.

9:20. SP211012. Physical education 2 (1TC, 0-1).Course content promulgated in Decision No. 3244/2002/Education and Training and Decision No. 1262/ Education and Training dated December 4, 1997, of the Ministry of Education and Training.

9:21. QP211001. QP211002. QP211003. QP211004. Military education (7 TC, 0-7). Contents issued Decision No. 81/2007/QD-MoET, dated December 12, 2007 of the Ministry of Education and Training.

9:22. FL211007. English CB 3 (2TC, 2 – 0-4). Provides some language knowledge on topics such as food and health life, views on jobs, environment, information, jobs, etc. These themes are expressed through the medium vocabulary grammar structures such as verb tenses present/past simple, ongoing, completed, conditional sentences two and three, passive/active structure, etc. and practise communication skills with language proficiency at the advanced level, as a basis for reading and studying English literature in the field of expertise.

9:23. FL211010. French CB 3 (2TC, 2 – 0-4). Provides some language knowledge on topics such as food and health, attitudes towards employment, environment,

information belief, etc. These themes are expressed through the medium vocabulary grammar structures such as verb tenses present/past simple, ongoing, pre-past, conditional sentences two and three, structured passive/active, etc. and practise communication skills with language proficiency at the advanced level, as a basis for reading and study French literature in the field of expertise.

9:24. YD212002. Anatomy 2 (four credits, 2-2). Structure, location, relevance and functioning of the human body in normal and pathological, people in total harmony relationship with the environment, people are always in a state of mobilisation, innovation and constant interaction between the environment on human health.

9:25. YD212004. Embryonic tissue (3TC, 2-1). Structure morphology in normal presentation including, molecules of tissues, organs in the body; identifying tissues, organs and their structures in detail using an optical microscope; the formation and normal development of the human from fertilisation through nuclear development stages; the origin of the generation, normal development; structure and function of the parts of the human embryo; THE formation of a number of common congenital malformations.

9:26. YD212006. Physiology 1 (3TC, 2-1). Functions and operational functions of the organs and organ systems in the body; regulatory mechanisms and function of organs and organ systems to ensure consistency between the body and the environment.

9:27. SP211013. Physical Education 3 (1TC, 0-1). Course content promulgated in Decision No. 3244/2002/Education and Training and Decision No. 1262/ Education and Training dated April 12, 1997 of the Ministry of Education and Training.

9:28. YD212017. General Immunology (1TC, 1-0). Introductory immunology, immune response and antigen recognition molecules of antigen-antibody; some effects of system T cells and plasma. Agencies involved cell immune response.

9:29. YD212018. Occupational exposure to HIV/AIDS (1TC, 1-0).

9:30. ML211002. Ho Chi Minh Thoughts (2TC: 1.5 to 0.5 – 4). Contents issued Decision No. 52/2008/QD-MoET, dated September 9, 2008, by the Ministry of Education and Training requires political theory teaching for all students of universities and colleges.

Prerequisite: the basic principles of Marxism-Leninism

9:31. YD212005. Biochemistry (four credits, 3-1). Structure and metabolism of cells mainly in the living body, the relationship and regulatory mechanisms of cells and tissues, the biological catalyst and bioenergy occurring in vivo. Some conventional tests.

9:32. YD212007. Physiology 2 (3TC, 2-1). Explore technology to enable diagnosis, treatment and the application of physiology knowledge in a clinical setting.

9:33. YD212011. Microbiology (3TC, 2-1). Associate microorganisms, infection, antibiotic resistance and the students; virulence factors of microorganisms; the

body's resistance to pathogenic microorganisms and bacteria, viruses and pathogenic organisms in humans.

9:34. YD212012. Basic nursing (2TC, 1-1). Understand and practice standard techniques for monitoring and care of patients in a hospital setting.

9.35. YD212013. Psychological medicine – ethics (1TC, 1-0). Fundamental concepts in psychology; the importance of the psychological impact on health; the types of psychological characteristics of the age; the mood swings typical of psychological illness; the basic skills when exposed to patients, communities and colleagues in professional practice; moral qualities characteristic of the practising physician and the medical research.

9:36. YD212003. Anatomy 3 (1TC, 1-0). The anatomic landmarks in a number of surgical procedures, obstetric and related specialist; some situations cause complications to surgery in some areas of the body; application of anatomical knowledge to diagnosis and treatment as well as serving basis to other subjects.

9:37. YD212008. Physiology 3 (1TC, 1-0). Particular characteristics of the function of organs and organ systems in the body of some ethnic groups in the central highlands, regulatory mechanisms of function of organs and organ systems to ensure unity between the body and environment of some ethnic groups in the central highlands and applying the knowledge of the characteristics of the organs and organ systems of a number of ethnic groups in the central highlands of classes in clinical medicine.

9:38. YD212023. Skills 1 (communication) (1TC, 0-1).

9:39. YD212024. Skills 2 (1TC, 0-1).

9:40. YD212014. Pathophysiology and immunology (four credits, 3-1). Develop an understanding of, the main function of organs, systems, common disease states; the pathogenesis of the condition to support the diagnosis therapy, addiction argued review and consultation; some common disorder in actual clinical use; the body's response in antimicrobial immunity.

9.41. YD212015. Parasites (3TC, 2-1). Understand physiology and ecology of parasites that cause disease and infection in Viet Nam. Harmful effects of common parasites in our country; the epidemiological characteristics of parasitic diseases in Viet Nam; the biological characteristics, epidemiology, prevention and control of parasitic diseases of animals; the diagnostic methods parasitic diseases and the principles and measures against parasitic diseases.

9:42. YD212016. Surgical patient management (3TC, 2-1). Fundamental knowledge about the morphological changes of cells and tissues in the disease process; identifying the relationship between morphology and function in the analysis of the clinical manifestations of the disease; and using the results of diagnostic biopsy and cytology for diagnosis of the disease is common in South Viet Nam.

9:43. YD212021. Diagnostic imaging (2TC, 1-1). Common diseases common in the X-ray film with typical pathological images, principles of imaging techniques in

modern medicine and the strengths and weaknesses of diagnostic methods in medical imaging.

9:44. Medicine D213031. YD213032. Civil basis (four credits, 2-2). Cardiovascular physical examination. The heart sounds normal and pathological. Subclinical cardiovascular system and clinical examination of respiratory system. Subclinical respiratory difficulty in breathing, coughing up blood and pus. The unusual sound when listening to the lungs and clinical examination in the digestive system. Subclinical digestive system and clinical examination and urinary system. Subclinical urinary system and clinical examination of the endocrine system. Subclinical endocrine system and clinical examination of the musculoskeletal system. Subclinical musculoskeletal system: patient method. The syndrome of heart failure. Syndrome, pneumothorax; syndrome, pleural effusion; pulmonary syndrome typical coagulation; ascites syndrome; jaundice syndrome; constipation; back pain; haematuria syndrome; syndrome, shortness of breath; and syndrome, consistent.

9:45. YD213033. YD213034. Offline basis (3TC, 2-1). Disease surgical plan. Surgical abdominal examination; detailed examination of the spine and pelvis; symptomatology fractures, joints; discover the urinary system and the male reproductive system; discover injuries, chest injuries; examination of blood vessels and peripheral nerves; discover injury, traumatic brain injury; sterile, surgical sterilisation; rectal examination, the rectum; general anaesthesia and general anaesthesia. Associate of burns; syndrome, increased intracranial pressure; peritonitis syndrome; intestinal obstruction syndrome. Syndrome: bleeding; obstructive jaundice syndrome; cord compression syndrome; symptomatic carbuncle, juniors, abscesses and nine edge.

9:46. YD212025. Skills 3 (TIP) (1TC, 0-1).

9:47. YD212026. Skills 4 (1TC, 0-1).

9:48. YD212019. Pharmacology (four credits, 3-1). Fundamental knowledge on the pharmacokinetics and pharmacodynamics of the drug classes used in clinical practice.

9:49. YD212020. Surgery practice (2TC, 1-1). The basic movements in general surgery on animals. These are some basic surgical emergency surgery normally.

9:50. YD213035. YD213036. General cancer (2TC, 1-1). Causes of cancer, the natural history of cancer, the detection and diagnosis of cancer, rating and ranking of clinical pathology of cancer and the methods of treating cancer.

9:51. YD212029. Education and health promotion (1TC, 1-0). Associate in health education (health education), the basic concepts of health education, the purpose of health education – process of behaviour change –the principle of health education in the health education group at the base and planning, implementing, evaluating a health education programme.

9:52. YD213087. WHO (3TC, 2-1). Associate of healthcare organisations; health strategy and the objectives of the health sector in 2002; law to protect people's health, Viet Nam; primary healthcare; health management; Viet Nam's health system; organisation and management of health facilities; Health plan; operating, monitoring and evaluation of health activities; statistical indicators of

health – illness – and evaluation of primary healthcare in the primary healthcare online.

9:53. FL213011. Specialisation in English (3TC, 3-0). Gives students the technical term care sector, helping students to read, understand documents and access information and new materials in English more easily and is then applied to the process of learning and professional studies students.

9:54. FL213015. Specialisation in French (3TC, 3-0). Gives students the technical term care sector, helping students to read, understand documents and access information and new materials in French easier and is then applied to the process of learning and professional studies students.

9:55. YD212030. Community practice I (1TC, 0-1). Based on what the students learned after 3 years, in addition to the basic subjects, students have been learning about: education and health promotion and health organisations. So, in the field, mainly students practise skills: outreach, conducted health education to the people and learn about the health system organisations at the grass roots.

