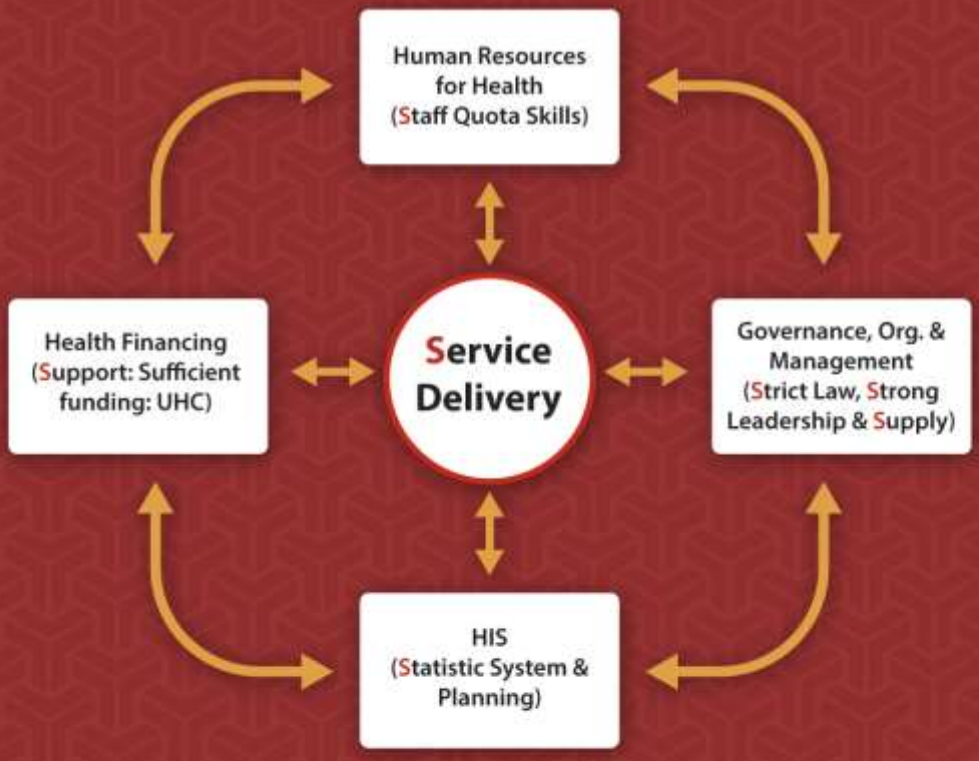
Lao People's Democratic Republic
Peace Independence Democracy Unity Prosperity

HEALTH SECTOR REFORM STRATEGY AND FRAMEWORK TILL 2025



2016

The Lao People's Democratic Republic

Peace Independence Democracy Unity Prosperity

HEALTH SECTOR REFORM

2013-2025

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Ministry of Health

World Health Organization

Foreword

Over the past decade, the Lao People's Democratic Republic (PDR) has made great achievements and significant progresses in the health sector. By 2015, six out of the nine health related MDG targets was achieved. Nevertheless, despite these notable improvements, major challenges remain; including the access to health services in remote areas and for vulnerable groups, the quality of services and the protection against health related catastrophes.

As a consequence, in order for Lao PDR to continue progressing towards a more improved health sector, it is essential to increase the emphasis on policies and measures that increase through the access to affordable, improved quality health services; and resources to everyone in the country via a result-based, system-wide approach toward universal health coverage in years to come.

Guided by the leadership of the Government and the Party, the Health Sector Reform (HSR) was endorsed by the National Assembly in January 2014. In following the guidance from the Party and the Government, the long-term direction of the national HSR is to establish an effective system ensuring universal health coverage for the population, and protect and promote the health of people in Lao PDR. This health sector reform is intended to respond to the Government's and the National Assembly's concerns for the Lao people's health status, their access to good services being locally delivered at reasonable and affordable cost and quality by appropriately qualified staff.

Strong Government leadership is needed to ensure the coherence of the health reform plan and the coordination of the reform implementation within the health sector, across central and provincial government agencies as well as with other concerned sectors and development partners. The Lao health sector reform process needs to have active, engaged and committed leading committee at national and sub-national levels. The leadership of MOH will be critically important to the success of the reform process.

Vientiane Capital,
Minister of Health

Ass. Prof. Dr. Bounkhong Syhavong

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Lao People's Democratic Republic
Peace Independence Democracy Unity Prosperity

Prime Minister Office No: ***029/GOV***

Vientiane Capital, Date: 20 January 2014

DECREE
For National Commission
to implement Health Sector Reform Strategy by 2020

- Persuant to the Law of Lao Government, No 02/NA, dated6 May 2003.
- Persuant to the rrequest letter from the Prime Minister Office, No215/PM, dated4 December2012 to submit a draft strategy on Health Sector Reform to the 4th General Meeting of the VII National Assembly for consideration
- Pursuant to the the adoptation of the National Assembly Meeting on a draft strategy on Health Sector Reform by 2020, No044/NA.VII, dated19 December2012.
- Persuant to the request of the Ministry of Health No...../MoH, dated...../...../.....

Prime Minister issued this decree:

Section I
General Provisions

Article1.Purpose

This Decree is to define roles, functions, rights, structure, scope of work, and working approach for the National Commission on Health Sector Reform. The Commission's mandate is to develop the Health Reform Plan and to mobilize and enhance Government organizations, mass organizations, international organizations and civil society throughout the country for the effective implementation of National Health Sector Reform.

Section II
Locations and Roles

Article2.LocationsandRoles

The National Commission for Health Sector Reform (HSRC) is an ad hoc Government Organization with the role of assisting the Government and the Prime Minister to implement and expand the Health Sector Reform strategy and mobilize resources and involvement of society in the Health Reform process.

Section III
Structure

Article3. Human Resources

National Commission for Health Sector Reform consists of:

1.	Deputy Prime Minister, responsible for social and cultural sectors	Chair
2.	Minister of Health	Vice Chair
3.	Vice Minister of Ministry of Finance	Vice Chair
4.	Vice Minister of Ministry of Planning and Investment	Vice Chair
5.	Vice Minister of Ministry of Foreign Affairs	Member
6.	Deputy Director of Central Party Committee	Member
7.	Vice President of the Socio-Cultural Commission of the N A	Member
8.	Vice Minister of Ministry of Justice	Member
9.	Vice Minister of Ministry of Education and Sports	Member
10.	Vice Minister of Ministry of Information, Culture and Tourism	Member
11.	Vice Minister of Agriculture and Forest	Member
12.	Vice Minister of Ministry Labour and Social Welfare	Member
13.	Vice President of Lao Women's Union	Member
14.	Vice President of Central Lao Youth	Member
15.	Vice Minister of Health and secretary of the Commission	Member

Article4.Secretariat

The National Commission for Health Sector Reform has a Secretariat which consists of Director General and Deputy Directors within the Ministry of Health:

1.	Director of Planning and Cooperation Department	Chief
2.	Deputy Director of Cabinet	Deputy Chief
3.	Deputy Director of Budgeting	Deputy Chief
4.	Deputy Director of Organization and Personnel Department	Member
5.	Deputy Director of Hygiene and Prevention Department	Member
6.	Deputy Director of Communicable Disease Control Department	Member
7.	Deputy Director of Health Care Department	Member
8.	Deputy Director of Food & Drug Department	Member
9.	Deputy Director of Training and Research Department	Member
10.	Deputy Director of Inspection Department	Member
11.	Vice Rector of University of Health Sciences	Member

Section IV
Functions and Rights

Article5. Functions

The main functions of the National Commission for Health Sector Reform are to:

5.1 Consider and approve the health sector reform implementation plan of Lao PDR.

5.2 Propose to the government and National Assembly for endorsement of newly reformed health system and health reform related laws, regulations and legislations.

5.3 Provide leadership, coordination with other ministries, organizations equal to ministries, authorities at different levels, and collaborate with developing partners in implementing the health sector reform strategy.

5.4 Mobilize resources from the public and private sectors, and external sources in implementing the national health sector reform strategy.

Article6. Rights

The National Health Sector Reform Commission has the following rights:

6.1 Set up the necessary secretariat and committees for the implementation of the health sector reform strategy

6.2 Issue the regulations, notice, and guidance to concerned parties.

6.3 Perform other rights assigned by the government and as identified in the constitution and laws.

Section V
Scope of work

Article7. Scope of Work

The National Commission for Health Sector Reform is an ad hoc Commission. The ordinary meetings of the Commission are organized twice every year; extraordinary meeting is organized when necessary. The Commission's decisions are made according to a majority's votes.

Section VI
Final Provision

Article8. Elaboration

The Chair of National Commission for Health Sector Reform is responsible for elaborating this decree and defining roles, rights and duties, and detailed responsibilities for the secretariat, committees, and its members.

Article9.Official Stamp

The stamp of the Ministry of Health is to be used officially by the National Commission for Health Sector Reform.

Article10. Budgeting

The budget for the Commission, its secretariat, committees, and its activities is under the annual health budget.

Article11. Implementation

Relevant ministries, equivalent organizations, provinces, Vientiane capital and concerned parties should strictly recognize this decree and provide collaboration for its successful implementation.

Article12. Effectiveness

This decree shall be effective from the date of its signature onwards; any decrees and regulations contradict to this decree are hereby repealed.

Prime Minister

[Sealed and signed]

Mr. Thongsing THAMMAVONG

List of Abbreviations

ANC	Antenatal Care
CBHI	Community Based Health Insurance
CRVS	Civil Registration and Vital Statistics
DHC	Department of Health Care
DHHP	Department of Hygiene and Health Promotion
DOF	Department of Finance
DHP	Department of Health Personnel
DP	Development Partners
DPIC	Department of Planning and International Coordination
DRF	Drugs Revolving Funds
DRT	Department of Training and Research
EDC	Education Development Centre
EPI	Expanded Programme on Immunization
GDP	Gross Domestic Products
GGE	General Government Expenditure
GGHE	General Government Expenditure on Health
HEF	Health Equity Funds
HIS	Health Information System
HRH	Human Resource for Health
HSR	Health Sector Reform
HSRF	Health Sector Reform Framework
ICD	International Clarification of Disease
ICT	Information Communication Technology
IT	Information Technology
JICA	Japan International Cooperation Agency
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MNCH	Maternal Neonatal and Child Health
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MPI	Ministry of Planning and Investment
MR	Minimum Requirement
MTU	Medical Training Unit
NCD	Non Communicable Diseases
NHA	National Health Account
NHI	National Health Insurance
NT	Nam Theun
ODA	Oversea Development Aid
OiC	Officer in Charge
OOP	Out-of Pocket
PHC	Primary Health Care
PPM	Providers Payment Mechanism
PPP	Public Private Partnership
RBF	Result Based Funding

SASS	State Authority for Social Security
SHP	Social Health Protection
SSO	Social Security Organisation
THE	Total Health Expenditure
TR	Technical Revenue
UHC	Universal Health Coverage
UHS	University of Health Science
VHV	Village Health Volunteer
VHW	Village Health Worker
WHO	World Health Organization

Lao People's Democratic Republic
Peace Independence Democracy Unity Prosperity

Ministry of Health

Strategy
Health Sector Reform by 2020

9 August 2013

I. Introduction

The resolution of the ninth Lao People Revolutionary Congress Party has stated that: ***"Apart from capacity building of mankind to increase their intellectuals, their knowledge, their career professional, good attitudes and ethical behaviour, we have to put more efforts in improving Lao people for their physical fitness, having good health. So we have to continue with our health care policy upholding prevention and promotion as a priority task and quality of treatment with high health care coverage as an important task***". In the Resolution, it also identifies that health development as a major priority towards the achievement of the Millennium Development Goals (MDGs) by 2015, and the National Poverty Eradication and leading Lao PDR from the least developed country by 2020.

Global changes in economic, financial and environment have direct impacts on health service delivery and these influence Lao PDR to reform health system in order to provide quality health care services for the people as there is an increase demand from the society. Lao PDR is facing great challenges with health service deliveries even though there are already investments on infrastructures, medical equipment and human resources, and yet health services are not yet met the demands of the population and are not up to the standard due to limited resources. There is a lack in management capacity, especially the planning, the implementation and the monitoring and evaluation at each level and also there is a lack of unreliable information.

Reform means changing the existing thing for the better, including changing structures and policies according to 4 breakthroughs initiatives according to the reality. Health reform is an ideal in contributing to improve the people, the nation and the society like, the people can be healthy, the nation can be wealthy, and the society can have solidarity, with democracy, justice and prosperity.

II. Background for developing strategy for Health Sector Reform

The National Health Sector Reform Strategy has been developed based on the following important policy documents of the Party and the Government:

1. The Resolution of the Ninth Lao People's Revolutionary Party Congress;
2. The Seventh Government Social-economic Development Plan 2011-2015;
3. Master Plan for the Health Sector Vision by 2020;
4. Resolution of Ministry of Health seventh Party Congress;
5. Seventh Five-year Health Sector Development Plan (2011 - 2015);
6. The statement of Political Bureau on "Health Reform Principle" 31 July 2012;
7. Based on the adaptation from National Assembly on "Strategy for Health sector Reform by 2020".

III. Health Development in order to achieve MDGs

1. Achievement:

For the past 20 years, health sector has expanded health services in hospitals and improved health centres for broader coverage with better quality of care, steps by steps. This is the same time as to achieve Millennium Development Goals (MDGs) by 2015, which health sector has 3 direct goals to

be responsible for such as: Goal 4 (MDG 4): Reduce Children Mortality; Goal 5 (MDG 5): Improve Maternal Health; Goal 6 (MDG 6): Combat HIV/AIDS, Malaria and other diseases and there are 2 more goals that MOH is responsible in some parts like: Goal 1 (MDG 1): Eradicate Extreme Poverty and Hunger; and Goal 7 (MDG 7): Ensure Environmental Sustainability. Through the implementation of the past 5 years National Health Sector Development Plan, it has been completed with notable progress and achievements contributing to achieve MDGs as demonstrated in the following Goals:

MDG 1: Eradicate Extreme Poverty and Hunger

Poverty Eradication and Hunger have many factors and this goal concerns many sectors, and under direct responsibly of health sector is nutrition, especially the children under 5 which have low weight under standard, this is a slow progress and will take time, more efforts have to be focused. From 2006, the figure showed 37% of children under 5 were malnutrition and survey result in 2012 was 32% but the goal by 2015 should be 22%. Under 5 children stunting: It is a slow progress also, figure from 2006 was 40% and survey result in 2012 was 38% but the goal by 2015 should be 34%.