9:56. YD212010. Methodology of Science (2TC, 2-0).

9:57. YD212009. Haematology basis (2TC, 2-0.) Basic theory of haematology and blood transfusion; looking at the division of haematology subjects: blood transfusions such as cells, coagulation, immunology, genetics and blood transfusion; and application techniques of haematology tests – blood transfusion to reality.

9:58. YD213037. YD213038. Civil pathology 1 (four credits, 2-2). Diagnosis, treatment and counselling are a number of common medical conditions; assessment and initial management of common emergency diseases: circulatory system (diagnosis and management of chest pain, angina, myocardial infarction, chronic heart discarded and respiratory system management of pneumothorax, lung cancer).

9:59. YD213043. YD213044. Secretary pathology 1 (four credits, 2-2). Diagnosis and aid some surgical patients; move the patient to a higher level of treatment in special time; the exchange of generalised disease: inflammation of appendicitis, bowel obstruction, intussusception, infection of the peritoneum, chest injuries, urinary system injuries, pyloric stenosis, gastric perforation, rupture of solid organs, andcancer.

9.60. YD212022. Nutrition – hygiene and food safety (1TC, 1-0). Chemical composition, nutritional value and the principles of hygiene and common diseases in every kind of food; roles and nutrient needs related to health and illness of the human body; propaganda for people in the community about issues on nutrition and food safety, given the preventive measures, and the importance of nutrition for health and human disease.

9.61. KC211006. Probability and statistics (3TC, 3-0). The basic knowledge of probability, events, probability of events and the nature of probability; random, discrete and continuous variables: expectation and variance; the basic types of distribution, distribution binomial, Poisson, exponential, standard, etc.; law of large numbers and limit theorems; theoretical estimation and hypothesis testing and regression and correlation.

9.62. YD213047. YD213048. Obstetrics 1 (four credits, 2-2). Issues of obstetrics course: production facility, physiology and gynaecology; normal pregnancy; real difficulty, anddifficult birth causes – diagnosis and management.

9.63. YD212028. Epidemiology (3TC, 2-1). Epidemiology in general; applied epidemiology: strategies for epidemiologic studies, descriptive epidemiology, epidemiological analysis, epidemiological intervention; the epidemiology of infectious diseases, the process of translation, the epidemiology of the disease is spread through the respiratory tract, the epidemiology of gastrointestinal diseases, the epidemiology of diseases transmitted through blood, the epidemiology of transmitted diseases in the mucocutaneous zone, community diagnosis and screening to detect disease in the community series.

9.64. YD212027. Environmental science and environmental health (3TC, 2-1). Biological and environmental population and community ecology environment; environment health and population and ecosystem agriculture energy and environmental pollution; water sanitation and supply of clean water, schools; the school-related diseases; hygiene urban residential areas, hospitals, air pollution, soil environment; general medical burden on labour and employment; the principles of preventive occupational hazards; the occupational hazards due to biological factors, adverse effects due to the physical elements of the production process; toxicology and occupational disease prevention and control measures; pesticides, herbicides, rodenticides, the poison gas and dust ergonomic precautions – diseases caused by dust in the manufacturing process.

9.65. YD213039. YD213040. Civil pathology 2 (four credits, 2-2). The digestive system (chronic hepatitis, cirrhosis, liver abscess, irritable bowel syndrome, constipation); endocrine system (diabetes, Graves, simple goitre); blood (diagnosis and treatment of anaemia, leukaemia level, economic leukaemia) and urinary tract (acute renal failure, glomerulonephritis levels, urinary bladder inflammation.

9.66. YD213051. YD213052. Paediatrics 1 (four credits, 2-2). Paediatric basis: physiological characteristic anatomical organs in children; the period of youth, mental development, advocacy, children's physical; programmes in child healthcare.

9.67. YD213085. VD population, the health protection BMTE – reproductive health (1TC, 1-0). Demography; consulting services in family planning; reproductive health education for minors; family planning and maternal and child health.

9.68. ML211003. Revolutionary policy of the Communist Party of South Viet Nam (3TC). Contents issued Decision No. 52/2008/QD-MoET, dated September 18, 2008, of the Ministry of Education and Training plans to hold teaching political theory courses for student members of universities and colleges.

Prerequisite: Ho Chi Minh Thoughts

9.69. YD213055. YD213056. Infectious diseases 1 (four credits, 2-2). Definition, characteristics and classification of infectious diseases; diagnostic criteria, causes and management of infectious diseases through the blood and skin and mucosa; methods of preventing blood-borne diseases and mucocutaneous; disease transmission through the digestive tract and respiratory tract; treatment

principle, the common complications, treatment for complications of gastrointestinal and respiratory precautionary principle transmitted diseases. Khang biotherapy of infectious diseases; use of corticosteroids in infectious diseases.

9.70. YD213067. YD213068. Lao (2TC, 1-1). Pulmonary TB (HIV); TB treatment; characteristics and current situation of tuberculosis; National TB Control Programme; tuberculosis; tuberculosis infection profile, tuberculosis meningitis, peritoneal TB, bone and joint TB, TB nodes; Urinary tuberculosis and pleural genital TB.

9.71. YD213077. YD213078. Rehabilitation (2TC, 1-1). Process and prevent disability; rehabilitation (rehab) based on the community; the secondary injury, detection and prevention; outline of the methods of commonly used physical therapy; overview of rehabilitation techniques; an examination of people with disabilities; manual muscle test; measurement of joint range; practise manipulating devices for rehabilitation; role of physical therapy (physiotherapy), rehabilitation of the physically handicapped; role of physiotherapy, rehabilitation of mental disability; role of physiotherapy, rehabilitation and disability in most severe disabilities; rehabilitation for patients with hemiplegia; rehabilitation for patients with spinal cord injury.

9.72. YD213079. YD213080. Neurology (2TC, 1-1). Recalling some anatomical, neurological function; hemiplegia syndrome; syndrome legs; increased intracranial pressure; seizures; cerebral vascular accident; several methods of subclinical nerve; encephalitis syndrome; second hip pain and coma.

9.73. YD213081. YD213082. Psychiatry (2TC, 1-1). Associate and psychiatric symptoms; drug addiction; alcohol abuse and alcoholism; mental disorder actual damage; schizophrenia; depression; stress-related disorders; agitation; suicide and mental healthcare in the community.

9.74. YD213057. YD213058. Traditional Medicine 1 (four credits, 2-2). traditional and brief history of our Party's view of traditional medicine today; theory of Yin and Yang; five elements theory; four diagnostic – bat diamond; eight principles of treatment methods; using the usually grave; acupuncture and traditional medicine. Some remedies are often used in traditional medicine.

9.75. YD213059. YD213060. Infectious diseases 2 (2TC, 1-1.) Use of corticosteroids in infectious diseases; antimalarial drugs; treatment of bacterial meningitis, malaria and dengue shock; retroviral drugs and how to use; treatment of drug-resistant typhoid, hepatitis malignancy and chronic hepatitis.

9.76. YD213061. YD213062. 2 Traditional medicine (2TC, 1-1). Rheumatoid arthritis; neck and shoulder pain; sciatica; VII nerve paralysis peripheral; flu – method wind; depression; peptic ulcers; cerebral vascular accident; treatment of dengue (level I, II) by traditional medicine; acupressure massage.

9.77. YD213063. YD213064. Clinical pharmacology (2TC, 1-1).

9.78. YD213084. National Health Programme (1TC, 1-0). Expanded programme on immunisation; the prevention of iodine deficiency disorders; the S/FP/RH; malaria control programmes; programme prevention of malnutrition; programme

prevention of diarrhoea; programme on HIV/AIDS; leprosy control programmes.

9.79. YD213086. Health economics – healthcare insurance (1TC, 1-0). Associate economy; health economics, the relationship between economics and health; applied health economics in health services; financial health, management applications in financial basis; general health insurance (HI); system organisation and operation of health insurance; the policies related to the state's health insurance in Viet Nam; the basic content of health insurance and the process of health insurance operations.

9.80. YD213065. YD213066. Allergies (2TC, 1-1). Some basic concepts and modern allergy immunity; allergens; anaphylaxis and anaphylactic shock; bronchial asthma; allergies; autoimmune diseases; allergic rhinitis; the specific method of diagnosing allergies; the specific treatment of allergic disease; urticaria – Quincke's oedema and dermatitis, contact dermatitis.

9.81. YD213069. YD213070. Dentistry (2TC, 1-1). Disease cavities; pulp inflammation; inflammation around the tooth stem; gingivitis and periodontal inflammation; inflammation of connective tissue and maxillofacial region; emergency jaw and facial injuries, and regular dental; trauma to the hand function; tooth extraction, tooth extraction contraindications, complications associated with systemic oral; co-infection of the mediastinum; congenital malformation of the maxillofacial region; maxillofacial region tumours (benign + malignant);and dental care in the community.

9.82. YD213071. YD213072. Otolaryngology (2TC, 1-1). Opening theme; symptomatology ear, mastoid; symptoms of sinusitis school; symptomatology of the throat, vocal; otitis media, inflammation of the ear bones; the major intracranial complications caused by the ear; rhinitis, sinusitis face; sore throat, tonsils – VA. Oesophageal foreign bodies – foreign body airway; bleeding from the nose; following a throat abscess and nasopharyngeal cancer (NPC).

9.83. YD213073. YD213074. Eyes (2TC, 1-1). again anatomy and physiology of visual-related eye diseases; diagnosing the cause of red eye; diagnosing the cause of blurred vision; glaucoma disease – pressure labels – market; disease conjunctivitis; trachoma; disease uveitis; disease and ulcerative keratitis cornea; visual acuity and refractive error; cataracts and eye injuries, burns in the eyes.

9.84. YD213075. YD213076. Dermatology (2TC, 1-1). Lesions, basic; skin toxicity due to drugs, cosmetics; atopic dermatitis; contact dermatitis; eczema fat; scabies; disease moment; shingles; chickenpox; herpes; psoriasis; tinea; gonorrhoea; syphilis; nongonococcal urethritis disease; management methods for STD patients with TC and HC; mucocutaneous manifestations of HIV/AIDS and leprosy.

9.85. YD213083. Forensic medicine (2TC, 1-1). Associate of forensic medicine – school corpses; injury legal medicine; toxicology forensic medicine; genital forensic medicine; suffocated: causes carbon oxide inhalation in animals; water to suffocate animals; asphyxiation by hanging animals and tabulation expertise – commercial licence.

9.86. YD212088. Military medicine (1TC, 0-1). Responsibilities and obligations of every citizen in the national defence, especially the specialised knowledge related to the service of defence of health workers; performing some anti-war engineering chemistry, microbiology and some knowledge of internal medicine, surgery field, initial emergency for the wounded and knowing how to deploy troops Y field stations in the field.
9.87. YD212089. 2 Community practice (1TC, 0-1). Examination and diagnosis is the basis of common human diseases; establish disease patterns in community internships; join the national health program; investigation, review and analysis of data 1 issue of environmental sanitation, a medical epidemiologist or a National Health Programme.
9.88. YD213041. YD213042. Civil pathology 3 (four credits, 2-2). Nervous system (diagnosis and management of coma, emergency cerebral vascular accident, headache); resuscitation (shock, emergency circulatory respiratory arrest, haemoptysis emergency, electric shock, water asphyxia, snakebite, management of acute poisoning, toxicity levels often); elderly pathology and diagnosis and management of back pain.
9.89. YD213045. YD213046. Secretary pathology 2 (four credits, 2-2). Exchange of injuries and diseases: diagnosis and aid of fracture and closed and open dislocations of the upper limb and lower limb; first aid vascular injuries, burns; diagnosis and early detection chamber tamponade; blood by fat embolism in fracture.
9.90. YD213049. YD213050. Obstetrics 2 (four credits, 2-2). Production diseases: lessons of the disease – diagnosis and management; gynaecology, the all gynaecological disease, diagnosis and management; family planning and reproductive healthcare.
9.91. YD213053. YD213054. Paediatrics 2 (four credits, 2-2). Pathology paediatric symptoms: the disease is common in children; how to detect and manage care; paediatric treatment, the syndrome, first aid and disaster and how to treat drug use in children.
9.92. YD216090. Graduation thesis (ten credits). Carry, implement and protect the content thesis: the theme of internal medicine, surgical, obstetrics, paediatrics, infectious, etc.; regarding public health and a number of specialised other sectors.
9.93. YD216091. Specialist subject LT final (1TC, 1-0).
9.94. YD216092. Thematic LT foreign final (1TC, 1-0).
9.95. YD216093. Thematic LT final product (1TC, 1-0).
9.96. YD216094. Paediatric symposium final LT (1TC, 1-0).
9.97. YD216095. Civil TH final (four credits, 0-4).
9.98. YD216096. Secretary TH final (four credits, 0-4).
9.99. YD216097. TH final product (four credits, 0-4).
9100. YD216098. Paediatrics final TH (four credits, 0-4).
9101. YD216099. Thematic diseases transmitted sexually (1TC, 1-0). Syndromes and common diseases transmitted sexually and the treatment regimen and preventive measures.

9102. YD216099. LCK foreign symposium (1TC, 1-0). Provision for common diseases: dentistry, eyes and ENT community.
9103. YD216100. Parasitology symposium (1TC, 1-0). Disease parasite transmitted from animals to humans: diagnosis, treatment and prevention.
9104. YD216101. Epidemiology symposium (1TC, 1-0).
9105. YD216102. Sanitation symposium (1TC, 1-0).

# Appendix B

Full table of health indicators and trends

| # | Indicator | Year | | | Criteria |
|---|---|---|---|---|---|
| | | 2009 | 2011 | 2015 | |
| 1 | Life expectancy (years) | 72.8 | 73.0 | 74.0 | B, C, H |
| | (Male) | 70.2 | 70.4 | N/A | – |
| | (Female) | 75.6 | 75.8 | N/A | – |
| 2 | Total fertility rate (childbearing-age women) | 2.03 | 1.99 | 1.86 | B |
| 3 | Reduction in fertility (annual %) | –0.9 | 0.5 | 0.1 | B, C, H |
| 4 | Population growth (%) | 1.06 | 1.04 | 0.93 | B, C, H |
| 5 | Population (millions) | 86.0 | 87.8 | <92 | B, C, H |
| 6 | Maternal mortality ratio (per 100,000 live births) | 69.0 | 67 | 58.3 | B, C, D, H |
| 7 | Infant mortality rate (per 1000 live births) | 16.0 | 15.5 | 14.8 | B, C, D, H |
| 8 | <5 years mortality rate (per 1000 live births) | 24.1 | 23.3 | 19.3 | B, C, D, H |
| 9 | Malnutrition rate <5 years (% underweight) | 18.9 | 16.8 | 15.0 | A, B, C, H |
| 10 | Malnutrition rate <5 years (% stunting) | 31.9 | 27.5 | 26.0 | B, C, H |
| 11 | Doctors (per 10,000 people) | 6.59 | 7.23 | 8.0 | C, H |
| 12 | Commune health stations with a doctor (%) | 67.7 | 71.9 | 80 | B, C, H |
| 13 | Commune health stations with ob/gyn expertise (%) | 95.7 | 95.3 | >95 | A, B, C, H |
| 14 | Villages with a health worker (%) | 75.8 | 82.9 | 90 | B, C, H |
| 15 | Public share of total health spending (%) | 42.2 | N/A | >50 | C, H |
| 16 | Health insurance coverage (%) | 58.2 | 64.9 | 80 | B, C, H |
| 17 | Catastrophic out-of-pocket health cost (%) | 5.5 | N/A | N/A | – |
| 18 | Hospital beds (per 10,000) | 20.2 | N/A | 23 | B, C, H |
| 19 | Communes meeting health benchmarks (%) | 65.4 | N/A | 60 | C, H |
| 20 | TB detection rate (per 100,000) | 52.2 | 57.7 | N/A | |
| 21 | HIV prevalence (per 100,000) | 187 | 224.4 | <300 | B, C, H |
| 22 | Dengue detection (per 100,000) | 122 | N/A | N/A | B |

(continued)



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| # | Indicator | Year | | | Criteria |
|---|---|---|---|---|---|
| | | 2009 | 2011 | 2015 | |
| 23 | Smoking prevalence (% age 16+) | N/A | N/A (47.4 in 2010) | N/A | B |
| 24 | Low birth weight (%) | 5.3 | N/A | N/A | B, C, D, H |
| 25 | Immunisation <1 year (%) | 96.3 | 96 | >90 | – |
| 26 | Pregnancies with >3 antenatal visits (%) | N/A | 82.6 | 80 | D, F |
| 27 | Skilled assisted deliveries (%) | 94.4 | 97.2 | 96 | D, F |
| 28 | Birth sex ratio (M/100F) | 111 | 111.9 | <113 | B, C, H |
| 29 | Medical facilities with waste treatment (%) | 74 | N/A | 80 | A, H |
| 30 | University-trained pharmacists (per 10,000 population) | 1.77 | N/A | 1.8 | C, H |
| 31 | Health workers with licence (%) | 0 | 0 | 400 | – |
| 32 | Health spending as % GDP | 6.6 | N/A | N/A | – |
| 33 | Per capita health spending (1000 VND) | 159.9 | N/A | N/A | – |
| 34 | Out-of-pocket share (%) | 50.5 | N/A | N/A | – |
| 35 | Inpatient spending per user over a year (1000 VND) | 2097 | N/A | N/A | – |
| 36 | Outpatient spending per user over a year (1000 VND) | 640 | N/A | N/A | – |
| 37 | Substandard drugs (per 10,000 tests) | 330 | N/A | N/A | – |
| 38 | Retail pharmacies (per 10,000 people) | 4.9 | N/A | N/A | – |
| 39 | Blood units screened for 5 infectious diseases prior to transfusion (%) | N/A | N/A | 100 | – |
| 40 | Inpatient admissions per year (per 100 people) | 13.3 | N/A | N/A | – |
| 41 | Outpatient visits per year (per 100 people) | 37.7 | N/A | N/A | – |
| 42 | People with hospital contacts with health or exemption card (%) | N/A | N/A (66.7, 2010) | N/A | – |
| 43 | Inpatient admission duration (days) | 6.9 | 6.8 | N/A | – |
| 44 | TB cure rate (per 100,000 people) | 90.6 | 90.8 | N/A | – |
| 45 | Malaria incidence (per 100,000 people) | 70.8 | N/A | N/A (15 by 2020) | – |
| 46 | Leprosy prevalence (per 100,000 people) | 0.04 | N/A | 0.20 | – |
| 47 | Leprosy detection (per 100,000 people) | 0.41 | 0.37 | 0.30 | – |
| 48 | HIV incidence (per 100,000 people) | 16.1 | 16.1 | N/A | – |
| 49 | Mental health service in communes (%) | 63.8 | N/A | N/A | – |
| 50 | Diagnosed hypertension in treatment (%) | N/A | N/A | N/A | – |
| 51 | Diagnosed diabetes in treatment (%) | N/A | N/A | N/A | – |
| 52 | Women over 40 screened for breast cancer (%) | N/A | N/A | 20 | – |
| 53 | Food poisoning (People) | 5212 | 4700 | N/A | – |
| | (Incidents) | 152 | 148 | N/A | – |
| | (Deaths) | 35 | 27 | N/A | – |