MDG 4: Reduce Children Mortality

Infant Mortality Rate seems to reach MDG, as estimated by World Health Organization (WHO) is 48/1.000 of live births and the goal by 2015 should be 45/1000 of live births. Under 5 Mortality Rate seems to reach MDG as well, as estimated by WHO is 61/1.000 of live births and the goal for 2015 should be 70/1000 of live births. Routine measles vaccination rate is 70% but the goal by 2015 should be 85%.

MDG 5: Improve Maternal Health

Maternal Mortality Rate has reduced from 650/100.000 of live births in 1995 to 339/100.000 in 2008, and it is a burden and challenging to reach MDG by 2015 as the goal is to reduce to 260/100.000 of live births. Rate of assisted birth deliveries is 37% but the goal by 2015 should be 50% and this is challenging and the causes of maternal mortality are many determinants.

MDG 6: Combat HIV/AIDS, Malaria and other diseases

HIV prevalence rate among general population is low as 0.2% in 2012 and it will reach MDG by 2015, as the rate set up among the general population should be less than 1%. Malaria mortality rate is low, and in 2009 it was 0.3/100.000 of the population and it will reach MDG by 2015, as the rate set up should be less than 0.2/100.000 of the population. TB prevalence is 151/100.000 of the population in 2009 and it will reach MDG by 2015 as the rate set up should be less than 240/100.000 of the population.

MDG 7: Ensure Environmental Sustainability

Water utilization rate among the population will reach MDG and in 2010 the utilization rate was 79.5 % and the goal set for 2015 is 80%. Latrine utilization rate among the population will reach the goal also and the utilization rate in 2010 was 55% and the goal set for 2015 is 60%, more funding support is important and increase awareness of the population for using latrine is crucial for theirs practical habits.

2. Challenges:

2.1 In spite of good achievements to reach MDG, but there are certain goals that will be slow and are risky, mainly goal 5 on improving maternal health, especially Maternal Mortality and Infant Mortality Rates are still high if compared to regional and global indicators. Immunization is not reached its goal; nutrition (malnutrition, low weight, and stunting) are still challenging; disease prevention and epidemic outbreak of some diseases, specifically malaria, dengue fever and diarrhoea are still

problems.

2.2 Even though there has been the improvement of health services in the areas of diagnosis and the treatment in hospitals at different levels for better quality, but the demands and the satisfaction of the society have not yet been met. Currently, the demand of the Lao people and the society is to have good quality and modern health care services.

2.3 There is a shortage in quantity and quality of health personnel in district hospitals and health centres in remote areas. Quota for recruitment is not consistent to the requirement.

2.4 Health expenditure in Lao PDR is still low compared to national GDP and if compared to neighbouring countries (details are in the annex). There is a limit investment on the part of private sector, and there is a lack of legislation.

2.5 Health information system is unreliable, incomplete; data reporting is not on time and is not consensus which cannot be appropriate for planning and policies development.

3. Causes for successes and constraints:

3.1 Causes for successes due to:

1. Guidance and investment from the Party and the Government on health development including resources mobilization for basic infrastructure of health facilities according to the new marginalization (direction) for making change from grassroots levels up.
2. The methodology in leadership, procedure and principle, and work methods of the Party Committee, the Committee of the ministries, leading committees at each level and all members of the workforce; and due to the existing laws, legislations and public participation, the awareness and understanding into a better health has been raised.
3. The humanitarian potential of the health sector is a condition for securing domestic and foreign assistance and cooperation on the basis of compassion, autonomous and self-reliance, with the leadership of MOH and in collaboration with all stakeholders for health planning development process based on the needs of Lao people, in line with policies and laws of the country.
4. Most of the population have understood better and have seen the importance of their health care like basic health care by following the historical of 3 cleans principle: drinking boiled water, eating cooked foods, build and use latrine and hand washing and improve their living conditions for their safety and clean.

3.2 Causes of constraints:

1. Some medical personnel don’t have good manners and appropriate ethical attitudes, the provision of health care service is not satisfied, and sometimes the services are not equitable between the rich and the poor, so that there are complaints from the society. In general, the health service is not good enough allowing the rich to seek health care abroad.
2. The organization in certain departments and some grassroots localities remain not strong and working procedures in certain areas remain out of line with the overall principles of democracy. Some staff is lacking competencies, working without responsibility, and has no intention to improve their work.

3. Wrong shaman beliefs in certain areas remain high due to low coverage of health education with lack of diversities, comprehensive and depth due to the fact information data and statistics remain unclear and unreliable.
4. Perception of value on health remains at low level, public participation and private investment remain low, and coordination for operations still fails to cohere to procedures and the demarcation of tasks and projects with everyone acting independently. At the same time, staff is waiting to be told what to do, depending on supervisors and wait for technical assistance from consultants.
5. Even though health expenditure has been increased but it is not sufficient according to the real needs, expansion of health insurance fund is still slow, and there are also lack of policies and legislations.
6. Some personnel are lack of competencies; they don't upgrade their knowledge and improve their working procedures (style).

IV. Opportunities and challenges

1. International Situation:

In the 21st century, a science technology revolution has been progressed, changing industrialization into informative world and broadly expand of intellectual property in all fields and all sectors. Globalization and international linking are the potential for cooperation and challenging in developing countries. Health areas have been revised regionally and globally, communicable and non-communicable diseases have been focused on, especially given attention to mother and child health in the developing countries.

2. Situation in the country:

Ninth Congress Party has stated that: "increase solidarity among Lao population and strengthen unity in the Party, promoting the roles and leadership capacity of the Party, re-enforce the implementation of new direction, with strong leadership that will lead the country out of the least developed country by 2020 aiming for socialism with the goal to develop the country toward sustainable, and modernized industry.

To reach that goal, it is very necessary for the people to have good health and it is the health sector main task to ensure good health of the Lao ethnic people, including prevention, promotion and health care. Health activities have attributed highly to the country development in accordance with the socio-economic frame work and consistent with the approach that our country is implementing marketing oriented mechanism with the Government management and changing norms from quantity to quality in line with the needs of the population in seeking their health care and to satisfy their needs.

3. Opportunities and challenges:

Overall situations at national and international levels have given opportunities for health sector to implement health reform for the fast progress and improvement. At the same time, we also have great challenges to struggle in order to reach MDGs through the capacity building for ourselves through our achievements and the advanced technologies that we have.

Even though, health sector has achieved many things, but it still faces many challenges mainly the

improvement of nutrition for children, reducing under 5 mortality rate and maternal death which relate to many factors for social development. More attentions should be given to improve immunization rate, especially in remote areas and for the poor people to reach the target set. The capacity for providing basic health care delivery and the healthy villages according to primary health care contents such as: hygiene and utilization of water supply need more funding and should be disseminated broadly in provinces. Our country needs to improve health information system in order to monitor the progress, to have its accuracy and reliable data to be used for planning purpose with set indicators for monitoring.

With globalization, compared to regional and international, compared to neighbouring countries or ASEAN, health interventions have a low coverage due to long term war, weather change that are risky to natural disasters and causing re-emerging diseases, there is a continuity growth of development, and the rapid increasing demand of the population, but on the other hand, we can't provide health services up to the path of the economic growth due to lacks of health work force, advanced technologies and financing. While the poverty can't be solved completely, maternal and child mortality and malnutrition rates remain high, in spite of some reducing rates, therefore it is an important effort to implement health system reform in order for MDGs achievements. From the overall situations, opportunities and the challenges, it is time for developing and implementing health system reform.

V. Guiding principles for the Health Sector Reform

According to the ninth resolution of Lao People's Revolution Congress Party, the guidance from poli-bureau committees and the approval from National assembly meeting, allowing the health reform with the following guidance:

1. Doctors and nurses should be improved for professional ethics, having good moral behaviour for providing better health care services to patients and the population of all ethnic groups through strengthening the institutional capacity, taking the importance of strong Party leadership. Train staff to increase their knowledge, and skills, focusing on monitoring at each level. Health interventions should be related to political and rural development issues and 3 establishment process.

2. Strive all efforts to achieve health related MDGs, especially reducing maternal maternity rate through the policy of free baby delivery and free health care for children under 5. Give attention to nutrition for children and ensuring accessibility of clean water and utilization of latrines of the population by developing projects, having interventions and with detailed budgets according to the reality for submitting to the Government for consideration.

3. Improve quality of health system delivery from central to village levels by assessing health infrastructure, equipment, and staffing, at each level for mapping the real situation according to the standard needed, and for better coverage at mountainous and remote areas and special zones by recruiting new staff and new graduates for grass root positions, train adequate village health workers and community midwives, give quota according to the needs. Equip hospitals for modernization to satisfy the population and provide quality of health care according to the mix demands, starting with a pilot from central hospitals mainly improving hospital financing to be consistent with market oriented mechanism by allowing hospitals to use their revenues for improving their services and their motivations for their better living conditions.

4. Improving health financing, expansion of health insurance for universal health coverage by

amending financing legislative documents in accordance with the reality to increase more funding sources to hospitals and ensuring that all people especially the poor can have access to health services. The government will allocate national expenditure to the health sector up to 9% as agreed by the National Assembly and promote a contribution from the society mainly the investment and the cooperation of private sector to health with strict and detailed legislation for the management.

5. Improving health information with data collection mainly on birth, death, weight, and height, from the grass root village level so that real needs can be assessed for the causes and areas for improvement according to the plan and goals.

6. Improving quality of food and drugs with regular monitoring at border areas and air ports. Send teams to monitor at markets, factories, restaurants and at the same time improve the laboratory for food and drug analysis to identify problems on time and up to standard with neighbouring countries.

VI. Structure of Organigram

National Commission for Health Sector Reform consists of:

1.	Deputy Prime Minister, responsible for social and cultural sectors	Chair
2.	Minister of Health	Vice Chair
3.	Vice Minister of Ministry of Finance	Vice Chair
4.	Vice Minister of Ministry of Planning and Investment	Vice Chair
5.	Vice Minister of Ministry of Foreign Affairs	Member
6.	Deputy Director Central Party Committee	Member
7.	Vice President of the Socio-Cultural Commission of the National Assembly	Member
8.	Vice Minister of Ministry of Justice	Member
9.	Vice Minister of Ministry of Education and Sports	Member
10.	Vice Minister of Ministry of Information, Culture and Tourism	Member
11.	Vice Minister of Agriculture and Forestry	Member
12.	Vice Minister of Ministry Labour and Social Welfare	Member
13.	Vice President of Lao Women's Union	Member
14.	Vice President of Central Lao Youth	Member
15.	Vice Minister of Health and secretary of the Commission.	Member

The National Commission for Health Sector Reform has an assistant team called: the secretariat consisting of Directors and Deputy Directors of the Ministry of Health:

1.	Director of Cabinet	Chief
2.	Deputy Director of Planning and International Cooperation Department	Deputy Chief
3.	Deputy Director of Finance Department	Member
4.	Deputy Director of Organization and Personal Department	Member
5.	Deputy Director of Hygiene and Health Promotion Department	Member
6.	Deputy Director of Communicable Disease Control Department	Member
7.	Deputy Director of Health Care Department	Member
8.	Deputy Director of Food and Drugs Department	Member
9.	Deputy Director of Education and Health Research Department	Member
10.	Deputy Director of Supervisory Department	Member
11.	Deputy Dean of University of Health Science	Member

The National Commission for Health Sector Reform has main functions to:

1. Consider and adopt health sector reform framework Lao PDR.
2. Submit to the Government and then to the National Assembly for the adaptation of the newly reformed health system and regulations, and laws necessary for the health reform.
3. Guide, and coordinate with ministries, organizations equal to ministries and local authorities at different levels and international cooperation to implement the health reform plan.
4. Mobilise resources from public and private sectors in the country and abroad for implementing the health reform strategy.

The National Health Sector Reform Commission has rights as the following:

1. To set up a secretariat team and other committees, necessary for the implementation of various interventions of health reform strategy
2. To issue the agreement, order, guidance, and notice on issues regarding health sector reform.
3. To comply with other ad-hoc obligations the government assigned to and the obligations stipulated in the constitution and law.

The National Commission for health sector reform is an ad hoc Commission, taking meetings as main forms of functions. The Commission has 2 general meetings per year; if in any necessary and urgent case, a general meeting can also be organized. For decision making in a meeting, it should be based by most votes of the members.

VII. Contents of the HSR strategy

To solve these constraints and challenges, especially in achieving health related MDGs by 2015 and that Lao PDR will no longer have the status of an underdeveloped country by 2020, we have to decide to implement the strategy for health reform for the change of each area focusing in 5 priority areas in the future and for the long term as the following:

1. Human Resource Development: In accordance with the Health Personnel Development Strategy by 2020 to increase staffing in the quantity as well as the quality, and to provide enough quota according to the real need especially at district and health center levels to ensure that there are enough nurses, midwives or birth attendants, for remote villages, far from the catchment areas of health centres to provide village health workers. Set up incentive or motivation for personnel who work in rural remote areas, especially sending new graduates before receiving their degrees.

2. Health Financing: Aiming for social health protection schemes by putting all health insurances covering target population to 50% by 2015 and 80% by 2020. Establish sustainable financing mechanism in hospitals by using their revenues to improve the quality and capacity building for hospitals for self-reliance step by step, and this is a mean for providing incentives to their service providers. The most important is to harmonise and integrate all funding sources with appropriate planning process and monitoring at each level and to enable the Government to increase national expenditure according to the approval of the National Assembly. Also, more private sector investments should be promoted and encouraged with comprehensive legislation.

3. Organization, management, and working style: Improving the organization, management, planning, monitoring and working style, upgrading and getting near to the standard of regions. Elaborate 4 breakthrough contents for the reality of health sector, mainly working style by the way of team work on basis of democracy, work division and responsibility sharing together with the planning process, the implementation, supervision, monitoring and evaluation of interventions

regularly, taking into account the coordination, cooperation and increase their responsibilities in order to mobilise and using resources as well as national budget increasingly.

4. Health services: Continue improving complete basic health service networks according to universal target coverage, ensuring that all Lao people have equitable access to quality health services, with the scope and standard of services at each level with referral system in case of emergency. Implement policy for free baby delivery and free health care for children under 5 children nationwide. Promote private investment or state enterprise for modernized treatment and keeping with regional and internationally standard, step by step.

5. Information, monitoring and evaluation: Improving in quality of data collection and reporting on health statistics to monitor in systematic MDGs indicators for its accuracy, at the same time it is for the planning to be consistent with the issues addressed and according to the reality. Improve data collection system on birth, death from village level in collaboration with local authorities including information reported by health facilities to be compiled and analysed, then compared for its accuracy through capacity building for each level and in collaboration with technical staff from National Statistic Department in data collection for different surveys at different period.