(continued)

| # | Indicator | Year | | | Criteria |
|---|---|---|---|---|---|
| | | 2009 | 2011 | 2015 | |
| 54 | Pregnant women having 2+ tetanus vaccinations (%) | 93.7 | 94.5 | N/A | – |
| 55 | Postpartum care within 42 days (%) | 81.9 | 87.7 | 85 | – |
| 56 | Total receiving postpartum care (%) | 81.9 | 85 | N/A | F |
| 57 | Contraceptive use prevalence (%) | N/A | 78.2 | 100 | D |
| 58 | Households with improved latrine (%) | 48 | 55 | 65 | – |
| 59 | Households with improved drinking water (%) | 79 | 78 | 85 | – |

Key to criteria:
*A* National Assembly indicator assigned to the health sector
*B* Government indicator assigned to the GSO and MOH for data
*C* Indicator in the 6-year health sector plan
*D* Millennium Development Goal
*E* WHO recommendation
*F* Indicator in the national health target programme
*H* National strategy for the protection, care and promotion of people's health 2011–2020
*HPG* Health Partnership Group
*GSO* General Statistics Office
*MOH* Ministry of Health
*NHA* National Health Accounts
*NN* National Institute of Nutrition
*NTP* National Target Programme

# Appendix C



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JANS comments on the process and content of the 2010–2015 health plan final draft

| Dimensions and attributes | Comments on process and content | Recommendations |
|---|---|---|
| **Dimension 1** Situation analysis and programming | | |
| **Attribute 1** National strategy is based on a sound situational and response analysis of the context | **Participation**: There has clearly been a great effort on the part of MOH to better integrate the Joint Annual Health Report (JAHR) and the plan. The plan has successfully identified a number of important issues to be covered. Analysis and inputs for the plan are more comprehensive and participatory than previous plan 2006–2010 | Despite significant progress, whilst maintaining stronger participation by existing stakeholders, expansions to others are important and ensure relevance, e.g. Social Committee of the National Assembly, consumer representatives, professional groups, private sector, education and other relevant sectors, representatives from grass-roots levels |
| **Attribute characteristic 1.1** The situation analysis is based on a comprehensive and participatory analysis of health determinants and health outcome trends within the context of the country | Key informants endorse strong participation and engagement by stakeholders in producing JAHR: DPF together with JAHR working group developed JAHR report framework and organised workshop with participation by HPG. Various departments of MOH and related stakeholders provide comments, recruit national consultants for each specific areas of JAHR, write up a report and organise three workshops to get comments (one WS discussed the difficulties, constraints and challenges of healthcare system; one discussed on priority setting for the next 5 years and one on identification of solutions and interventions) | |
| | Various departments of MOPH also contribute to the situation assessment, though they describe situation of their routine works but not focused on problem identifications and other health system context. It is one of difficulties that the planning team has to face with | |
| | After three workshops between planning team and JAHR teams, there were increased linkages and dialogues. Especially the JAHR WS on setting priorities, outputs from WS were sent immediately to the planning group. Vice versa, the outputs of the WS organised by the planning group on solutions were fed back to JAHR team. In the workshop, indicators were identified which are appropriate with both priorities identified in JAHR and objectives of 5-year health plan | |

| | | |
|---|---|---|
| | **Comprehensiveness**: JAHR furnishes based on (i) assessed current situation; (ii) identified priorities of the health sectors and (iii) support for developing annual health sector plan. Annual JAHR exercise focuses each year on thematic topics. JAHR 2010 aims to provide inputs for the development of the plan, and it looks at 6 health systems building blocks | Analysis of determinants could be improved considerably based on existing studies and surveys. Understanding the actual cause behind those indicators and determinants is important and will be helpful in justifying planned interventions |
| | However, analysis of indicators and determinants is still not comprehensive enough to show the actual causes behind those indicators and determinants. For example, the analysis shows there are large disparities between regions in some of indicators such as IMR and child malnutrition but did not assess the reasons for that. Similarly for analysis of health determinants, it focuses on listing health determinants but not much on pointing out their root causes such as social, cultural, economic and especially organisational/system context | It is necessary to demonstrate geographical disparities and its causes of MMR for specific interventions in the plan |
| | | Health determinants: comprehensive analysis of physical and social-cultural-economic, ethnicity, education, gender determinants. Note that injuries and accidents are health outcomes, not determinants |
| **Attribute characteristic 1.2** The analysis uses disaggregated data to describe progress towards achieving overall health sector policy objectives in line with the policy dimensions of resolution WHA 2009 62.12 on primary healthcare: universal coverage, to improve health equity; service delivery, to make health systems people centred; public policies, to promote and protect the health of communities; leadership, to make health authorities more reliable | Draft 3 did not adequately describe progresses towards achieving overall health sector policy objectives in line with the policy dimensions of resolution on PHC | Need to be added in draft 4, though some parts are reflected in the human resources development |

(continued)

| Dimensions and attributes | Comments on process and content | Recommendations |
|---|---|---|
| **Attribute characteristic 1.3** Identification of priority problem areas and programmatic gaps | Priority problems and solutions are identified separately by specific areas | It would be important for the situation analysis to better prioritise key issues to be addressed |
| | The causes of those priority problems are not well assessed in the situation section. It is necessary to look at specific problems in the context of health system to devise specific and effective policy interventions | Among the seven building blocks [pharmaceutical and vaccines are separate item from the medical equipment] and three other issues in section 12, what are the priority and major entry points, given that resource might not be available to address all of them? |
| | Though a number of key issues have been identified, HPG suggests there should be a stronger interrelationship and interactions across different key issues | |
| | The lack of integration across different areas (partly as a result of financing flows to different subsectors) represents one of the major weaknesses in the health system, in large part due to the fact that a number of vertical programmes are operating in parallel with each other and are not well integrated in terms of implementation as well as management. As Viet Nam has reached middle-income-country status, these issues will become increasingly important over the next 5 years. As donor funding to health starts to decline, it is important for the government to consider ways in which efficiency can be improved | |
| | Where some programmes still do not achieve indicators as targeted, it is necessary to analyse reasons for that of which referring to its implementation | |
| | Section 12 describes the priority issues to be addressed, the plan proposed 10 areas, seven out of ten are health systems building blocks and three other health issues, namely, family planning, health status and disparities and preventive medicines at primary healthcare level, are highlighted. It is unclear how these were prioritised. There is no clear process on the priority setting | |

| | | |
|---|---|---|
| **Attribute 2** Clearly defined priority areas, goals, objectives, interventions and expected outcomes that contribute to improve health outcomes and meeting national and global commitment | | |
| **Attribute characteristic 1.4** Objectives are measurable, realistic and time bound | The objective described in draft 3 is rather general. The objective is too broad and includes, to reduce morbidity and mortality, promote health and increase life expectancy, improve the quality of our race, contribute to improving the quality of life and the quality of the human resources and foster the formation of a synchronised system of healthcare from the central to the grass- roots levels and people's habit of keeping good health, in response to the needs of industrialisation, modernisation, national building and defences | It is necessary to provide specific objectives of the plan of which measurable, realistic and time-bound criteria need to be taken into consideration, although the target to achieve by 2015 is clearly written in the table under section 3 on basic health indicators |
| | It is felt that the objectives and target indicators by 2015 are realistic; however, hospital bed per 10,000 inhabitants (exclude CHS bed) would increase from 20.5 to 23.0; this means around 21,000 new beds would put in place by 2015. There is a need to ensure that this target is realistic | There is a need to plan for adequate number of health workers to operate these beds and retain them in public health sector. It is not clear on what are the policy interventions on rural retention and increase enrolment of new graduates in rural health services |
| | The reduction in MMR from 68 in 2010 to 58.3 by 2015 needs a statement that this would be achievable | |
| | It would be extremely difficult to increase population coverage on insurance from 60 % in 2010 to 80 % in 2015 due to nature of the contributory scheme for the informal sector despite the high level of budget subsidies | |

(continued)

| Dimensions and attributes | Comments on process and content | Recommendations |
|---|---|---|
| **Attribute characteristic 1.5** Goals, objectives and interventions address health priorities, equitable access and quality and health outcomes across all population subgroups, especially vulnerable groups | Goal, objectives, results and key interventions are not well structured. It is not clear how prioritisation was done, what strategies and specific interventions will be carried out and how they will respond to the needs of vulnerable groups (age, gender, wealth, urban/rural). Also, it is not clear what effective interventions would be chosen to meeting national/global commitments | It is necessary to address health priorities, equitable access and quality and health outcomes across all population subgroups, especially vulnerable groups in the objectives and interventions |
| | Though a number of priority areas are identified, these remain broad and seemingly cover the range of interventions included in the plan. Subsequently, interventions are not systematically organised and appear to be a listing of existing/planned *projects/ programmes in the sector*. This is because the situation analysis does not provide sufficient in-depth analysis in certain key areas; therefore, the real cause of the problem is often not considered in a systematic way | It should better focus the perspective of patient-centred care and linked with this a more holistic approach to PHC, for example, the development of patient right or charter and empowerment of consumer protection groups |
| | | DPF should include intervention to improve health governance and support MOH and its subnational system and strengthen capacity to undertake more and better its stewardship role |
| | Although there is no systematic burden of disease study in Viet Nam, routine statistics shows that chronic NCD is increasingly a major problem of disease and economic burden. Unfortunately, there is no priority programme to address the chronic NCD. References on cost-effective clinical and community-based interventions should be referred from the DCP2 | Suggest that influenza, rabies, cholera and acute watery diarrhoea are added under the section on preventive medicine. Also suggest a specific reference to preparedness for complex public health emergencies including pandemics and strengthening disease surveillance and co-ordination between human and animal health. At the end of the section on preventive medicine, suggest adding a sentence on multi-sector co-ordination on complex health issues, including multi-sector pandemic preparedness |

| | | |
|---|---|---|
| | There is a sporadic reference to chronic obstructive pulmonary disease which is attributable to tobacco use. There is a need to address how Viet Nam would bring down prevalence of regular smoker and better protect the health of the non-smokers and enforce a smoke-free environment | A new priority programme on effective intervention to prevent and control chronic NCD should be provided |
| | Although the need to improve primary healthcare is described, there appears to be no clear strategy concerning how this will be done. For example, there is no reference to the linkages/ interaction between different levels of care (especially primary and secondary), in order to offer a comprehensive package of care to the population (particularly those disadvantaged groups) and ensure proper referral backup services at the provincial level or how to make patient-centred care as well as how to make healthcare becomes universal coverage | |
| | Due to lack of in-depth analysis of the context in identifying causes of priority problems and programmatic gaps, therefore, there are no specific programmes to improve health governance and support MOH and its subnational system to strengthen capacity to undertake more and better stewardship role when it is seen as crucial in the next 5 years. This also includes more detailed activities in strengthening the legal framework | |
| | The private sector has been touched on briefly, but no specific or concrete programmes/interventions to harness the potential of private sector in healthcare (other than a relatively general statement on developing mechanisms to strengthen collaboration with the private sector). Careful management of the growing magnitude of the private sector is so critical in various dimension, e.g. universal coverage, human resource migration dynamics, inefficiency and potential supplier-induced demands and catastrophic health expenditure to the households | |

(continued)

| Dimensions and attributes | Comments on process and content | Recommendations |
|---|---|---|
| **Attribute 3** 'Planned intervention is feasible, locally appropriate, equitable and based on evidence and good practice, including consideration of effectiveness and sustainability' | | |
| **Attribute characteristic 1.6** Planned strategies and interventions are based upon analysis of effectiveness and impact and clearly identify how they contribute to expected results | Planned strategies and interventions are not clearly reflecting that they are based on analysis of effectiveness and impact. There is no reference how these interventions contribute to expected outcomes | Given there are a number of programmes that have been implemented over the last 5 years and these programmes are found to be implemented again in this plan without specificity of whether or not they are truly effective and necessary to be maintained. A critical assessment of the programmatic outcome is an important foundation to guide better interventions |
| **Attribute characteristic 1.7** The plan identifies and addresses key systems issues that impact on sustainability including equity, financial and human resource and technical sustainability gaps and constraints | Interventions are described as key task under section 4 of part II of the plan | The interventions need to be clearly identified based on more in-depth (causal) analysis |
| | **Feasibility:** From a technical point of view, the current listing of interventions is not sufficient to guarantee the feasibility of the plan because concrete interventions on 'how to do' are not clearly defined | |
| | **Appropriateness and effectiveness:** Interventions presented appear to be appropriate despite the need for a greater linkage between them | |
| | **Equity:** Equity is only partially considered in the plan. In other words, it is not clear how the plan would minimise the geographical inequity in IMR and child malnutrition (Tables 1 and 2 of the plan). There is a need to refer to intersectoral action, such as education and improved female literacy rate which have a major bearing on health of children. Economic development, poverty reduction and equitable income distributions are important contribution to health equity goals | |
| | **Sustainability:** Without formal assignment of responsibility to department concerned on implementation and adequate financial commitment, it is unlikely that interventions will be sustainable | |

| | | |
|---|---|---|
| **Attribute characteristic 1.8** Plan describes short- and long-term strategies to meet technical assistance requirements for its implementation | There is no assessment on the requirement of technical assistance in the plan | Further analysis may be needed to determine which of the interventions require technical assistance |
| **Attribute characteristic 1.9** Contingency plans for emergency health needs (natural disasters and emerging/re-emerging diseases), in line with the international health regulations, are included in national planning process at all levels | Contingent plans for emergency health needs in case of natural disaster and major disease outbreaks are still not included in the plan | Contingent plans for emerging threats, pandemics and complex emergencies need to be included or referred to if there are these plans elsewhere |
| **Attribute 4** Both assessment of risks and proposed mitigation strategies are present and credible | | |
| **Attribute characteristic 1.10** The plan includes a risk assessment of potential barriers to successful implementation | The plan does not appear to have formal risk assessments and mitigation strategies are not well defined | Risk assessments should be addressed in draft 4 that all potential risks are well aware and plans to mitigate these risks are well thought out |
| | One key barrier in achieving 80 % population coverage with prepayment scheme is the contributory nature for the informal sector where enforcement and contribution collections are difficult | Risk assessment should be examined not only from health sector perspective, and risks and challenges are also examined from economical and social, natural environment perspectives |
| | There is a need to identify barriers and risk to achieving goals of the ten key tasks in section 4 of part II of the plan and how to mitigate these barriers | |

(continued)

| Dimensions and attributes | Comments on process and content | Recommendations |
|---|---|---|
| **Dimension 2** Process soundness and inclusiveness of development and endorsement processes for the national strategy | | |
| **Attribute 5** Multi-stakeholder (including the government) involvement in development of national strategy and operational plans (led by the government, with a transparent participative process) and multi-stakeholder final endorsement of national strategy | Positive steps have been taken by MOH in adopting a new approach to planning based on openness, transparency, engaging and being more participatory | Add one section to document the process on how the plan was gradually developed to demonstrate the level of involvement and participation by stakeholders |
| | The application of WHO six health systems building blocks in the construct of the plan sounds reasonable and useful in strengthening health systems, the vital contribution to good health of the population | |
| | Genuine partnership between JAHR and planning team and efforts in involving provincial health bureaus in the plan development processes in a bottom-up manner were appreciated by key informants | |
| | However, only 20 % of provinces and cities submitted their provincial 5-year plan to the MOH. Influenced by the vertical nature of their programme, the level of involvement by some MOH departments is not high, with limited commitments. At times, they comment only their department's mandate without concerns over the plan as a whole. MOH officials perceive annual health plan more important than the 5-year plan | |
| **Attribute 6** High level of political commitment (at the highest level) to national strategy | In general, key informants indicated that the plan was developed based on the direction and guideline of relevant policies, strategies and related regulations. There is verbal financial commitment by political and government agencies, but it is difficult to predict the level of annual budget and limitation of other legal frameworks | |
| | Integral part of the plan contributes to the development of health chapter of the national socio-economic development plan compiled and synthesised by the Ministry of Planning and Investment. This demonstrates highest-level commitments on the plan | |

| | | |
|---|---|---|
| | The regulatory framework for developing and implementing the plan is clear. Implementation issues may arise if ownership is not present (defined as active involvement/oversight of development and adoption in day-to-day management activities) of the plan by the MOH as a whole | |
| **Attribute 7** National strategy consistent with relevant higher- and/or lower-level strategies, financing frameworks and underlying operational plans | MOH departments, national targeted programmes and the provinces each developed their plans based on guidelines and templates provided by the DPF. These plans apply similar formats. DPF staff summarised and incorporated into the 5-year plan. However, DPF could not control the orientation and quality of these provincial plans and NTP | Full involvement by other MOH departments and NTP and reflection in the plan of subsector strategies are currently being developed. Though those strategies may not yet be completed and approved, it would be very helpful for the plan to draw on these, in order to ensure full consistency |
| | In a departmental plan, the national targeted programmes were developed in consistent with the national strategies and policies relevant to their areas | Further extension of consultation with ample time to allow inputs provided by a broad range of stakeholders such as professional groups, private sector and education and academic institutions |
| | Full involvement and contributions by provincial health bureaus are materialised when their inputs were well reflected in the plan. Bottom up ensure relevance and interrelationship between the national and subnational plans | |
| **Dimension 2** Finance and auditing | | |
| | Although the planning process has been robust, there is room for improvement in the linkages between the strategy, expenditure planning and resources, including with MTEF | |
| **Attribute 8** Expenditure framework with comprehensive budget/costing of the programme areas covered by the national strategy | | |

(continued)

| Dimensions and attributes | Comments on process and content | Recommendations |
|---|---|---|
| **Attribute characteristic 3.1** The strategy is accompanied by a sound expenditure framework with a costed plan. It should ensure pertinent recurrent and investment financing of, e.g. human resources, access to medicines, decentralised management, infrastructures and logistics | Budget plan attached to draft 3 is not in the budget plan template that will be attached to the final version. Comments focus on the process of budget development, not on the attached budget draft | In addition to the government-defined standard format of budget plan, an additional budget table should be attached to the 5-year plan in order to clarify the JANS attributes 8 and 9 |
| | Key informants said the budget plan was developed for all programme areas, including cost details of all systems support areas such as human resources, infrastructure, medicines and equipment and logistics. Recurrent budget is based on standard cost norm (which is always unrealistically low). But budget breakdown to each category of spending (human resources, medicines, etc.) is not clear in the budget table attached to draft 3 | The 5-year budget plan should provide comprehensive coverage of central and provincial budget |
| | National health accounts are not widely used in development of the provincial 5-year health plan | A linkage between priority tasks and budget should be made more explicit in the budget plan |
| | The budget plan in draft 3 does not provide cost details of systems support areas such as human resources, infrastructure, medicines and equipment and logistics | Budget scenarios in areas of high degree of unpredictability should be provided |
| | There is no description of linkage between priority tasks of the plan and budget plan; therefore, there is de-linkage between priority setting and budgeting | |
| | Viet Nam has a very decentralised healthcare system, in which budgeting is also decentralised according to the budget law. Each province develops their own health budget proposal in line with national strategy, to be approved by the Provincial People's Council. The multiyear budget has been developed for the decentralised structures (provincial health sector). The MOH budget plan consists of budget of NTP, all its departments, health facilities and institutions under the MOH jurisdiction. The current draft budget does not show details of budgets for provincial health systems | |