VIII. Objectives and goals for Health Sector Reform from 2013-2025

1. General Objective:

1. Good health is a basic need for a good quality of life, so that national health sector reform is to establish an effective system ensuring universal health coverage for all the population, and protect and promote the health of people in the Lao Democratic People's Republic. The main goals of the health sector reform being proposed are to ensure that the Lao Democratic People's Republic will: 1) reach the health related MDGs by 2015; and 2) Achieve Universal Health Coverage (UHC) by 2025. These two overarching goals are based on the Lao Government's values of equity, social justice and human rights in line with its commitment to the primary health care (PHC) principles spelled out in its PHC policy.

2. Health system development requires adequate and availability of skilled motivated and well supported health workers for effective service delivery; and with sufficient investment in order to reach the targets set up. The health sector reform should focus on basic health care based on 5 years health plan VII (2011 - 2015) that identified: 1) Contributing to eradicate poverty to improve quality of life of the population, aiming to achieve the health related MDGs; 2) Creating basic materials and technological health infrastructure in order to bring the country out of the least developed country status by 2020; 3) Expanding and strengthening the health system in order to meet the needs of the people, especially the poor and the disadvantaged in synergy with the rapid modernization and industrialization of the country.

2. Specific Objectives:

1. Ensure adequate availability of skilled, motivated and well supported health workers for effective service delivery with enough quota for recruitment of health personnel at district and health center levels; and villages out of catchment areas from health centres should have village health workers;

2. Develop a strong and effective leadership and governance for better managing the health sector

with the breakthrough initiatives and implementing Health Personnel Development Strategy effectively;

3. Increase in health education propagation, scale up the model of healthy villages and contributing to 3 builds or 3 pillars (the province as a strategic unit, the district as a comprehensive, developed and strengthened unit and the village as the development unit across the country), ensure the availability and accessibility of essential medicines and appropriate medical technologies and supplies;
4. Secure and increase adequate financial resources, particularly from the government to support the provision of basic healthcare services to all ethnic people and implementing effectively the policy on free baby delivery and free health care for children under 5;
5. Improve and scale up the health insurance scheme, and social health protection schemes to cover all target populations to ensure that all Lao people have equitable access to quality health services, especially the poor;
6. Focus on nutrition, water supply and latrines, turning them into specific projects and put them to areas in need in collaboration with concerned ministries and authorities;
7. Strengthen hospitals by improving their health financing for their increased autonomy and to enable them to use their revenues aligning with market oriented mechanism in order to improve services and motivations for service providers, with legislation in place according to the real situation and professional remuneration is based on performance assessment;
8. Continue to promote private sectors to invest on health facilities development and using modern equipment for the treatment of diseases, combining the use of modern and traditional medicines. Improve quality of health system delivery by increasing private sector involvement between the Government and privates. In the near future, it is planned to implement in Vientiane Capital and Urban districts, for the people to have more options and have more satisfactions;
9. Establish and strengthen an effective health information system to monitor and evaluate the progress of achieving MDGs and UHC so that it can be a strong system from the grass root, mainly data on birth, death and malnutrition.

3. Goals

a. Goal by 2015

- The proportion of underweight in children under 5 year of age targeted at 22%;
- The proportion of stunned children under 5 year of age targeted 34%;
- Infant mortality rate targeted at 45/1 000 live births and Under 5 Mortality rate targeted at 70/1 000 live births;
- Maternal mortality ratio targeted at 260/100 000 live births;
- HIV prevalence rate among the general population targeted at less than 1%, mortality rate due to malaria targeted at less than 0,2/100 000 of the population and mortality rate due to tuberculosis (TB) targeted at 240/100 000 of the population;
- Proportion of the population with sustainable access to clean water targeted at 80% and proportion of the population with access to latrines targeted at 60%;
- Life expectancy of Lao people targeted at 68,3 years old.

b. Goals by 2020

- The proportion of underweight in children under 5 year of age targeted at 20%;
- The proportion of stunned children under 5 year of age targeted at 32%;
- Infant mortality rate targeted at 30/1 000 live births and Under 5 mortality rate targeted at 40/1 000 live births;
- Maternal mortality ratio targeted at 160/100 000 live births;
- Proportion of the population with sustainable access to clean water targeted at 90% and the population with access to latrines targeted at 80%;
- Life expectancy of Lao people targeted at 73 years old.
- National health insurance coverage targeted at 80%;
- Each community hospital can perform surgical operations targeted at 50%;
- Each small hospital targeted at 01 doctor and 01 midwife;
- Each village targeted at 01 village health worker.

IX. Government Priority programmes

To implement health reform, the health sector will focus on related, direct and indirect, programmes for achieving MDGs that are priorities of the Government:

1. Direct programmes consist of:

- Healthy village model programme (9 elements of primary health care);
- Nutrition program: supplement food, breast feeding, iron and acid folic distribution, vitamin A distribution, distribution of deworming tablets, distribution of iodinated salt, nutrition education …;
- Integrated MNCH programme: family planning, safe motherhood (antenatal care, attended birth delivery by medical personnel, post-partum care), integrated disease treatment in children, growth monitoring and child survival …;
- EPI;
- Skilled birth attendants training programme: nurses, community midwives, and village health workers …;
- Sending new graduates to grass roots and increase quotas for districts and health centres programme;
- Improving quality of community hospitals and referral system in emergency cases programme;
- Communicable Diseases Control programme: malaria, tuberculosis, HIV/AIDS, surveillance and responsive epidemic outbreaks …;
- Improving health financing system programme: free baby delivery and free care for children under 5, including health insurances, health equity fund for the poor...;
- Improving health information system: birth and death registrations...;
- Water Supply and Sanitation programme: water supply, latrines …;

2. Indirect Programmes consist of:

- Strengthening Health System and expansion of infrastructure from central to village level, mountainous and remote areas: improving the organization and working procedures or working style style...);
- Transforming hospitals into modernization and improve quality of services: provide medical equipment...;
- Improving sustainable hospital financial systems;
- Promoting Public Private Partnership;
- Improving food quality and management of consumers;
- Combining the use of modern and traditional medicines;
- Health Work Force Development: Train personnel for each technical priority area, a pool of experts needs to be established;
- Coordinating of projects on planning, monitoring, and evaluation: capacity building for district planning...;

X. Overall architecture and strategies for implementing health reform:

- To reach targets, directions and goals set up especially reaching universal health coverage in Lao PDR by 2020/25, health reform will be implemented in 3 phases such as:
- Phase I (2013-2015): focuses on the achievement of health related MDG and lays out a solid foundation for universal access to essential health services;
- Phase II (2016-2020): aims to ensure that essential health services with reasonable good quality are available and accessible to, and used by a majority of the people;
- Phase III (2021-2025): expects to achieve universal health coverage with an adequate service benefit package and appropriate financial protection for a vast majority of the population.

1. Phase I: Achieving health related MDGs (2013-2015)

1. **Human Resource Development:**

- Educate and train enough qualified health personnel with comprehensive quality such as: strong political commitment, personnel attributes: good attitudes, ethical behaviour, honesty, dedication to human rights, and with technical and managerial skills, appropriate in quantity and quality and to deploy them where and when needed to actively serve the nation and all people;
- Ensure availability of sufficient and balanced number of health personnel with 3 categories and 3 generations and effective utilization;
- Promote gender and ethnic equity and equal opportunities among health personnel;
- Strengthen health personnel management system with well-defined devolution between central and local levels;
- Ensure appropriate HP incentives based on the national policy and legal frameworks through attention to equity issues.

2. **Health Financing:**

- Reform health financing mechanisms, especially improving the legislation, mainly on the health financing strategy, and the decree on national health equity fund;

- Improve the decree no 52/PM on user fees at public health facilities (1995);
- Improve legislation on private partnership.

3. Organization, management and working procedures:

- Improve effective organizational and management of service delivery, especially define clearly what services should be delivered at each level according to the decree of polite- bureau on 3 builds or 3 pillars;
- Solve problems on working procedures, slow management with many layers, to fast moving by using modern technology going through one door, but assuring that the process is a correct and right way, according to rules and regulations;
- Review relevant existing policies for amendment, and develop new policies as appropriate, and in line with the real situation.

4. Health Services:

- Evaluate the existing health networks from central to village level for mapping where new health centres and hospitals are needed according to the real needs;
- Consider setting up regional hospitals based on population size and to be aligned with the Government's priority;
- Mobilize resources from Government and private sector in the country and abroad for the construction/renovation of facilities and procure equipment, commodities for laboratory examinations and for the treatment for the transformation of public hospitals for modernization and industrialization step by step to avoid our people from going abroad seeking for health care;
- Establish functional medicine and traditional medicine units in hospitals in parallel with modern medicine.

5. Information, monitoring and evaluation:

- Improve health information system, the monitoring and the evaluation;
- Delegate to existing village health workers and village health volunteers to collect data from the villages especially data on birth, death, weight, and height related to MDGs;
- Monitor and evaluate the effectiveness of national investment and other assistant programmes;
- In 2014, MDGs indicators need to be assessed to report to the Government.

2. Phase II: Improve access to basic health care and financial protection (2016-2020)

1. Human Resource Development:

- Adjust the training plan for health professions according to the country needs, and at the same time, continue with quality improvement;
- Strengthen the training capacity/health personnel training of National Educational Institute (Education Development Centre) including expanding training sites for clinical skills and health professions educational capacities will be further developed and strengthened in order to serve according to the need of the country;
- Develop detailed plan on infrastructure building, teaching resources, time frame and budget for training of village health workers and the increase in the quantity to assure competencies or experiences (for theories and practical purposes);
- By 2020, all health centres should have health personnel for the quantity and the quality

depending on the increase number of health facilities and the accessibility of the population for health services.

2. Health Financing:

- Develop regulations and guidelines on co-investment between private and states for health sector;
- Continue to implement the decree of the Prime Minister on health insurance by expanding population coverage and consolidate social health protection schemes into one scheme at the end of phase II, population coverage should be 80%;
- Continue the efforts to allocation more funds to rural areas and to strengthen the integrated service delivery network from health centre to district up to provincial level (primary to secondary and tertiary care);
- Coordination among different provider payment mechanisms and alignment of the incentives need to be considered;
- The revenue from drug revolving fund needs to be revisited, and appropriate adjustments may be needed, as more funds from social health protection schemes are available to support the operations of health facilities, particularly at the health centre and district hospital levels.

3. Organization, management and implementation:

- Post-graduate training programme on health management for mid-level managers will be introduced to train future health managers;
- Supervision system should be well institutionalized and functioning to follow up performance of health personnel by developing clear job descriptions, conditions and indicators to assess their performance, in order to provide incentives and awards for those personnel who perform well;

4. Health Services:

- Improve basic infrastructure, supply equipment, and provide tools appropriate with health service facilities set up by the Ministry of Health;
- Develop policies ensuring that all the remote villages should have at least one village health worker working there. All the health centres will also have a reasonable catchment area with an appropriate size of the population to serve;
- Set up monitoring system to be used according to the real situation;
- Improve principles and referral system between health facilities at different levels to enable for the implementation of health insurance system;
- Train quality management for health centres, district and provincial hospitals;
- Improve clinical treatment guidelines for hospitals including district hospitals, internal system for quality assurance and auditing should be established;
- Develop appropriate policies and regulations to manage the increased autonomy of hospitals, especially from central level up;
- Information, monitoring and evaluation: Continue to improve health information systems, the monitoring and the evaluation, so that they are concise, suitable for actual circumstances and can be used for vital statistics such as birth, death and migration;
- All departments in the health system should learn to use information for policy, and planning development and for better management of interventions effectively;
- Design new and integrated information system for the policy makers for decision making according to their responsibilities and their rights in line with the divided managerial policy.

3. Phase III: achievement universal health coverage (2021-2025)

1. Human Resource Development:

- Continue with further development of health workforce, ensuring the access of all population to skilled health workers, while phasing out unskilled or low level cadres through bridging programmes
- Incentives and performance based payment mechanisms will be introduced in accordance with overall changes in provider payment mechanisms;
- Health management capacity will be well fit into the needs of expanded network of health care and social health protection schemes;
- Health personnel should have competencies and good intentions, receive clear support from the institutions and are distributed appropriately.

2. Health Financing:

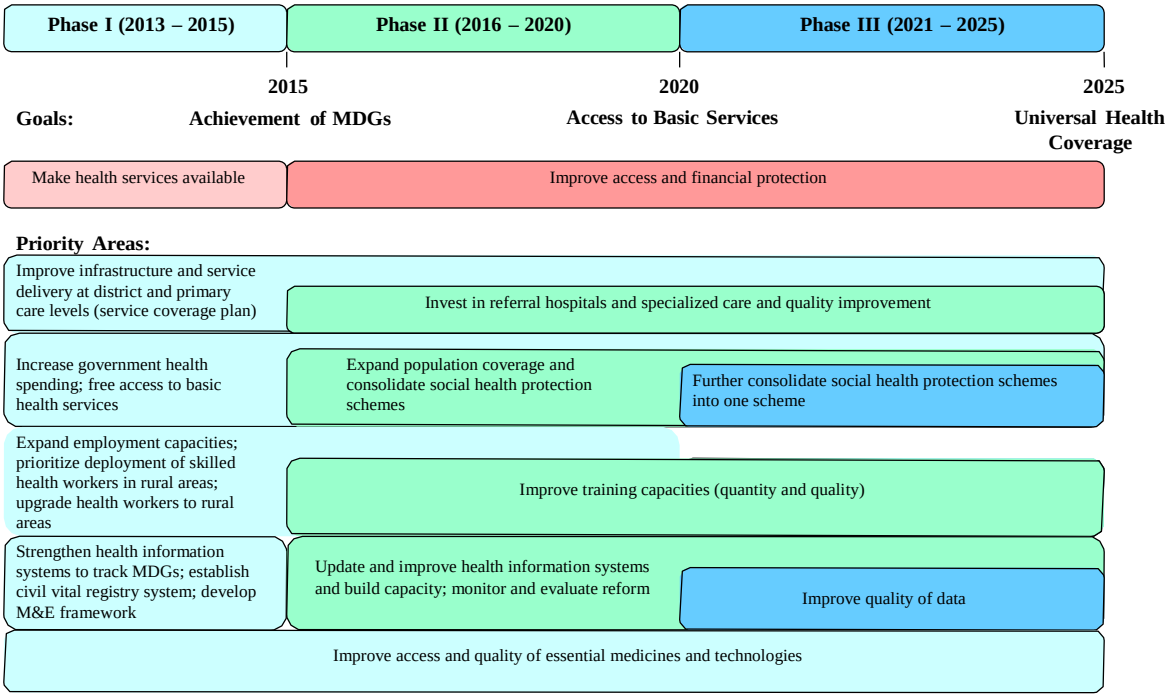
- Continue the expansion of population coverage by the social health protection schemes, extend service benefit package, and consolidate the different schemes;
- Consolidate social health protection schemes into a single pooled fund scheme, with compulsory participation for all. It is expected that over 90% of the population will be covered by the social health protection scheme;
- The service benefit packages offered by different schemes should be aligned with increased government subsidies to the scheme for informal sectors. The service package should include health promotion, preventive and clinical services with essential medicines, as well as rehabilitative interventions;
- Develop clear regulations for service providers' payment the pooled fund through a set of carefully designed mixed provider payment mechanisms.

3. Organization and management of service delivery:

- Adjust the structure of the service provider system, resource requirement (such as the level of skills, technologies and medicines) and performance targets, as the needs of, and demands, for healthcare will increase significantly;
- The management of service delivery at each level should be more standardized, in terms of service provision and quality assurance.

Compliment documents

Figure 1: Timeline of the three phases of health systems reform in the Lao People's Democratic Republic



Estimated budget for health reform

Economic growth in Lao PDR has been average of 8% during the past 10 years, which seems to be good growth if compared to other countries in the region. In 2011, MoH has developed seventh 5 year strategic health plan (2011-2015) with estimated budget of US $1,208 million (including 6 programmes and 120 projects), with yearly requirement budget average to US $240 million per year. In spite of the increasing of health expenditures rate every year, but it is still at low level with only 4.2% of national budget in 2012-2013 or equivalent to 1% of GDP.

Estimated required budget for the reform to achieve MDGs by 2015, targeted at 9% of health expenditures (2012-2013) doubling of current national budget ($194 million = $29/capita= 1,9% GDP)

National budget for health sector		Health budget				Budget required to achieve MDGs			% total national expenditures in 2013
		2010	**2011**	**2012**	**2013**	**2013**	**2014**	**2015**	
Priorities for the Reform (millions USD))	National	29	36	47	77	92	131	149	194
	National + International	60	76	87	117	132	144	153	259
Total (million USD)	National + International	69	94	100	130	185	197	206	259
Per capita (USD)	National	5	6	7	12	14	19	22	2
	National + International	11	15	15	20	28	29	30	39
% GGE	National	2.7%	2.8%	3.1%	3.6%	4.3%	5.3%	5.3%	9.0%
	National + International	3.6%	4.0%	3.9%	4.1%	4.6%	4.4%	4.1%	9.0%
% GDP	National	0.4%	0.5%	0.6%	0.8%	0.9%	1.1%	1.1%	1.9%
	National + International	0.9%	1.0%	1.0%	1.2%	1.3%	1.2%	1.2%	2.6%

Figure 2: Estimated budget

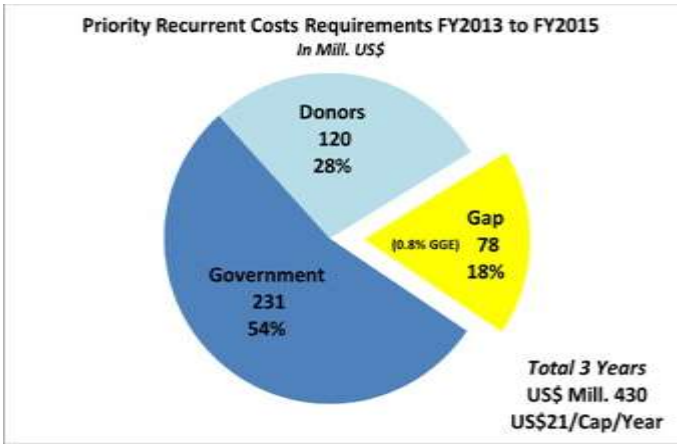


Table 1: Important indicators for countries in the region

Countries	Population (1,000)	GDP	GDP	Maternal Mortality Rate (per 100,000 of live births)	Under 5 Mortality Rate (per 1,000 of live births)	National Health Expenditures compared to % of GDP
China	1,337,825	4,433	10.4	37	18.4	2.7
Lao PDR	6,201	1,158.1	8.5	357	73	1
Sri Lanka	20,653	2,400	8.0	35	16.5	1.3
Thailand	69,122	4,613.7	7.8	48	13	2.9
Vietnam	86,928	1,224.3	6.8	59	23.3	2.6

Sources: World development indicators, except for maternal mortality ratio (MMR) and under 5 mortality rate (U5 MR) for Lao PDR which comes from Lao Social indicator Survey (LSIS) and Government spending on health which is from the WHO National Health Accounts data base.

Note: All indicators are for 2010, except for MMR and U5 MR for Lao PDR which are for 2012

Health Sector Reform Framework

2013 – 2025

Executive Summary

The resolution of the ninth Lao People Revolutionary Congress Party states that: **"**Apart from capacity building of mankind to increase their intellectuals, their knowledge, their career professional, good attitudes and ethic behaviours, we have to put more efforts in improving the physical fitness of the Lao people. We have to continue with our health care policy upholding prevention and promotion as a priority task and quality of treatment with high health care coverage as an important task".

Global changes in economic, financial and environment have direct impacts on health service delivery and these influence Lao People's Democratic Republic (PDR) to reform health system in order to provide quality health care services for the people as demands from the society increasing. Lao PDR is facing great **challenges** with health service deliveries even though there are already investments on infrastructures, medical equipment and human resources, and yet health services are not yet met the demands of the population and are not up to the expected standards.

- There is lack of capacity in management, especially in planning, implementation, supervision and monitoring and evaluation at all levels.
- The challenges in reaching the Millennium Development Goal (MDG) targets, especially those related to maternal and child health require swift and rigorous action if targets will be reached.
- Low capacity of human resource and skills of the health workforce hinder the effective and quality of the health system and health services.
- Funding for health in Lao PDR has been among the lowest in the region, especially from domestic sources. The recently increase in the national health expenditure, though progressive, still does not reach the minimum requirement for sufficient funding and external funds still cover most of the health service and operational costs.
- The health information system is in need for improvement in all aspects – quality, completeness, frequency and accuracy. This has become more urgent as evidence-based planning and policy making is prominent for effective planning and management.

The Health Sector Reform (HSR) aims to introduce a different perspective of implementing sector work plan: through a sector-wide, systematic approach to achieve a sector common goal: affordable, reliable and accessible health services to all.

The HSR Framework is the guiding document to the implementation of the HSR Strategy with policy matrix and strategic planning matrix. The matrix provide a legal and action framework for action planning of the implementation at central, provincial and district level, under the "Three Build" principle. The development process of this Framework is country led, with close consultation between all related departments of MOH, line ministries, development partners (DPs) and international experts invited through WHO and JICA to provide technical supports for each of the priority areas. A team of technical focal points from related entities within the MOH is appointed by the Minister to be fully responsible for the technical contents of the framework. The team work together with development partners under coordination by the Department of Planning and International Cooperation (DPIC) of MOH.

The structure of this framework is based on the principles of focused approach and learning through doing. Therefore the expected results for each of the priority areas are determined; then, activities are identified to reach the expected results. Built-in review and learning process is also part of the framework.

Operational principle of health sector reform:

- Powerful leadership by the Party, the Government – especially the MOH together with an authoritative coordinated management of the reform process

- Develop a clear, evidence-based plan with clarified roles of government and development partner, funding sources as well as the commitment by the stakeholders
- Clear defined responsibility and accountability, sufficient authorised management mechanism
- Implementation should focus on outcomes and quality, through an inter-related systematic approach with small and achievable steps.
- Monitoring and evaluate (M&E) the progress of the implementation at different levels. The results, achievements should be published along the way.

The three builds decentralisation model that has been promoted by the Party will give the provincial and district governments the opportunities and responsibility to prioritise, invest and direct the services to where it is needed in order to ensure equity and equal access to health to all.

This is also learning by doing process, which means the lessons learnt through implementation of each phase will be applied, adapted to the implementation of the next phase and beyond.

Overall goals of the health sector reform:

- *To reach the Millennium Development Goals by 2015*
- *To reach Universal Health Coverage by 2025*

The health sector reform strategy has identified five priority areas to improve the health system: *i) Human Resources for Health; ii) Health Financing: iii) Governance, Organisation and Management; iv) Health Service Delivery; and v) Health Information System*. The reform in these areas is aiming to reduce proportion of underweight children under 5 years old to 22%; infant and under 5 mortality ratio to 45 and 70 respectively per 1,000 live births; Maternal Mortality Ratio (MMR) to reach 260 per 100,000 live births by 2015. The efforts made to increase coverage of social health protection schemes, especially among the poor will reach 80% by 2020. By then, average life expectancy at birth for Lao people will reach 73 years. By 2025, the health service will be affordable to 90% of the population, the issue of equity and equality to health service access will be addressed.

Potential benefits from the health reform process

The first population that benefits from the reform is pregnant women and children under 5 years old, especially those who are poor, live in rural and remote areas, where access to reasonably health services currently is limited. The health insurance through the existing social health protection schemes and the free MNCH/under 5 service will cover the cost of basic health care for people who live under the poverty line, pregnant women and children under 5. Towards phase 2 and 3 of the HSR, 90% of the Lao population will be covered by health insurance.

The cross-sector approach applied in HSR will provide the population easy access to integrated health services at community level of basic preventive care and of the basic health care services that are provided by village health workers, health centres and a locally adapted referral system.

For health facilities, improvement in health staff training, deployment, incentives, working conditions (medical supplies, infrastructure, equipment, etc.) and supportive supervision will be part of quality assurance, together with standardisation of guidelines and regulations.

The Health Sector Reform Process

Overall the SHR process aim to reach each the ultimate goal of universal health coverage (UHC) by 2025. This process is divided into three phases:

Phase 1(2013- 2015):

Objective: To achieve MDG targets

The focus in this phase is on Primary Health Care which is the first level for the community to health services. The entry point is delivery of the maternal, neonatal and child health (MNCH) service package

which will allow an opportunity to strengthen the health system as whole – since MNCH interventions are intrinsically linked to other programmes (cross-cutting) and rely on all aspect of the system (from community level to hospital care) – which also seeking to reach the agreed targets such as percentage of women breastfeeding, population covered by safe water and sanitation, etc.

Key activities in the phase are: to promote and introduce quality assurance in health care institutions; increase financial resources allocated by government to the health sector; reduce the out of pocket expenditure proportion of health revenue to less than 40%; and expand social health insurance to cover more of the poor. The introduction of free facility based delivery and free health services for under five years old children is to be completed. In this phase government employed staff numbers in the health centres and district hospitals are to increase, and community/ midlevel training midwives are to be appointed in each health centre. Compulsory birth registration is to be introduced and facility reporting is to be significantly improved.

Phase 2 (2016-2020):

Objective: Improve access to basic health care and financial protection

This phase is to focus on improving secondary and tertiary (hospital) care. It will bring a new national health plan, upgrading of the health services package to include national interventions in non-communicable diseases, and health facilities adopting quality assurance measures will be greatly expanded. Some 80% of the population will be covered by social health protection schemes and out of pocket expenditure will be further reduced. The workforce of all health centres is to meet national plans and professionally trained graduates are to reach required levels. Management and statistical reporting by over 90% of health facilities is to achieve timing and quality standards, and provincial and district health managers are to be able to make full use of data. ICT systems will be appropriately established in all health facilities to support patient empowerment and improve service provision.

Phase 3 (2021 – 2015):

Objective: Reaching Universal Health Coverage

In this phase, it is expected to complete the health sector reform with good health services being effectively delivered to the population, with the risk to people's health well covered by social protection, delivered by an appropriately trained workforce whose efforts are adequately rewarded and encouraged. Health facilities are to be rationally distributed, adequately equipped and maintained and information systems are to be well established to support services delivery and understanding of achievements.

Key contents:

- **Priority Area 1: Human Resources for Health**

  Expected results:

  - All Health centre (HC) will have at least 1 Skilled Birth Attendants (SBA)/community midwife.
  - All trained health workers will have been recruited as the training meets the workforce needs.
  - By 2025, there will be relevant skilled health workers deployed at various types of health facilities according to the skills needs.

- **Priority Area 2: Health Financing - Secure sufficient financial resources for basic health services provision with focus on Free MNCH/Under 5 services.**

  Expected results:

  - Not less than 9% of General Government Expenditure (GGE) is allocated to the health sector.
  - All MNCH (under five) services are free of charge to users, nationwide.
  - Social Health Protection coverage of the total population is 50% and of the poor is not less than 70%.

- Out of pocket payment is less than 40% of Total Health Expenditure.
- Health expenditure is efficiently managed and monitored.
- Public Private Partnership engagement is reviewed carefully introduced.
- Merging of all social health protection schemes under the national health insurance agency.
- Coverage of social health protection schemes is expanded and reached 90%.

- **Priority Area 3: Governance, Management and Coordination**

  Expected Results:

  - Establish a strong mechanism and structure for sector wide, result oriented management of HSR.
  - Management through clear job description, responsibility, clear regulation and decision making process; one-window service and moving towards E-governance.
  - Intra-ministerial involvement and commitment; regulatory implementation enforcement; oversight and supervision through a M&E system.
  - Performance based funding mechanism is introduced.
  - Improve health management capacity.

- **Priority Area 4: Service Delivery**

  Expected results:

  - Basic integrated service package focus on MCH that met national standards is provided first at health centres and district hospitals, late on to nationwide; the package will be expanded at later phases, including non-communicable diseases prevention and treatment.
  - Health facilities have sufficient capacity and adopt a set of quality assurance measure.
  - Healthy village model is expanded.
  - Effective, localised referral system is set-up and utilised.
  - Quality of service is improved with increase in % of outpatient visit and health facility utilisation.

- **Priority Area 5: Health Information System**

  Expected results:

  - A set of standardised National Indicators with proper data collection; analysis and utilisation arrangement is established and used.
  - Baseline for HSR set-up.
  - Compulsory birth and death registration introduced.
  - Public health facilities are able to provide statistical reports timely and accurately.
  - Apply of information technology for health information reporting.
  - The health information system serves as a backbone to planning, policy making and other management decision making process.

For phase 1, the implementation plan for central level is reflected in the strategic planning matrix (annex 2). While for phase 2 and 3, the matrix expresses the direction and details will need to be added as the implementation of phase 1 will provide lessons learns as well as further directions for later on.