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| | As required by the Prime Minister in Directive N. 751 on the 5-year SEDP preparation, MOF sent very detailed budgeting and reporting templates and guidelines to all sectors, including health sector, for development of the plan. The 5-year health budget plan (not yet attached to draft 3) is based on the log frame sent to all provinces and all MOH departments | |
| | Not all provincial health departments sent back the log frame with filled-in budget information. MOH does not have adequate information regarding annual plans, budgets and resource allocation of provinces | |
| | MOH also used expenditure data from MOF. The provincial financial reports (standard template) are submitted to MOF by October each year | |
| | Key information reports that different budget scenarios for areas of high level of uncertainty were not prepared (not common in current practice) and cannot be found in the current budget plan (draft 3) | |
| **Attribute 9** 'Expenditure framework includes financial gap analysis – including a specification of known financial pledges against the budget from key domestic and international funding sources (specification of sources of domestic funds desirable)' | | |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| **Attribute characteristic 3.2** Revenue projections are based upon explicit assumptions, include all sources of finance (local and external) and account for any foreseen uncertainties or risks | There was calculation of revenue projections, based on estimated allocation of government funding. No calculations on revenue from health insurance have been provided and discussed, neither analysis of revenue by low-, medium- and high-funding scenarios | Provide estimate of revenue from other sources especially health insurance fund and user fee collections in different scenarios of insurance coverage |
| | There was a process for trying to gather data on possible revenue from government funding sources and external sources, but not from health insurance funds, where by law, universal coverage should be achieved by 2014. Missing funding from VSS is a major weakness of this section | Provide calculations of potential revenue on a multiyear period by source, with beginning and periods for each source of funding |
| | Calculations of potential revenue for a multiyear period by source are not provided in the current budget plan | Provide analysis on bed-based government budget allocation and suggest more advanced options |
| | At the provincial level (Hanoi as an example), only revenue from government budget is reflected in overall revenue projections, no other sources provided | |
| | Government budget allocated for recurrent healthcare budget is based on capitation principle (according to the Prime Minister Decision No. 151/2006/QD- TTg and N. 219/2006/QDD-TTG) | |
| | Recurrent budget for each hospital is based on the number of beds given in hospitals, whilst recurrent budget for preventive care is estimated based on capitation formulae | |
| **Attribute characteristic 3.3** Ensure health financing systems that avoid catastrophic healthcare expenditure and impoverishment from result of seeking care | Health insurance law ensured most the poor, and ethnic minorities living in disadvantaged areas (about 15 million persons in 2009) are covered by health insurance scheme through full subsidies by the government | Develop policy/strategy to ensure coverage of the near-poor and informal sector |
| | The near-poor households are eligible by compulsory health insurance scheme, with 50 % premium subsidised by government budget, but there is no effective mechanism to increase high level of enrolment and results in adverse selection; members have higher utilisation and are chronically ill | Develop policy and strategy to discourage the informal payment, setting the maximum of ceiling of copayment preventing catastrophic health expenditure and impoverishment. Develop policy/strategy to achieve universal coverage |

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| | There is no suggestion on how to achieve universal coverage of health insurance by 2014, as stipulated in the health insurance law | |
| | High level of informal payment as well as unlimited copayment under current health insurance policy is likely to result in impoverishment from seeking care | |
| **Attribute characteristic 3.4** Costing and budget estimates for scaling up equitable services are based on sound economic analysis | There is neither economic analysis nor costing and budgeting estimate for scaling up key programme activities | Include economic analysis and cost models for scaling up priority programmes |
| **Attribute 10** Description of financial management system (including financial reporting against budgeted costs and accounting policies and processes) and evidence that it is adequate, accountable and transparent | The country PFM generally meets the requirements, but moderate to substantial risk exists. The 5-year plan partially meets the disclosure requirement of JANS as it does not yet have discussions regarding the finance and audit aspects. Some improvements can be introduced in the plan and the applicable FM arrangements be discussed and references made to relevant specific regulations and other existing documents | Health financing and audit section needs to be included in the document. It could discuss ways to expand the health resource base and its management in the future taking into account current and future developments in health financing. For instance, it could provide ways to guide nongovernment resources to attain national health goals. It could include alternative health financing options. The information thus generated could be used to plan the effective use of those resources |
| **Attribute characteristic 3.5** Financial plans have transparent criteria governing allocation of funds across programmes, including subnational levels and non-state actors (where appropriate) | Financial allocation criteria across subnational levels are fairly well defined and known to all (via Prime Minister's letter). Resource allocation negotiations between sectors take place at the provincial level and transparent mechanisms are used | The government may wish to consider a contractual arrangement in order to ensure that the national strategy and priorities are consistently applied at lower levels, and the allocation of resources reflects those priorities |
| | Since the provinces are fully independent, their prioritisation may defer from the national priorities for the health sector | |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| **Attribute characteristic 3.6** Financial management system meets national and international standards as well as produces reports appropriate for decision-making, oversight and analysis | Meets substantially the national and partially international standards. The spending units produce quarterly and annual reports within reasonable time. The MOH central unit consolidates those reports annually, albeit 11 months after the end of the FY – Financial Management System – which substantially meets the national standards and is in turn partially consistent with the international standards of reporting. It does not seem to systematically produce management reports but rather ad hoc and as requested. The MOH consolidates the annual reports 11 months after the end of the FY which is slightly later than the national requirement but below international standards. There seems to be also a difference between the spending units accounting principle and the treasury (the former is modified cash/modified accrual and the latter is cash basis) that needs to be understood and resolved | As suggested above, the plan should establish clear responsibilities for financial reporting and needs in terms of frequency and content of the reports for each level and the compilation/consolidation process and responsibilities |
| **Attribute characteristic 3.7** Sufficient staff capacity and skills to provide oversight, detect and prevent unauthorised use of funds at all levels | Meets substantially in light of the treasury staff function and capacity – the financial instructions are clear and the segregation of duties between the spending units and the treasury which handles funds is in general a robust control. On the other hand, we concluded that the 'internal audit' exists only partially | We suggest that, in consultation with the central ministries, the plan provides clear internal audit framework and procedures that deters mismanagement and ensures detection of internal control weaknesses |
| | The 'internal audit' can be considered as only very partially existent. It takes the form of annual verification by staff from the MOF verifying the annual reports and random checking of expenditures. There are several other controls by different organs of government, but the effectiveness is not evident | |
| **Attribute characteristic 3.8** Sufficient staff capacity and core competencies to ensure efficient disbursement to all levels and, where appropriate, to different implementing partners | The reconciliation between the spending units and the payments by the national treasury has been reported to be problematic across the sectors and provinces. However, we were informed that this is done correctly and monthly by MOH and DOHs in provinces | This issue deserves further review at the spending units at the provincial level as the health sector would be a good model for other sectors and the use of the national system would become a real possibility for the health sector, should the reconciliation be practised on a monthly basis |