Leadership, Coordination and Operation

Strong Government leadership is needed to ensure the coherence of the HSR plan and the coordination of the reform implementation across central and provincial government agencies. The Lao HSR process

needs to have active, engaged and committed leading committee at national and provincial levels. The leadership of MOH will be critically important to the success of the reform process.

- Establish a National Commission for HSR, chaired by the Vice-Prime Minister, co-vice chairs by the Minister of Health, Minister of Finance, and Minister of Planning and Investment. Other members include representatives from line ministries and National Assembly (NA). The key functions of the Commission include providing strategic and policy guidance; approving planning and budget; inter-sectoral coordination; submitting legislative documents for approval. The Commission will meet biannually.
- The Health Sector Reform (HSR) Secretariat heads by the Minister or Vice-Minister of Health and/or the Officer in Charge of the SHR. Members consist of director of key departments within the MOH, including DPIC, DOF, Cabinet, and key development partners (DPs). The secretariat is responsible for overseeing the implementation of the reform process and supporting the function of the National Commission, as determined by the National Commission. The Secretariat will meet quarterly and report directly to the Commission.
- The Technical Focal Point Team (TFT) consists of members who are Vice-Director and technical staff from all related departments within the MOH. The TFT has function as the think tank of the reform implementation and responsible for the technical input during the planning and implementation of the reform process.
- The “Three Builds” model will be applied as management structure and line of responsibility at national, provincial, district and village levels.
- A multi-sectoral coordination mechanism will be established with clear objectives and actions to be taken by different line ministries, under the supervision of the National Commission.

Operational initiation:

- Prepare and submit for the PM Decree regarding the SHR Strategy, HSR Framework and its structure.
- Establish the National Commission, the HSR Secretariat, the Provincial and district Committees.
- Appoint the OiC at National and Provincial level.
- Identify needs for HSR interventions.
- Develop criteria for selection of provinces that initiate the HSR implementation.
- Conduct provincial annual action plan in selected provinces.

CONTEXT

Background

The resolution of the ninth Lao People Revolutionary Congress Party has stated that: **"**Apart from capacity building of mankind to increase their intellectuals, their knowledge, their career professional, good attitudes and ethic behaviours, we have to put more efforts in improving the physical fitness of the Lao people. We have to continue with our health care policy upholding prevention and promotion as a priority task and quality of treatment with high health care coverage as an important task".

The Lao People's Democratic Republic (PDR) remains one of the poorest countries in East Asia with some of the worst social outcomes. It is ranked amongst the bottom quarter of countries (138/187) on the UNDP Human Development Index (2012). The Lao is also one of ASEAN countries that have challenges in achieving some MDG targets by 2015 (see table 1). People in the Lao PDR suffer from both communicable and non-communicable diseases, as well as other health threats. The physical and human geography of Lao PDR generates further complexity. The rural areas have many mountainous regions where the inhabitants are ethnically and linguistically diverse and access to seek or provide services is difficult and can become impossible during the rainy season. Significant proportions of the rural and urban population live in poverty and the cost of services creates a further barrier for them to seek health care.

Table 1:

Countries	Population (1,000)	GDP per person (2011)	GDP growth (2011)	MMR (per 100,000 of live births)	Under 5 Mortality Rate (per 1,000 live births)	National Health Expenditures compared to % of GDP
China	1,337,825	4,433	10.4	37	18.4	2.7
Lao PDR	**6,201**	**1,158.1**	**8.5**	**357**	**73**	**1**
Sri Lanka	20,653	2,400	8.0	35	16.5	1.3
Thailand	69,122	4,613.7	7.8	48	13	2.9
Vietnam	86,928	1,224.3	6.8	59	23.3	2.6

Source: The National Health Sector Reform Strategy till 2020

The 7th Five-Year Health Sector Development Plan (HSDP) 2011-2015 aims to strengthen the existing health system, particularly at the primary health care level, to ensure access to quality health services to the poor and vulnerable populations in remote areas. The goals of the 7th NHSDP are as follows:

- Contribute to eradicating poverty to improve the Lao people's quality of life, aiming to achieve the five health-related MDGs;
- Create basic material and technological health infrastructure in order to bring the country out of the least developing country (LDC) status by 2020; and
- Expand and strengthen the health system in order to meet the needs of the people, especially the poor and vulnerable in synergy with the rapid industrialization and modernization of the country.

To achieve these goals, the National Assembly (NA) has recently approved the resolution calling for four breakthroughs in the areas of ideology, human resources, management and assistance for the poor. Recently, the Prime Minister instructed that the health sector in Lao PDR has to improve the access to, and use of quality health services through the health sector reform in order to acquire a rapid improvement in health and healthcare for Lao's population. In doing so, the Lao PDR government will pursue the implementation of appropriate health policies by prioritizing the provision of basic health services, via an approach to universal health coverage in years to come.

The Lao Government has signalled its commitment to improving the sector through recent additional expenditure in the health sector to substantially increase the salaries of quota staff. It has also started

the implementation of the national policy on free MNCH/Under 5 in conjunction with Development Partners in most parts of the country. Initial analysis of outcomes of the latter innovation is that at this stage, further tuning is needed to ensure that the benefits of the free services are equitably spread with a focus on the needs of the poor, and that available funds are carefully managed to ensure that they are directed to primary care services for the many ahead of expensive secondary and tertiary hospital services for relatively few people in need.

The "Three Builds" decentralization program is transferring responsibility for services planning, financing and delivery, including health services, to provinces and districts. Decentralization calls for new relationships between the Ministry of Health and departments of health in provinces and districts, and for clear policy directives to be transmitted by central government for implementation using locally relevant strategies.

Current challenges

Global changes in economic, financial and environment have direct impacts on health service delivery and these influence Lao PDR to reform health system in order to provide quality health care services for the people as demands from the society increasing. Lao PDR is facing great challenges with health service deliveries even though there are already investments on infrastructures, medical equipment and human resources, and yet health services are not yet met the demands of the population and are not up to the expected standards.

The physical and human geography of Lao PDR generates further complexity. The rural areas have many mountainous regions where the inhabitants are ethnically and linguistically diverse and access to seek or provide services is difficult and can become impossible during the rainy season. Significant proportions of the rural and urban population live in poverty and the cost of services creates a further barrier for them to seek health care.

  - There is lack of capacity in management, especially in planning, implementation, supervision and monitoring and evaluation at all levels.
  - The challenges in reaching the Millennium Development Goal (MDG) targets, especially those related to maternal and child health require swift and rigorous action if targets will be reached
  - Low capacity of human resource and skills of the health workforce hinder the effective and quality of the health system and health services.
  - Funding for health in Lao has been among the lowest in the region, especially from domestic sources. The recently increase in the national health expenditure, though progressive, still does not reach the minimum requirement for sufficient funding and external funds still cover most of the health service and operational costs.
- The health information system is in dire need for improvement in all aspects – quality, completeness, frequency and accuracy. This has become more urgent as evidence-based planning and policy making is prominent for effective planning and management.

Recent data from MOH on the progress reaching health related MDG targets shows that MDG 1 and 5 targets are still off track. This means, more efforts will be needed if all MDG targets are to be reached by 2015. Thus the Government and MOH initiate the SHR with focus on reaching MDG, of which MDG 5 should be the trigger area for the reform process.

GUIDING AND OPERATIONAL PRINCIPLES

The HSR implementation infuses another perspective to the system, through a sector-wide/systematic approach **to achieve a common goal – affordable, reliable, accessible health service to all Lao people**. The reform process begins with implementation of phase I through improving the delivery of Maternal Neonatal and Child Health (MNCH) services, which will have effect on the changes of the other components and will later expand to the other areas of health services.

Overall Objectives

- *To reach the Millennium Development Goals by 2015.*
- *To reach Universal Health Coverage by 2025.*

Specific Targets

As specified in the National Health Sector Reform Strategy, the goals that the health sector aims to achieve as results of reform are:

Targets	**2015**	**2020**
Life expectancy (year)	68	73
Reduce proportion of underweight among under 5 years old (%)	22	20
Reduce proportion of stunted children among under 5 years old (%)	34	32
Reduce Infant mortality (per 1000 live births)	45	30
Reduce under 5 mortality (per 1000 live births)	70	40
Reduce maternal mortality (per 100,000 live births)	260	160
Reduce malaria related mortality ratio (per 100,000 population)	Less than 0.2	
Reduce TB mortality ratio (per 100,000 population)	240	
HIV prevalence among adult population (15-49)	Less than 1%	
Proportion of population that have access to clean water (%)	80	90
Proportion of population that have access to latrine (%)	60	75
National Health Insurance Coverage (%)	50	80
Number of village health worker per village		1

(1) Guiding principles

The Ministry of Health has the policy on health sector reform, which is specified in the followings:

(1) Doctors and nurses should uphold professional ethics when providing health care service. Strengthen institutional capacity.
(2) Strive to achieve health-related MDGs, especially reducing maternal mortality ratio through the policy for free delivery and health care for children under 5.
(3) Improve the quality of health service delivery from central to village levels.
(4) Ensure sustainable health financing, expand health insurance for universal health coverage and amend legislation on financing in order to mobilise funding sources for health services.
(5) Improve civil registration and data collection from village level to better assess the needs for health services.
(6) Improve the quality of food and drugs through monitoring at border areas and airports.

(2) Operational Principles

As reform addresses change, in this case, changes in the way that the health system is currently managed and the health service is delivered. To be able to effectively initiate the reform process and to steer it towards the goals and targets set by the Government of the Lao PDR as mentioned in the Health Sector Reform Strategy, the obtaining the following principles is essential:

- Powerful leadership by the Party, the Government – especially the MOH together with an authoritative coordinated management of the reform process.
- Develop a clear, evidence-based plan with clarified roles of government and development partner, funding sources as well as the commitment by the stakeholders.
- Clear defined responsibility and accountability, sufficient authorised management mechanism.
- Implementation should focus on outcomes and quality, through an inter-related systematic approach with small and achievable steps.
- Monitoring and evaluate (M&E) the progress of the implementation at different levels. The results, achievements should be published along the way.
- Maintain Government's commitment to an on-going health reform programme. Use the results to show the community that they can have confidence in the health sector and to show the Government that health reform is effective.

(3) Potential Benefits from the reform process

The first population that benefits from the reform is pregnant women and children under 5 years old, especially those who live in rural and remote areas, where access to reasonably health services is limited, even impossible in rainy season.

The other immediate beneficiary group will be the poor, as the reform will target those have problems getting access to health services, of which majority are poor, and/or living in remote areas. The health insurance through the existing social health protection schemes, especially the Health Equity Funds (HEF) and the free MNCH/under 5 service will cover the cost of basic health care for people who live under the poverty line, pregnant women and children under 5. Towards phase 2 and 3 of the HSR, 90% of the Lao population will be covered by health insurance.

The cross-sector approach applied in HSR will provide the population easy access to integrated health services at community level of basic preventive care and of the basic health care services that are provided by village health workers, health centres and a locally adapted referral system.
For health facilities, improve in health staff training, deployment, incentives, working condition and supportive supervision will be part of quality assurance, together with standardisation of guidelines and regulations.
The three builds decentralisation model that has been promoted by the party will give the provincial and district governments the opportunities and responsibility to prioritise, invest and direct the services to where it is needed in order to ensure equity and equal access to health to all.

(4) Overall structure of the reform process

The reform is intended to respond to the Government's and the National Assembly's concerns for the Lao people's health status, their access to good services being locally delivered at reasonable cost and quality by appropriately qualified staff.

There are many obstacles to introducing change no matter where it is attempted. Health services reform is a very difficult task as can be seen in the problems faced by many nations both developed and developing that are undertaking reform of their health sector. In Lao PDR, a stepwise approach to health sector reform should enable reform goals to be achieved and at the same time provide good lessons on how to most efficiently and effectively introduce change. The urgency generated by tight deadlines for international reporting on MDGs together with the limited senior management experience available for implementing the reform program supports the need for a "learning by doing" approach.

A focused approach is required, starting by using the MNCH package as an entry point which will allow for an opportunity to strengthen the health system as whole – since MNCH interventions are intrinsically linked to other programs (cross-cutting) and rely on all aspects of the system (from community level to

hospital care) – while also seeking to reach the agreed targets such as percentage of women breastfeeding, population covered by safe water and sanitation, etc.

The National Health Sector Reform has three phases:

- Phase I (2013 – 2015) aims to achieve the health-related MDGs and layout solid foundation for the next phases.
- Phase II (2016 – 2020) aims to ensure essential health services of reasonably good quality are accessible and utilised by majority of the population.
- Phase III (2021 – 2025) aims to achieve universal health coverage (UHC) with an adequate package of services and appropriate financial protection for a vast majority of the population.

The reform strategy identifies five interrelated aspects of health services to be covered under the HSR process**: i) human resources; ii) financing; iii) governance, organization and management; iv) health services delivery; and v) health information system.**

Figure 1: Inter-relations amongst the priority areas of the health service

Source: DPIC/MOH. Presentation on the HSR overall process, 2013

Figure 1 above shows the relationship amongst the five priority areas and what requires to make the system effective.

(5) Structure of the health sector reform framework

The structure of this framework is based on these principles: focused approach and learning through doing. Therefore the expected results for each of the priority areas are determined; then, activities are identified to reach the expected results. Built-in review and learning process is also part of the framework.

5.1. Development process of the Health Sector Reform Framework

Reform means changing the existing conditions for the better, including changing structures and policies according to the four breakthroughs initiatives. Health reform is an ideal in contributing to improve the people, the nation and the society like.

In this context, the health sector reform in Lao PDR is not an intervention programme. Instead, this reform process is about the approaches applied to improve the service delivery through a practical area

base on the existing system to reach desired outcome of reaching MDG targets in phase 1 and therefore, will contribute and shape the reform process to reach universal health coverage in phase 2 and 3.

This Health Sector Reform Framework (HSRF) is formulated based on the structure and guidance given in the National HSR Strategy 2013-2020 of which the National Assembly has endorsed. The contents of this Framework also thrive from other documents resulted through the development process of the strategy.

The HSRF development process is country led with close consultation between all related departments and centres in MOH, line ministries, DPs, and international experts invited through WHO and JICA to provide technical supports for each of the priority areas. Field trips were organised for international experts, especially those visited Lao PDR for the first time, to discuss and get the perspectives on health services from health staff at different levels, as well as with the villagers. These experts were responsible for facilitating the technical discussions and then drafting the action plan matrix of each of the pillars of their expertise as results.

In MOH, with approval from the Minister, each department nominates a HSR focal point for their specialty areas, under the overall coordination of the Department of Planning and International Cooperation (DPIC) for the comprehensive development of the HSR Framework. This focal point team (TFT) was responsible for coordinating all the consultations related to their specialty area of work and responsible for the technical inputs and finalisation of the document. The formulation of this focal point team has not only accelerated the development process of the Framework, but it also enhances the ownership of MOH towards the reform process as the focal points channelling their understandings and the concept of the HSR to the other colleagues. This team will, at later stage, form a strong task force for the initiation period of the implementation of the HSR as the 'champions' of the reform.

5.2Contents of this framework:

This document is resulted from, the collaboration and contribution by national and international experts involved in the development process. The focal point team contributed to the contents of the matrix; international experts contributed to the draft of the narrative in addition to the contents of matrix (see annex 5 for list of contribution)

- ***Narrative section*:** This section covers all the key contents describing on the HSR and how it will be implemented in principle. The narrative provides a lay-out of the implementation throughout the HSR process, overview context of the HSR, the policy framework; the strategic planning framework; the leadership, management and coordination of HSR implementation; costing; and final the M&E framework of the reform process.

- ***Annex 1-*** Policy Matrix provides details of legislative and policy documents that will need to pass and approved in order to move the implementation of the HSR forwards. The implementation of this matrix will provide a strong legal ground for the sector reform.

- ***Annex 2 –***Strategic Planning Matrix provides details on the expected results and key action needed to achieve these results for each of the priority areas in each phase. This matrix will serve as guiding framework document for the annual action plan at national and provincial levels that will take place at the implementation process. Phase 1's matrix provides more detailed actions while phase 2 and 3 matrixes mainly provide direction and key areas as more details will be added as the experiences from phase 1 occur. Together with the national sector development plan in the coming years, these details will be added in the matrix for phase 2 and later, phase 3.

- ***Annex 3 –***Costing provides details on the costing methodology, data sources and how the costing is done. It also gives details on the estimate of budget needs for each area of implementation and by implementation phases.

- ***Annex 4 –***M&E indicator matrix, this annex provides a list of indicators that is complementing with the M&E framework mentioned in the narrative section and with the actions describe in priority area 3 on management. These indicators will be the guide for data collection and reporting throughout the implementation of the HSR process.

- ***Annex 5 –*** List of key contributors and their inputs to the contents of this framework

POLICY FRAMEWORK

As the reform will stimulate the whole health system to work together to achieve the national common goals, the policy framework provides guidance and actions needed in legislation and policy to give the sector reform a legal ground for its implementation process. At the same time, this is also an opportunity to revise and improve the existing legislation to support the improvement of the health services to the Lao population. This policy framework is built based on the legislative requirements that came up in the development process of the planning matrix, as well as well with results from the regional legal and legislation review conducted by the WHO Western Pacific Regional Office (see annex 1 for details)

Priority Area 1: Human Resources for Health

- **Improve employment capacity.**

The proposed Ministry of Health (MOH) Decree on quota for health staff based on the projected staffing needs will help to standardize the procedure for MOH to request to MOHA the numbers of health staff that reflects the needs across sector in both number and skill mix. This Decree will guide MOH in presenting MOHA with a clear plan that justifies the requested number of staff for each year. In addition, it will provide guidelines for monitoring staffing needs to maintain up-to-date information on health personnel. As the quota will unlikely to cover all the village health workers (VHW), a Prime Minister (PM) Decree on Deployment of Village Health Workers will cover this group of health workforces. The Decree will give way to the DHHP, DHP, DTR, DHC to upgrade the existing Village Health Volunteers (VHV) to VHW though might be smaller in quantity but will be better trained, well supported and provide services to the villagers in rural and remote areas of Lao PDR with clear job description.

1.2. Increase deployment of skilled health workers to rural and remote areas

The MOH Decree to regulate the employment of health staff at health facilities and public health offices at all levels will provide guidance on the use of the quota as well as authorising other means of employment the trained health staff that goes beyond the quota. Currently, many of the trained staff work in public health facilities as volunteers, having this Decree will allow health manager to contract the needed additional health workers while waiting for the quota system to match with the needs and the training outcomes. This Decree will also allow the graduates who are located to remote rural areas to receive the incentives and supports needed to maintain and perform their skills.

1.2. Enhance the capacity of health professional education and training

This Decree would reinforce the need to strengthen the clinical training of the health professionals, an area that is very specific to the health sector and plays a crucial role in skills training for them. Currently, only two of the central level hospitals have the Medical Training Unit set up in the hospital to support the clinical and practical training for students and trainees. This model has proved essential and effective in improving the quality of training, thus, the skills of the students. The Decree will provide the needed legal ground for DTR and UHS to expand this model to the eight provinces that have training institutions for health professional.

Lao PDR is a member of the South East Asian Nations (ASEAN). Its health system will gradually meet the regional standards, of which providing licenses for health professionals is in the regional standardisation for health professionals across the region. The Decree on Registration and Licensing of health workers will not only guide the health sector to meet the regional standards, but it also help assuring the quality of trained health workforces.

1.3. Improve HRH information system

In order to collect information that reflects the employment, training and structure of the health workforces, the Decree that instructs all facilities and entities to report on their employment situation will help the Department of Health Personnel (DHP) to project the staffing needs as well as its skill mix. The projection for health school enrolment will also benefit from the improved HRH information.

Priority Area 2: Health Financing

2.1. Increase government funding from domestic sources to finance basic health services

Domestic government spending on health in Lao PDR is low compared to other neighbouring countries. To improve health outcomes in the country, additional and sustained financial resources for health will be crucial.

In 2012, the National Assembly endorsed a commitment to allocate 9% of General Government Expenditure (GGE) to the health sector. A National Assembly Decree and a Prime Minister Decree to determine that 9% of GGE is allocated to the health sector will guarantee the Government's fiscal commitment to adequately fund the health sector and to improve health outcomes and increase health service access for the poor. Also included in these Decrees is the directive to ensure a minimum funding disbursement of funds for each quarter in line with the MOH budget plan

2.2. Improve resource allocation focusing on the district health system

In order to improve health outcomes and achieve MDGs, it is essential to target areas with high poverty levels, high burden of disease, and other specific demographic characteristics. The Prime Minister Decree on Free MNCH will support implementation of free MNCH services and allocate funding to rural and remote areas. The PM Decree for scaling up free MNCH will help make MCH services available at the district and provincial levels, nationwide. In additional, a MOH decree will prioritize the use of Nam Theun 2 (NT2) funds to support key free MNCH and HEF, which is essential to promote improved health outcomes among women, children, and the poor. The Decrees will set the legal framework for a more equitable allocation of funds.

2.3. Improve coordination of funding flows to the health sector

A MOH Decree on harmonising all funding sources for health with the HSR and the health sector annual plans will seek to ensure that funds for the health sector are channelled to support the HSR expected results and activities. In addition, improved coordination of funding flows will prevent overlap and make sure that funding flows at all levels (provincial, district, and donor funding) support HSR and health sector priorities. In addition, this policy measure will include guidelines on better coordination of donor funds and a progressive move from a project-based to program-based funding model.

2.4. Improve oversight and financial management and tracking of funds in the health sector

This area requires different sets of legislations, namely a MOH decree to develop the National Health Accounts (NHA) institutionalization plan, including the establishment of a NHA team (composed of members from MOH, MOF, MPI, LSB, NIOPH, UHS) (which will generate accurate and timely health expenditure information); as well as revising Decrees 03 and 53; to be better aligned with the Budget Law, Accounting Law, and others; revising the charter of accounts for health. All amendments in these legislative documents will contribute to improved financial management with the purpose of strengthening transparency, accountability and efficiency. A technical committee will be required in order to develop guidelines and update regulations on how health facilities should use different sources of revenues. Guidelines on auditing and financial reporting should also be included under the legislation/policy framework.

a. Adopt appropriate provider payment mechanisms (PPM)

Under this area, improved regulations are needed in terms of a MOH Decree on governance arrangements for the National Health Insurance Bureau and its branches; and a MOH Decree on phasing out of the Drug Revolving Funds (DRF) through Government Funding (for priority service delivery areas based on the Essential Drugs List) and expansion of Social Health Protection schemes.

A balanced mix of Provider Payment Mechanisms will allow for a more efficient management of resources to health services. In order to improve the current payment system to providers and better direct incentives for good quality services, the MOH will update existing PPM to be more applicable to the current country situation. Prior to the assessment of PPMs it is necessary to conduct a costing study which will provide data for all health service levels (district to central).

Priority Area 3: Governance, Management and Coordination

3.1. Establish a strong mechanism for coherence and coordination for a results oriented management of the HSR

The PM Decree endorsing the HSR process will focus efforts and clarify roles and responsibility of Ministry of Health, and Provincial and District governors in order to specify leadership roles for implementing MNCH services. The central HSR Commission, also included in the Decree, will coordinate among government stakeholders and development partners. Furthermore, the appointment of the officer-in-charge at the national and provincial levels through the PM Decree will put in place a responsible party to oversee implementation at different levels. These policies and legislation will help to link partners in the health sector and clarify leadership and accountability.

3.2. Strengthen HSR management of the implementation of HSR

One of the key features of HSR is clear assignment of roles and responsibilities at managing level. The formal directive from MOH will provide clear guidelines for managing and support the implementation at all levels to assure the HSR is smoothly implemented at selected provinces and then to nationwide. The support mechanism will focus on increasing supportive alliances from central to provinces and from provinces to districts and to health centres in the area of planning, ensuring smooth flow of funds and for conducting the activities. Technical support will also be needed where necessary, together with a clear and strong sense of responsibility at each level as a measure for quality assurance. The directive will also specify standards for supportive supervision

3.3. Define clear reporting and feedback flow mechanism for effective oversight and supervision of the HSR implementation

1. A policy on result based planning and management is needed to officially acknowledge the result based planning approach, in response to the HSR. This will trigger the needs for capacity building in at national and provincial level in order to conduct planning and manage its implementation effectively.
2. MOH Decree on the M&E system to support the routine reporting and assessment of the implementation of HSR at all level. This will also enhance the need to use the outcome of M&E for improving planning and implementation of HSR and as a tool to report progress to the leaders and the population.

3.4. Develop a cross-cutting mechanism for Performance Based Funding (PBF)

A policy on Performance Based Funding is to strengthen the health sector's commitment in quality assurance. The policy will cover the ethical code of conduct of health care profession, their outcome performance in accordance with the national standards and regulations as well as the incentives that come with good performance and/ or vice versa. This policy should also address the action required and responsibilities of all the involved sectors namely health, finance, home affairs.

Priority Area 4: Improve Infrastructure and Service Delivery

4.1. Rationalise allocation of service arrangement through localised planning that is harmonised from central to district levels to ensure availability of services to the population

In order to reach MDG health-targets, public health services should be made available under the HSR plan. As the reform's first aim is to boost the health sector's performance to reach the MDG, a guideline is needed for the criteria to select the provinces that needed the reform most. Once the provincial planning process is conducted, it needs a national standards and framework to set the facilities and services against. The aim is to standardise health facilities and make primary health services available and accessible to the population. The policy on PHC and Decree on Hospital Regime will set standards for health facilities at each level, with special focus on MNCH services in phase I. These policies/ legislation will outline responsibilities at all levels for service delivery and determine what facilities are responsible for EmONC services.

4.2. Strengthening referral system and accessibility

Mountains take a major part of the Lao PDR terrain. It makes accessibility of the people to health services a challenge. For emergency and for health conditions that need referral, the reform process pays attention to the needs of the patients and what can be used at local level. A MOH Decree that allows province, or district to work with health centres and villages to agree and sustain a locally adopted, feasible, flexible and economic referral system will enhance the community involvement as well as to save time and money for those in need.

4.3. Improve health legislation coverage on community health

Both the Law on Hygiene, Disease Prevention, Health Promotion; and the Primary Health Care Policy were issued since 200O. The Law on Health Care was issued in 2005. All these legal documents stipulate how the health services should be delivered at community health. The recent collaboration between the WPRO and Lao MOH to assess the current public health related legislations in Lao DPR have raised the needs to amend these important documents, especially the Law on Health Care to meet regional and current national standards, as well as the needs of the population.

Strong, people oriented legislative and regulations that focus on the needs of health care services at community will be essential for the planning and implementation of health services delivery at community level. The revised legislation will provide legal corridor for a flexible PHC services that adapt well with the diversity of local social, geographical condition, especially in rural areas of Lao PDR.

4.4. Improve hospital management for better quality and efficiency of services

The main objective of this action area is to assure health staff adhere and motivated to follow guidelines and manual of service provision. A policy on quality of care assurance will provide a strong framework for hospitals and health facilities to ensure the quality of services and its management.

In order to improve service quality and increase hospital accountability, the accreditation regulation will allow hospitals to seek accreditation for MNCH services. Accreditation is important to encourage improved service delivery and designate quality facilities.

4.5. Improve regulatory capacity on drugs, pharmaceutical, and essential medicines

The National Drug Policy; Decree on National Drugs; Regulation on Good Manufacturing Practices; Decree on Essential Medicines, and others related legislative documents are all in need of revised and update according to the regional and national standards. As this is an area of health services that evolves fast and can have effect on the service delivery, it is important that the produce, trade and distribution of drugs and related products are well regulated, in line with regional and international standards, to ensure its accessibility to the needed. Enforcement of dugs related regulations is an area that needs strengthening with designated entity to be overall responsible.

4.6. Ensure uninterrupted supply of medicines and medical products

Quality service delivery depends on clear linkages in the pharmaceutical supply chain and the continuous flow of drugs and supplies, especially for drugs supporting MNCH services. In order to ensure for the uninterrupted supply of essential medicines, key medicine policies need to be reviewed and updated. The National Medicine Policy should be revised and a NMP implementation plan aligned with budget should be finalized. The policy should include revised and updated lists of essential drugs to cover the basic health package and promote supply chain integration for the supply of essential medicines and medical supplies essential to MNCH service delivery. Pharmacy staff should be trained on inventory management and good storage techniques to ensure sustainable availability of essential medicines and medical supplies at health facilities. In addition, the MOH Decree on pooling funds should include recommendations on pooling funds to provide for life-saving, essential medicines.

Priority Area 5: Health Information Systems

5.1. Improve the routine national health information system, covering all the MDG targets

Strengthening health information and data collection systems is essential to monitor progress towards achieving MDGs and other targets. The MOH Decree on a national standardised health indicators and data collection form should present standardised procedures for reporting that can be followed nationwide, at all levels of service delivery. Strengthened legislation is required to set standards for information collection from different facilities as well as the private sector. Specifically, procedures should be strengthened for community-level data collection. The Decree should cover procedures for data analysis, including training for staff in this area. The Decree on data auditing will ensure that information systems are audited to check the accuracy of data.