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| **Attribute characteristic 3.9** There are formal and systematic mechanisms to ensure timely disbursements and identify fund flow bottlenecks and resolve them | It is not clear how the treasury staff prioritise payments in periods of cash shortfalls and competing demands for payment (e.g. between paying salaries or the suppliers) | This is also an area for further review at the provincial and district level at the treasury units. No systematic mechanism to identify bottlenecks and their resolution were reported |
| **Attribute 11** Description of audit procedures and evidence of appropriate scope of audit work, as well as independence and capacity of auditors | Country situation partially meets the requirements; the plan is silent on the subject | |
| **Attribute characteristic 3.10** There are effective fiduciary processes, as evidenced by routine internal and external audits of financing, procurement and resource management at all administrative levels | Meeting partially, the external audit is performed by the SAV every other year providing partial audit; the internal audit is done once a year before the consolidated financial reports are issued. This is also considered as very partial internal audit. The procurement risk has been assessed by the World Bank and by other DPs [progress towards the use of country system seems to have stalled – to be completed] | The external financial audit would need to become annual without any audit gap and be complemented with 'value for money' and procurement audits; the role and attributes of the inspectorates and verification bodies need to be better clarified in the laws. We recommend that the use of carefully selected qualified private sector auditors be considered as complement to the SAV audits |
| **Attribute characteristic 3.11** Independence, authority, skills and competencies of auditors meet national and international standards | Partially adequate, the capacity and competency of SAV auditors have been improving but still partial | The external financial audit would need to become annual without any audit gap and be complemented with 'value for money' and procurement audits; the role and attributes of the inspectorates and verification bodies need to be better clarified in the laws. We recommend that the use of carefully selected qualified private sector auditors be considered as complement to he SAV audits |
| **Attribute characteristic 3.12** Audit system which assures performance is routinely assessed against 'value for money' | Partially adequate, the capacity and competency of SAV auditors have been improving but still partial | Many private sector audit firms have good capacity and comply with the international standards. As an interim measure, they can be used to complement the SAVs' capacity |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| **Attribute characteristic 3.13** A parliamentary or other public account auditing committee credibly investigate alleged irregularities. Appropriate sanctions are applied | Meeting very partially, the SAV does from time to time include in its work the performance angle, whilst its audits are mainly planned as performance and financial | Given the workload of SAV and level of staffing, the SAV could subcontract the audit work to private auditors, under its responsibility. Moving forwards, and as an interim measure, we recommend that this type of audit for DPs be contracted out to private auditors |
| **Attribute 12** In the context of national development policies (where applicable) – explanation of how external resources will be channelled, managed and reported on – description of relevant domestic financing policies (in relation to different approaches to resource pooling), if relevant, and description of how fiscal space constraints to scaling up spending will be managed | The plan partially meets the JANS criteria both in terms of describing the internal financial arrangements and flows and the fiscal space constraints | |
| **Attribute characteristic 3.14** Plan clearly describes all internal financial arrangements and funding modalities and how internal and external funds will be channelled, managed and reported on | The plan does not describe | The finance and auditing section would need to be added as per JANS guidelines |
| | Whilst on-budget resources are discussed, planned and monitored, there are external resources that flow directly to some provinces. Allocation of these resources is not transparent. As a result, there could be duplication of efforts. Similarly, fund flows from households are not well known. Whether or not such resources contribute towards attaining national health goals is not clear | The DPs who directly provide funding are advised to disclose fully their contributions and the priorities they are aiming. The plan should attempt to include 'all resources' on or off budget and try to map resources to priorities and expenditures and develop scenarios showing how/where would potential additional funding be directed for scaling up |
| **Attribute characteristic 3.15** The plan has explicit guidance on how programmes will manage fiscal space constraints to scaling up | Meets very partially. Plans to overcome fiscal space constraints are not in place | The document would need to discuss beyond budgetary resources |

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| **Dimension 3** Financing and auditing: cross-cutting | | |
| **Dimension 3** Strengths | The 5-year plan highlights resource inadequacy and revenue shortfall for which funding source is not known | |
| | There is increasingly a transparent process and criteria for allocation of resources. Workshops and consultations have been organised to reach consensus for allocation of resources in 4 categories of provinces (namely, in urban area, plain area, mountainous-minority ethnic residential area, highland and island area) | |
| | The costing of all activities is presented in a useful and easy-to-understand manner | |
| | The PFM system has a strong separation between the budget holder and payment system in the treasury system which controls and if legitimate makes payments. The budget holders do not receive funds or make payments directly (except for the DP projects with PMUs and designated accounts exist) | |
| | Many years of detail planning and several years of MTEF piloting and other public financial management reforms under implementation by the GOV have already benefited the sector (e.g. TABMIS deployed in about 35 provinces and the central MOH with plans going forwards to complete full deployment by the end of 2011) | |
| | Despite the fact that the plan document doesn't include much on financial management and audit, as expected by JANS guidelines, the planning process has been very robust | |
| | With the results from many studies and workshops/exercises, weaknesses and issues related to financial planning are known to the management which would help their resolution | |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| **Dimension 3** Weaknesses | Although the planning process has been robust, there is room for improvement in the linkages between the strategy, expenditure planning and resources, including with MTEF | Health financing and audit section needs to be included in the document in a succinct manner with reference to other documents which have more specific details. It could discuss ways to expand the health resource base and its management in the future taking into account current and future developments in health financing. For instance, it could provide ways to guide nongovernment resources to attain national health goals. It could include alternative health financing options. The information thus generated could be used to plan the effective use of those resources |
| | The plan document does not have enough description or cross reference to other documents regarding financial management and audit. The health financing and audit section needs to be expanded and adequate reference be made to other existing documents | A discussion on the interlinkages between HSDP, health financing strategy and the health insurance expansion and how they interact would be useful |
| | Alternative government and nongovernment financing options are not adequately discussed. The plan should have adequate analysis and discussion of such options | There is a need to provide a road map for resource generation and allocation based on clear and realistic assumptions. Alternatively, if optimistic assumptions are made, the document could list the ways to get there |
| | MOH does not have adequate information regarding annual plans, budgets and resource allocation of provinces. This is a weakness for management decision-making that would be resolved once the MOH is given access in TABMIS. The same comment applies to the reporting on the budget execution, due to delayed reporting and consolidation of information | Various future health financing scenarios need to be considered in the light of certain new developments including the growth of the GDP, population, aging and nongovernment funding mechanisms |

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| | Analysis concerning health financing is not effectively linked with priorities and targets. The section on health financing describes shortcomings, but no suggestion and alternative options to overcome has been given; the linkages and solutions to overcome the shortcomings are critical. We haven't been given any material on this issue other than the 3rd draft of the 5-year HSDP | Scalable health financing experiments and other health financing means such as domestic philanthropic resources could be attracted and tracked so as to streamline them or scale them up for their wider and targeted use |
| | Resource prioritisation is unclear whether it will be based on the resource envelope or what is achievable within a time span of 5 years. The HSDP seems to have followed an 'arithmetic approach' compiling all the resource needs rather than a consolidation or 'chemical approach' wherein different resource options and needs are well synthesised into a single plan for the sector. More analysis and clarifications are advisable | Household out-of-pocket spending is mentioned as a health financing challenge. But the document does not provide any strategy to overcome the challenge. It will be useful if the document provides an action plan to minimise the household reliance on the out-of-pocket spending to finance healthcare. It could spell out how these resources could be channelled using the existing or to-be-developed prepayment mechanisms |
| | Internal and external audits do not provide a full scope reasonable assurance on a timely manner, nor do they look at 'value for money' aspect. The systematic skipping of audit of every other financial year by SAV increases the fiduciary risk. The MOH, in consultation with others (SAV, MOF, DPs), should establish a workable audit framework which satisfies the need for reasonable assurance to all financiers. The document should elaborate on the audit framework | |
| **Dimension 4** Implementation and management | | |
| **Attribute 13** 'Operational plans are regularly developed through a participatory process, and detail strategic plan objectives will be achieved' | | |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| **Attributable characteristic** | | |
| **4.1** Roles and responsibilities of implementing partners are described for each strategy and intervention | Roles and responsibilities of implementation partners are not clearly proposed in the plan, and it is hard to assess how ten key tasks would be successfully implemented | |
| **4.2** Each strategic objective has measurable annual milestones to assess progress towards implementation | There are no clear milestones for each strategy/intervention presented | |
| **Attribute 14** 'Description of how resources will be deployed to achieve clearly defined outcomes' | | |
| **Attributable characteristic** | | |
| 4**.3** The organisation of service delivery is defined and identifies equitable allocation of resources (recurrent investments) by the level of care and roles and responsibilities of service providers, including plans for referrals and supervision | In the implementation section of the draft 3, it is not clear how financial/human resources will be deployed to achieve clearly defined outcomes. It is assumed from the experience in implementing the previous plan 2006–2010 that the resource gap is not significant | Should have a section to describe and discuss on resource deployment from national and international sources |
| **4.4** Human resource (management and capacity) needs are identified, including staffing levels, skill mix, training, supervision and incentives. Gaps needed to implement the national strategy are identified and a plan provided to solve identified gaps | | |
| **4.5** Current logistics, information and management system constraints are described, and credible actions are put in place to resolve constraints | | |

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| **Attribute 15** Procurement policy that complies with international guidelines and evidence of adequate, accountable, and transparent procurement and supply management systems with capacity to reach target populations | | |
| **Attribute 16** 'Specification of governance, management and co-ordination mechanisms for implementation' | Governance management and co-ordination are not clearly defined in the plan; there is no specific reference to who are held responsible for each of the specific objectives, central versus the provincial, district and commune levels. In other words, the accountability arrangement is non-existent | |
| **Dimension 5** Results, monitoring and review | | |
| **Attribute 17** Plan for M&E that includes clearly described output and outcome/impact indicators, with related multiyear targets that can be used to measure progress and make performance-based decision | The M&E section of the plan is very modest compared to other sections. Totally, there are 19 basic indicators which are categorised into input, process and outcome. Selected indicators are presented as follows: | The current set of indicators and targets should be expanded to capture the whole process (from input to impact) as much as possible and incorporate the left-out areas. More specifically, as suggested by the HPG, 'the set of indicators could be strengthened by being made more specific and tailored to national needs and stratified (e.g. geographically) to incorporate inequity'. HPG also suggested the following areas be better covered: equity, efficiency, safety, effectiveness, quality, compliance with diagnostic/service protocol indicators, pharmaceuticals, NCD, communicable diseases, injuries, newborn health, maternal and child nutrition, TB (see more specific information in comments from HPG) |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| | Input indicators: proportion of bed/10,000 people; proportion of physician/pharmacist/10,000 people; proportion of CHC having a physician/nurse. | In order to develop a good set of indicators that can summarise the M&E plan, it is important to develop a logical frame that describes clearly objectives and interventions selected and then input, process, output, outcome and impact indicators |
| | Process indicators: proportion of CHS meeting national benchmark standards, coverage of health insurance, etc. | The following include some of the indicators we suggest to be classified into the set of indicators: |
| | Outcome/impact indicators: infant mortality rate; population growth rate; maternal mortality rate; prevalence of HIV; life expectancy at birth | Health status: under-five malnutrition rate (height for age – stunning) |
| | All indicators are divided into multiyear targets for the whole period to measure progress and performance | Effectiveness of curative and preventive measures: AIDS mortality rate per 100 000 population; TB incidence rate (AFB+) per 100,000 population; Dengue fever incidence; average length of stay; proportion of detected hypertensive peopled get treated |
| | The indicators were developed based on (i) the party's documents and government's strategies or national plans; (ii) annually targeting indicators designated by the national assembly; (iii) the MDG indicators; (iv) achievements of the 2006–2010 period; (v) orientations for the development of socio-economics for the 2010–2020 period proposed in the draft document of the National Party Congress XI (Official of DPF); and (vi) references from other developing countries with similar socio-economic conditions | Quality of human resources: proportion of health workers with university and higher education; proportion of doctors licenced (required by the law of examination and treatment) |