5.2. Develop civil registration and vital statistics (CRVS)

In order to monitor demographic changes, burden of disease indicators, and the overall population size, it is necessary to record birth rates and mortality through a standardized registration system. The Prime Minister Decree would routinize documentation at all levels and ensure clear reporting of CRVS from the village to central level. Legislation on birth and death registration will outline a standardized, national system for reporting. The legislation will also cover a provision for birth certificates and cause of death registration, especially focused on cases of maternal mortality. National birth registration will be the source of data for national vital statistics. In addition, MOH legislation is needed on international classification of diseases (ICD) in public hospitals to utilize ICD in patient morbidity records and to have standard use and recognition of ICD nationwide.

5.3. Better apply Information Communication Technologies in health information system

Establishing a computer-based information collection and reporting system is a key element to strengthening health information systems. The MOH Decree on a unified reporting system will provide details for closely linking health reporting through computerized systems between the district and health centre level, all the way to the central level. To facilitate this goal, hospital computer systems will be up-graded and medical records will be entered electronically for more long-term, and widely available access (by other health professionals), as well as safe storage. Under the area of improved information technology, mobile phone data collection will also contribute to overall data collection, as outlined in the MOH Decree on the use of mobile phones for reporting. Mobile phone data collection can help provide essential linkages in data collection between the community and health centre level to the district, provincial and central level. Since many people do not access to hospitals when they are sick or in need of services, it is essential to have reporting mechanisms available at the village level.

5.4. Strengthen information standard and exchange of information amongst different reporting systems

In order to meet international standards of disease classification, and report diseases according to recognized standards, capacity development is needed to use ICD first at the national level. Health staff, including doctors and managerial staff, who have received relevant disease classification training, should apply ICD in selected health facilities for patients and mortality records. Overtime, ICD application should be scaled-up according to capacity to all hospitals for patient and mortality records.

STRATEGIC PLANNING FRAMEWORK

See annex 2 for the details in the Planning Matrix

PHASE I: 2013-2015

Overall Objective:

- *The Phase 1 of the HSR envisages the aims at reaching the Millennium Development Goals (MDGs)*

Specific Objective:

- *Reliable basic primary health care services are available to all, with focus on MNCH services at village, health centre and district hospital level.*

Phase 1 is to focus on Primary Health Care which is the entry point for the community to health services. This phase is also to promote and introduce quality assurance in institutions, increase financial resources allocated by government to the health sector, reduce the out of pocket expenditure proportion of health revenue to less than 40%, and expand social health insurance to cover 70% of poor people. The introduction of free facility based delivery of babies and free health services for under five years old children is to be completed. In this phase government employed staff numbers in the primary health services are to increase, and midwives are to be appointed in each health centre. Compulsory birth registration is to be introduced and facility reporting is to be significantly improved.

The implementation of the reform process is coming at an appropriate time for the health sector. Government's interest and commitment is high and there are serious primary health care delivery issues to be tackled in the near future if MDG 5 is to be reached by 2015.

Many benefits can be gained by initiating the Reform by delivering the basic health service package with a single focus on improving maternal health to reduce maternal death rates at primary health care level. This is a high priority issue for Government and for the welfare of the whole community. Maternal health traverses a significant proportion of the issues confronting primary health care. Because MNCH service provision relies on the function of the whole health system, the Ministry and Departments of Health at the Provincial and District levels can learn a great deal from taking this first step and then carry those lessons forward into the wider health reform program. When maternal health improvement is securely underway, the next step would become the reform of the rest of primary health care. Moreover, starting by using the MNCH package as an entry point will allow for an opportunity to strengthen the health system as whole – since MNCH interventions are intrinsically linked to other programs (cross-cutting) and rely on all aspects of the system (from community level to hospital care) – while also seeking to reach the agreed targets such as percentage of women breastfeeding, population covered by safe water and sanitation, etc.

Though improving MNCH service delivery at primary level is the focus of action in phase I of the HSR implementation, other aspects of the health system such as implementing the health personnel strategy; mobilizing resources for health; strengthening health insurance coverage; nutrition and water, sanitary; strengthening hospital management; private sector partnership…will be conducted according to the national plans with emphasizes on the areas that related to MNCH service delivery. The changes made in the system to improve the MNCH services will be recorded and continued/expanded to other areas of health services in phase II and III of the health reform in order to reach the universal health coverage.

Priority Area 1 - Human Resources for Health (HRH)

Expected Result: By 2015,

- All health centres will be staffed with at least one mid-level midwife and/or community midwife.
- Increase quota to employ all trained health workers, with priority to health centres and district hospitals.

For Phase 1, in achieving MDGs by 2015, the immediate action will be increasing the number of staff and deploying in rural health facilities. Immediate interventions will focus on expanding employment recruitment capacity to ensure utilization of available trained health workforce through increased quotas or other mechanisms as well as ensuring better distribution and improving education capacities. Upgrading/training of village health workers and upgrading courses for exiting low level cadres are other priority actions, as well as compulsory service in rural areas, allocating quotas to rural areas. Improving education capacities in terms of faculty, infrastructure, and clinical training sites will be important to scale of health workforce production to address low density. Existing health management capacities will be strengthened through short term courses.

In order to make services available, the health sector reforms need to ensure availability of and access to skilled health workers for improved health services. However, the shortage and uneven distribution of human resources for health (HRH), especially in rural areas, exposes serious challenges. The inadequate skills and competencies of the existing staff and concerns with the quality of health professions education are added to these challenges.
The priority strategies in addressing these challenges are as follows:

1. **Improving employment capacity:** *To ensure that all trained health workers will be employed and allocated according to the skill needs by the public health system.*

Lao PDR experiences a critical shortage of health workforce with a quite low density of health workers. While there is a need for scaling up the numbers, there are already health professionals who are trained, but unemployed or working on voluntary basis for a couple of years. Thus, increasing employment capacity would be a priority strategy in order to ensure the efficient use of available health workforce in the country. Two different types of actions can be undertaken:

- Increasing quotas for health personnel*:* Recent years witnessed some gradual increase in the quotas, though the increase is still limited in meeting the HRH requirements as well as absorbing the available trained health workers. The target of achieving MDGs by 2015 implies a rapid scale up in recruitment of health workers. The MOH will conduct an assessment of the skills needs and distribution of health work force to all levels, including villages, as the base line to rationalise the request for number and skills to Ministry of Home Affairs (MOHA) that will enable the primary health care (PHC) service to deliver basic health service, begins with deployment of mid-level midwives to where needed.

    - *Considering other innovative ways for recruitment*: Until adequate numbers of quotas are ensured, some transitional actions need to be taken to employ available trained health workers i.e. contracting, etc. Contracting is a practice which is still in effect, but more resources from other sources will be diverted and the procedures will be made more standardized and improved. As adequate numbers of quotas are received, the contracted staff will be phased out by converting them as permanent civil servants.

2. **Prioritizing deployment of skilled health workers in rural and remote areas:** *Allocate enough health workers with the right skills to rural and remote areas, where it is needed most*

To this end, a number of interventions will be employed. While improving the employment capacity, it is critical to address the mal-distribution of health workers, and to introduce measures for deployment of skilled health workers in the rural and remote areas. A mapping of the staff in health centres will be the first step to identify vacancies and gaps. In allocating new quotas, the priority should accordingly be given to the rural facilities.

The service delivery and, therefore, staffing will be strengthened in the rural areas. The emphasis will be given to frontline health workers, which include staff based at health centres and in the communities.

- The staffing requirements for various levels of health facilities will be reviewed and staff deployment will be planned accordingly. It has been planned that each health centre will have between 5 to 7 staff depending on its catchment area and population. A review of the health centres will be undertaken to identify the staffing needs and skill-mix. The targeted staffing level will be reached gradually and deployment of some cadres will be prioritized.

- It is targeted that each health centre will have at least one mid-level community midwife in the Phase 1, thus priority will be given to ensure that all health centres will be staffed at least with one mid-level community midwife by 2015.

- In addition to deploy more health workers to the rural areas, the capacity concerns will also be addressed. Approximately over half of the existing health workers in the health centres are 'low level' health workers. The capacity of existing health workers at health centres will be upgraded through accelerated continuous training courses.

- Some interim solutions will be introduced to enhance the service delivery at outreach, community level. In the remote, hard to reach villages; village health workers will be considered as part of the health centre. Where they exist, the village health volunteers will be upgraded as 'village health workers' with a 6 months of training (3 months theory and 3 months practical training) in order to ensure defined preventive and promotive services in the remote villages.

    - The village health workers will be identified within the communities. Ideally, these candidates should be middle-secondary school graduates, with 8 years of basic education. Female candidates, and from ethnic minorities will be prioritised. However, adaptation of these criteria should be considered, based on the needs and the local situations.

    - The village health workers will be expanded on the basis of clearly articulated policy and legislative framework which will define *their functions, their training through a curriculum in accordance with their expected functions, their selection how they will be integrated into the system, their remuneration and supervision*. The village health workers will be provided a regular compensation. The mechanism to provide this compensation will be identified. The systematic upgrading and expansion of village health workers will require detailed planning and improvement of training sites (8 public health schools and 3 colleges of health science) for both theoretical and practical and provision of teachers. Simultaneously, the capacities of the health centre staff should be built to be able to provide support and supervision to the village health workers.

    - When the network of health facilities expand and the number of skilled health workers increase, village health workers will be gradually phased out as being replaced by skilled health workers, such as middle level PHC workers, nurses, etc. Village health workers will have the opportunity to upgrade through upgrading training programmes.

- Opportunities will be provided to the students from rural areas as well as ethnic groups to study in health professions training institutions, through allocation of certain quotas in admission to education, provision of scholarships. It is aimed to provide opportunities to the students from rural

areas and it is also expected that they are likely to work in the rural areas. In collaboration with the Ministry of education, orientation programmes will be ensured to bridge the gap in the weaknesses in basic education.

Other mechanisms will also be introduced to attract to and also retain health workers in rural areas, including compulsory service upon graduation, non-financial and financial incentives. The decree on financial incentives will be put in effect. The local administrations and communities will be encouraged to take some responsibility in providing some non-financial incentives, such as accommodation. etc.

3. **Strengthening health professions educational capacities:** *Trained health workers are capable of performing their job up to the national and regional standards and competences*

The health professions education faces both quality and quantity problems. The need for scaling up health workforce challenges the health professions education capacities in Lao PDR in terms of both quantitative and qualitative concerns, including educational approaches, faculty shortages, infrastructure, teaching resources and materials. Health professions Education Development Centre provides an opportunity to review and update educational approaches and build faculty capacity. A master course on health professional education will be initiated by the Education Development Centre in addition to short courses.

Innovative solutions will be explored in expanding the training sites for clinical skills, which is of concern for many academic staff. The clinical training sites will be extended to more facilities; however, there is a need to build capacity of preceptors in these facilities where the Educational Development Centre can be instrumental. The Medical Teaching Units (MTU) will be established in hospitals starting from central level and provincial hospitals. The facilities will be assessed by a group including Department of Training and Research (DTR), Department of Health Personnel (DHP), Department of Health Care (DHC), Education Development Centre (EDC), the University of Health Science (UHS) on the basis of a tool which will be developed to assess the capacities of facilities to provide clinical training. The scaling up the capacity of education will be based on HRH plans both in terms of numbers and skill mix.

National exit exam is a strategy which is about to be introduced to ensure that the graduates are equipped with adequate skills and competencies to practice. Based on these assessments, licencing of health professionals will be introduced. As the capacities of the professional councils are developed and institutional mechanisms are in place, the responsibility of licensing and then relicensing will be given to the professional councils.

<u>Improving performance and productivity</u>

The conditions will be provided to improve performance and productivity of health workers.

- Working conditions and environment will be improved with appropriate infrastructure, equipment, supplies in accordance with the functions of the facilities they work and their well-defined terms of reference.
- Continuous professional development opportunities will be provided in a systematic way.
- Supportive supervision mechanisms and capacities will be developed to ensure the health workers receive adequate support to improve their performance
- Incentives and performance based payment mechanisms will be introduced in accordance with overall changes in provider payment mechanisms for health services.

4. **Strengthen HRH information:** *The reporting system for HRH is able to provided information on the quantity, skills and allocation of health workforce to extend that it will provide evidence for rationalising quota as well as skills needs by location.*

Though some efforts and investment have been done in HRH information recently, some challenges are faced in getting complete, accurate, reliable information encompassing whole health workforce of the country.

Significant efforts have been made to develop a computerized HRH database and interventions will be made to strengthen HRH information as well as the sharing and use of the information. Linkages between various databases will be developed and capacity will be ensured to analyse and use data from different data sources.

Emphasis will be given to strengthen HRH data at the provincial and district levels.

5. **Strengthening HRH Governance capacities:** *To ensure that health managers are appropriately trained and HRH is invested.*

The HRH governance capacities are critically important in the implementation of the HRH strategies. The HRH Governance capacity of MOH plays an important role in engaging and coordinating other stakeholders as well as implementation of HRH strategies. The departments of Personnel and department of Training & Research will play important role in engaging other stakeholders in the HRH related issues.

The capacities in other stakeholders are equally important. Especially the capacities of professional councils and associations will be strengthened and their roles and contributions will be defined, such as regulation through licensing, continuous professional development, etc.

Investing in health management and support workforce

The need to strengthen health management at all levels is well recognized and measures will be taken to address this challenge. Some executive short-training opportunities will be provided to health managers who are currently in post. The current programme on master of public health will be strengthened. Eventually a post graduate training programme on health management will be introduced to build capacities for longer term.

Short courses will be provided to middle level managers at health facilities.

The health facilities also suffer the lack of other support staff such as statisticians, medical secretaries, biomedical engineers and technicians. Efforts will be made to train these cadres of attract the trained staff.

Expand the fiscal space for investing in HRH: All these interventions would certainly imply increasing fiscal space for human resources for health through more investment in human resources for health from both domestic and external resources.

Priority Area 2 - Health Financing

Expected results: By 2015;

- Not less than 9% of General Government Expenditure (GGE) is allocated to the health sector
- All MNCH/under five (U5) services are free of charge to users, nationwide.
- *Social Health Protection coverage of the total population is 50% and of the poor is not less than 70%*
- *Out of pocket payment is less than 40% of Total Health Expenditure.*
- General Government Health Expenditure (including ODA channelled through the government system) is efficiently managed and monitored at all levels.