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| | In order to develop health indicators, the DPF carried out several steps as follows: (i) conducted an assessment of the achievement of health indicators in the previous plan (2006–2010); (ii) sent proposed indicators and multiyear targets measuring progress to all related departments and asked for comments; (iii) consolidated all comments and feedback and sent the proposed indicators back to the related departments for second comment if they have; and (iv) organised a meeting with MPI (Department of Labour and Social Affair and Department of Synthesising) and the National Assembly (the Committee for Social Affair) and then finalised a set of health indicators (the document No. 5597/BYT-KHTC, dated August 20, 2010) | Pharmaceutical industry: proportion of pharmaceutical manufacturers given GMP/GLP/GSP-WHO certificate; proportion of pharmacies given GPP certificate |
| | The proposed indicators are related to the following aspects: population; human resources; primary healthcare; health financing; preventive medicine; and maternal and child health. However, it is important to note that the proportion of indicators falling into population and human resources aspects account for more than 50 % of total indicators | Health spending: proportion of state health expenditures spent on preventive medicine and out-of-pocket payment |
| | There were no indicators related to food safety, infectious and non-communicable diseases, quality of care; health information system; pharmaceutical industry; large investment programmes (i.e. Decision No. 930), although they are considered key focuses. As a result, it is difficult, if not impossible, to measure progress and performance of prioritised actions listed in the plan using the proposed set of indicators | More indicators could be found in NTP and other national strategies |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| | In-depth interview with an official at DPF revealed a couple of reasons for selecting 19 indicators: 'These indicators are most common and representative the potential impact. If we selected the indicators that are too specific, we may not able to collect them from all provinces. More importantly, these indicators can be monitored and evaluated easily. It is impossible for indicators to be selected if they are not evaluated or we do not have baseline information, i.e. qualitative indicators. To some extent, these indicators could be considered targets from which specific programs and its performance indicators such as proportion of people at risk using bed- net… would be developed and implemented'. Other justifications supporting for not detailing the M&E is that 'this 5 year plan should be seen as a guiding document from which specific programs will be developed with detailed indictors by in-charge Department or Institutions. Moreover, many indicators such as quality of care, financial management are not measurable' | A regular performance analysis should be officially in place |
| | A JAHR team member thought that 'it is important to emphasize that the 19 selected indicators serve the national 5-year plan. They could not adequately reflect performance of the health sector. A full list of indicators for the 5-year plan would be as large as ten folds' | The JAHR process could be further developed, in order to serve the purpose of joint annual monitoring process (which would also have to draw from an internal monitoring process set-up) |
| | A regular performance analysis was not found in the plan, but it's mentioned when interviewing health officials | |
| | The JAHR indicator recommendations, which were developed in a consultative process, do not appear to have been included in the plan. Currently, JAHR is not an M&E of the Plan. 'If JAHR was a tool for M&E of the Plan, it would have been done differently. Now, the two are different. Therefore, the plan should have a separate M&E section and indicators representing each activity, while JAHR still focuses on crucial issues of the health sector' (IDI with JAHR team member) | |

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| | Health officials understand very well about the M&E and its indicators. They acknowledged that these selected indicators are not adequate and more should be added. However, they gave several reasons for not selecting all related indicators, for example, 'it could create a huge workload while we do not have time, human resource and finance' | |
| **Attribute 18** Plan for M&E that includes sources of information for indicators and description of information flows | The M&E section includes sources of information for each indicator and ranges from epidemiological data, routine HIS, census and Viet Nam living standard survey | For some indicator such as infant mortality rate and under-5 mortality rate, there are two sources of information including census and routine health information system. It is important to keep an eye on the results reported by these sources in case there is discrepancy between two sources |
| | With respect to indicators collected by the MOH through the routine HIS, in 2009, the MOH issued a Decision No. 3440/ QD- BYT promulgating a standardised health statistics reporting formats. These standardised data collection tools ensure that data collected is logically linked to one-third of the selected M&E indicators at all levels and on a routine basis (3, 6 and 9 months), although quality of this data is still debatable | To serve as a good reference document for the M&E section, it would be very important to reconsider the role of JAHR. It would also be crucial to review the set of indicators developed for the JAHR to make sure that the adaptation into the 5-year plan is legitimate. This is also a comment from HPG: 'Though it is mentioned that the JAHR are used as a reference source to assess annual health sector performance, it is not stated that the JAHR will be used as a basis for jointly monitoring the implementation of the plan. It is essential, therefore, that the role of the JAHR be further clarified and redefined in the context of M&E of the Plan' |
| | For M&E plan indicators that cannot be monitored from a routine basis such as infant mortality rate, life expectancy and maternal mortality rate, information from census will be applied | |
| | The M&E plan specified the role of related organisations in collecting and reporting the selected indicators following the regulations on the national set of indicators. It also stated that the M&E framework proposed in the JAHR conducted by the MOH under support from the Health Partnership Group will be used complimentarily for the M&E plan | |
| | There was no information gap reported, and we found it adequate. However, this might be an issue if more indicators are added | |

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| Dimensions and attributes | Comments on process and content | Recommendations |
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| **Attribute 19** Plan for M&E that includes descriptions of data collection/data management methods, tools and analytical processes (including quality assurance) | The M&E describes information source but not methods of data collection for each indicator. In fact, it assigned responsibilities to related organisations to collect data and reporting. It is assumed that these in-charge organisations will be responsible for managing and conducting data analysis. As there are several data sets such as routine HIS and census, data collection, management and analysis would vary and be out of reach of the MOH | Given that more indicators will be selected, details of roles and responsibilities of related stakeholders should be specified and stated in the 5-year plan |
| | The JANS team felt that data from national survey or census would be in good quality and that quality control is well in place, whilst information from the routine HIS collected from public facilities only would be inadequate as private sectors play an increasing role in service provisions | |
| | Comments from HPG revealed that: 'Information currently reported can be unreliable and internally inconsistent. Denominators are inappropriate (e.g. coverage based on attendances not population'; numerators are incorrect (e.g. not all infant deaths are fully counted); sources are inappropriate (e.g. hospital source for incidence/prevalence data) and there are perverse incentives for over-reporting. There is no systematic data definition, collection, data processing, independent validation, reporting and use. The issue of independent validation is particularly important)'. Even an official at the MOH admitted that 'number of maternal deaths reported from public hospitals is not correct because a lot of patients were discharged before death, and died at home' | |
| | Information from the routine HIS is collected quarterly from commune to district, from district to province and from provincial to central level – the MOH. As mentioned above about the Decision No. 3440/QD-BYT, there was a very detailed guideline on how health information is collected and reported from the commune level to central level | |

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| | It should be noted that, 'Quality of information collected from the routine HIS is not very good. However, it varies from one to another indicator' | |
| **Attribute 20** There is a plan for join periodic performance review (reporting of results against specific objectives and respective targets explaining any deviations) and processes for the development of related corrective measures | The M&E section described how performance will be monitored over time. Specifically, the National Assembly will carry out an M&E annually over the indicators designated to the health sector; the MOH will be responsible for M&E the overall performance of the health sector under support of the Health Partnership Group through the Joint Assessment of Health Report. Finally, provincial departments of health will be responsible for M&E the performance of the health sector within their province | It is suggested that not all indictors are evaluated at the same time, for example, input and process indicators should be evaluated or monitored annually, whilst output indicators should be evaluated at least after 2 years of the implementation of the plan |
| | Outputs of these activities are comprised of JAHR, M&E report of the National Assembly and annual performance report of the Provincial Department of Health | |
| | Although the M&E did not mention about using of feedback on performance, we did find a two-way feedback mechanism in which information flows to central level and back to those providing them. For example, the National Assembly will keep the MOH informed about their M&E activities on the indicators they assigned to the health sector. At provincial level, the M&E is implemented quarterly. 'Currently (October) we are asking the organizations to report their performance within the first 9 months and submit the following year plan. All organizations have to provide justifications for changes in the plan in the following year' (IDI with an official of Hanoi DOH) | |
| | An annual report is submitted by the Provincial Department of Health to the Provincial People's Committee and sent a copy the MOH | |

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| Dimensions and attributes | Comments on process and content | Recommendations |
|---|---|---|
| **Attribute 21** M&E plan describes processes by which monitoring results can influence decision-making (including financial disbursement) | The M&E section did not describe how the outcome is formally incorporated into future reorientation of policy decisions. But officials at MOH and Provincial Department of Health emphasised the importance of the annual performance assessment reports. 'The budget and plan targets can be adjusted after 9 months implementation. If responsible agencies found that they could not meet the designated targets, they would propose for adjustments' (IDI with an official at provincial DOH) | |
| | Usually, an annual performance assessment is conducted in September to report how the plan was carried, what indicators are achieved and which activity and budget would be added in the following year | |

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A.G. Shillabeer, *The Health of Vietnam*, DOI 10.1007/978-981-287-709-3