In order to achieve the health sector reform goals, securing sufficient financial resources for basic health services provision with a focus on MNCH services is a pre-requisite and one of the major priority areas for 2014-2015. Equally important is the improvement in the efficiency in how these additional funds are allocated and used, which will allow for the priorities set under the reform to be met.

Key areas of intervention under the Health Financing pillar include:

2.1. To increase government health funding from domestic resources to make basic services available and accessible

Domestic spending on health in Lao PDR is very low, at 0.5% of GDP and 3% of General Government Expenditure (2009-2010)[1]. The majority of this existing funding is allocated to investment and salaries, with only US$1.4 per capita per year (2009-2010) spent from government domestic non-wage recurrent health budget (analysis of the final implementation figures of the government budget once released might show a more positive trend towards funding for the sector). This results in high levels of out of pocket health expenditure by households for user fee payments (i.e. technical revenues and drug revolving funds) which health facilities use to cover their recurrent costs. With consistent GDP growth rates around 7% to 8% in the past decade, there seems to be some fiscal space for increased general government expenditure on health (GGHE).

2.1.1. To increase and secure sufficient domestic resources for health

One of the major objectives of the HSR is to secure sufficient domestic resources for health. To this end, it is crucial that the Lao Government ensures that not less than 9% of GGE is allocated to the health sector as stipulated in the National Assembly's decree and that total health expenditure (THE) as a share of government domestic product (GDP) reaches 2.5% by 2015. This will require the preparation and passing of a Prime Minister's Decree. Given the differing definitions of GGHE used by various government entities, a common technical agreement between government bodies on the categories (e.g. if TRs is included or not) used to calculate GGHE is needed prior to the start of 2014-2015. For the fiscal year 2014-2015, the MPI and MOF should allocate 9% of GGE to the health sector (if excluding ODA and TRs). In addition, due to the delays in the disbursement of the funds from the MOF side (most funding being disbursed in quarters 3 and 4), the MOH had difficulties in absorbing its allocation. Therefore, it is recommended that a MOF liaison officer is assigned to work in the MOH to support the development of quarterly budget plans and that MOF ensures that there is a minimum funding allocation for each quarter according to the agreed budget plan for the health sector.

2.2. To improve resource allocation focusing on the district health system

The district health system faces considerable challenges with the current resource allocation mechanism in terms of ensuring the delivery of appropriate health services to the populations most in need and meeting the health sector reform goals. Particularly problematic is the lack of non-wage recurrent funding to support the operations of health facilities. The recommended actions are the following:

2.2.1 To allocate resources for scaling up MNCH/U5 services through Free MNCH/U5 schemes and Health Equity Funds and

2.2.2. Prioritize the use of NamTheun (NT) 2 funding to HEF and Free MNCH/U5 schemes

Towards the end of phase I, the goal of providing Free MNCH/U5 services to the entire target population across the country through joint funding (government and ODA) is to be achieved. Sufficient resources should be allocated to the district health system to ensure the sustained provision of basic health services, with a focus on MNCH services. To this end, it is recommended that NT2 resources are prioritized within the health sector to fund the Free MNCH/U5 and HEF schemes. This recommendation is in line with the priority focus of the reform on MNCH services and the goal of reaching MDG 5.

2.2.3. To increase non-wage recurrent budget allocation to health centres, district hospitals and district health offices (including funding for outreach activities)

The increasing of non-wage recurrent budget allocation to the district level will enable the operations of health facilities at lower levels to deliver adequate health services in line with their responsibilities (such as outreach activities, management and supervision). The increase will be reached through a more efficient balance across the government budget chapters.

[1]Based on the latest implementation figures officially released by the MOF and analysed through the National Health Accounts review.

2.2.4. To allocate funding to provinces and districts in line with the disease patterns, demographic characteristics and poverty levels (includes the development of an allocation formula/budget norms)

An allocation formula or budget norms should be developed and used to allocate funding to provinces and districts - in a more equitable and efficient manner - that have specific disease patterns, demographic characteristics, and/or poverty levels that require funding. Allocated funding based on these criteria helps provinces and districts to better plan their budgets and enable them to provide health services to those populations most in need.

2.3. To improve coordination of funding flows to the health sector

Improved coordination of funding flows from all funding sources, including the government and development partners, can lead to allocative and technical efficiencies specifically at the district levels. The following actions are recommended:

2.3.1. To align and harmonize all funding sources (including provincial, district and donor funding) to the HSR Strategy and Planning Matrix; and to the health sector annual plans

In order to align the health sector budget with the HSR priorities and with the health sector annual plans, a joint budgeting process for government entities at central, provincial, and district levels and development assistance to the health sector should be established to provide a complete and accurate representation of all of the budget sources and planned activities and avoid duplication of funding/actions. In addition, the establishment of a common system for expenditure reporting by development partners will contribute along with the joint budgeting process to improve the efficiency of the planning and reporting processes at the district and health centre levels. By 2015 all major donors should use a common system of expenditure reporting and all funding bodies should report through a single window, which involves the development and sharing of a common database between MPI and MoF.

2.3.2. Encourage development partners to progressively move away from project funding and towards targeted sector support and provincial programme approach

The problems of delivering development assistance through vertical projects such as fragmentation, high transaction costs, lack of communication / sharing of experiences are well known. Therefore, development partners are encouraged to gradually move away from such delivery modes and adopt targeted sector and provincial programme support.

2.4. To improve oversight and financial management, and tracking of funds in the health sector

With the health sector receiving funds from several sources—government, donors, and development partners—challenges remain in the oversight, financial management, and tracking of funds, which are linked closely to improving the coordination of funding flows and priority areas in the governance, management, organisation, and coordination; and health information systems. It is important to ensure efficient, transparent, and accountable practices at all levels of the health system. The recommendations are the following:

2.4.1. To strengthen financial management practices to improve efficiency, transparency and accountability

The first step towards strengthening the financial management practices will be to update existing financial regulations - amend decrees 03 and 52 - to clearly define how health facilities should use different sources of revenue (user fees, drug revolving fund, free MNCH/U5 and other Social Health protection schemes); and what type of costs should be paid by supply-side budgets and what by demand-side budgets (User Fees /SHP schemes) and establish a clear regulation process of User Fees (who has authority to define the rates, what periodicity to review, and on what basis – e.g. costing reviews, inflation rate). This will be followed by the development and implementation of guidelines for accounting and reporting of funds to health facilities at all levels of the health system. Separate

guidelines for health centres and hospitals will be developed. Thirdly, regular audits according to the accounting law will be ensured. The fourth priority action under the enhancement of financial management practices is to reach an agreement with the MOF on a more adequate chart of accounts which can better reflect the needs of the health sector, with specific health budget lines for social health protection subsidies, Free MNCH/U5, allowances for staff in remote areas, remove donors funding from chapter 17 and allocate it by chapters. The fifth recommendation is to avoid the overlap of allocations for Free MNCH/U5 services with those of SASS, SSO, CBHI, and HEF. Related to the development of Social Health Protection (SHP) schemes, free MNCH/U5 services should pay for the MNCH/U5 services in the benefit package and SHP schemes should pay for the other health services (in line with their benefit packages). Improved transparency, accountability, and accuracy of funding management can help reduce duplication of funding and identify any gaps in funding across health priorities and health facilities, and over time.

2.4.2. To institutionalize National Health Accounts (NHA) in order to provide accurate and timely health expenditure information

The MOH Department of Finance is currently finalizing its NHA study for the fiscal year 2009-2010 which tracks funding flows to the health sector and provides accurate health expenditure information to evaluate health systems performance. Through the institutionalization of NHA, health expenditures and funding flows can be evaluated over time and across countries and used to inform health planning and policies. By the end of 2014, an institutionalization plan, which includes country capacity building, and a team from different relevant entities (MOH, Lao Statistics Bureau, State Audit Authority, Ministry of Finance, development partners etc.) responsible for producing NHA should be established and operational. By 2015 yearly NHA reviews should be conducted as a part of the institutionalization process.

2.4.3. To ensure that there are integrated annual operational plans by districts and provinces and that these plans reflect expected results, programme areas, activities and government budget chapters

An important element of the reform will be to ensure that all provinces and districts prepare integrated annual operational plans. Currently, some provinces/districts do so but others not. Those preparing the plans tend to be the ones receiving funds through donor assisted projects with a health systems strengthening component. The second part of this activity is to ensure that all plans reflect the expected results that the province/district intend to achieve over the course of the year; detail the programme areas that will be covered (e.g. water and sanitation, MNCH, etc.); present the required activities linked to the programme areas and the expected results; and show the budget breakdown following the government budget chapters (not only the budget lines according to the donor projects).

2.5. To adopt appropriate Provider Payment Mechanisms (PPM)

The impact of current Provider Payment Mechanisms (PPM) on patients, health provider behavior and facility performance relates to several areas, such as human resources for health, health service delivery, and essential medicines and technologies. Adoption of appropriate mechanisms can enhance health provider and facility performance through the specific actions of having a detailed assessment of the existing PPM and phasing out of the Drug Revolving Fund (DRF). The following actions are recommended:

2.5.1. To assess existing PPM (capitation, case-based payments, fee for services) and adopt appropriate ones as well as levels of payment across health facilities, including those contracted through Social Health Protection Schemes

In order to assess and adopt appropriate PPM, a costing study should be conducted that covers health services at all levels by the end of 2013. From this study, payment levels across health facilities and user fees can be reviewed and revised, if necessary.

2.5.2. To prepare for the stepwise phasing out of Drug Revolving Fund (DRF) to be replaced by government funding (to provide for essential medicines in public health facilities) and through the expansion of social health protection schemes

The current Drug Revolving Fund (DRF) mechanism of supplying essential medicines to public health facilities and communities at the village level has several limitations. Crucially it as provides (perverse) incentives to providers to over prescribe medicines in order to increase their revenues (supplier-induced-demand). This results in irrational drug prescribing with potential consequences in terms of drug resistance and risks to patients' health as well as overall increase in health expenditure without corresponding health benefits. An assessment of how to phase out DRF is needed with the preparation of the phasing out plan to avoid drug stock outs to be completed by the fourth quarter of 2015.

Given the priority of reaching the MDG 5, by 2015 costs for Reproductive Health and MNCH related medicines on the Essential Medicines List should be included in the government budget to health facilities to initiate the implementation of the phasing out process. In phase two, all Essential Medicines in the list should be covered either through government funding or the SHP schemes.

2.6. To develop Social Health Protection (SHP) schemes in areas where basic services are accessible

Social Health Protection (SHP) schemes are mechanisms that provide financial risk protection for people, and enable them to access health services through a pre-payment system and thus avoid that people face financial hardship or impoverishment from paying for these services out of pocket at the point of delivery. SHP mechanism includes health insurance schemes (e.g. SASS – health insurance for civil servants) and safety net arrangements (e.g. Health Equity Funds). Out of pocket health expenditure for the fiscal year 2009-2010 was about 46%[2] according to the recent National Health Accounts study; thus revealing the limited level of financial risk protection of the population. The target by 2015 is to reduce out of pocket health spending to less than 40% of total health expenditure. In order to achieve this target, SHP schemes are to be merged and their coverage expanded in areas where have basic services are accessible. The recommended actions are the following:

2.6.1. To develop and implement an operational plan to merge all existing SHP schemes through the National Health Insurance Bureau

One of the immediate steps to developing an operational plan to merge existing SHP schemes through the National Health Insurance Bureau is to set up its governance arrangements and for its provincial branches. This includes the development of the institutional management structure, definition of mandate and roles, drafting of TORs for the divisions and branches and job descriptions of the staff. Additional plans for a common information technology database for all schemes, provider management system, quality assurance mechanisms for accreditation, and mechanisms to evaluate incentive structures should be developed, in addition to a plan to review and harmonize the benefit packages of all schemes. From the costing study, contribution and payment rates for all schemes should be assessed (and eventually revised if the results of the costing study so indicate). Finally, the responsibility for coordination and management of the Free MNCH/U5 scheme is to be transferred to the National Health Insurance (NHI) Bureau with a view of integrating it into the other schemes.

2.6.2. To expand coverage of SHP schemes

The target to reach 50% of the population by SHP schemes in which not less than 70% of the poor is covered is to be achieved by 2015. In the process of expanding population coverage, a plan to manage and track eligibility, enrolment and membership by each SHP scheme should be developed to accurately measure population coverage and ensure that members under the SHP schemes are able to avail of the benefit package. Regular campaigns should be conducted for increased awareness across all schemes, enrolment (mainly SSO and CBHI schemes), and utilization (mostly HEF) - in order to secure increased overall population coverage and financial risk protection. In addition, subsidies for the poor (through HEF and Free MNCH/U5) and informal sector (through CBHI and SSO) at 100% and 50% of the premium,

[2]Final figure pending release of NHA 2009-2010.

respectively, are to be operationalized with not less than 70% of the poor and 50% of the informal sector targeted to be covered through a SHP scheme by 2015.

Priority Area 3 – Governance, Organisation, and Management

Expected Results:

- The SHR has a strong structure from central to provincial, district levels lead by the minister of Health and accountable to the Government of Lao PDR.
- The legal and policy framework required for the implementation of the reform process is developed and approved timely.
- The HSR implementation is result oriented and jointly planned, funded and implemented by the Government and Development Partners (DPs).
- The implementation of the HSR process is regularly monitored and supervised.

The fundamental importance of good governance for health sector reform*:*

To deliver the change required for the sector reform, it is crucial to begin the reform from within – first in MOH, then its network of different entities, the local authorities and the service providers. The health sector reform is about to endeavour a new approach to deliver the health service in an approach that is results oriented, sector-wide and systematic. The common goal for phase 1 of the reform is to reach the health related MDGs with priority to MNCH services. The essential key to the reform is that all involve staff in the health sector; local authorities and development partners must embrace the change and committed to the reform process. There will be changes needed in policy, regulations and legislation as to create a legal corridor for the reform process to more forwards.

In developing policies and plans to improve maternal health care at the very beginning of Health Sector Reform, particular attention should be paid to the way in which change is to be introduced, managed and monitored. Many of the problems cited in reports on services, such as those summarized above appear to stem from weakness and at times failure of systems of accountability and governance.

A reformed system must not allow for such failures. Good governance needs to be at the heart of the reform program. The decision of the Lao Government to reform of the health sector can bring significant benefit to the citizens and if properly implemented should also bring social and economic benefits to the nation as a whole. All of this benefit is predicated on successful implementation which in turn is dependent on the adoption of good governance in the health sector. Therefore, the sector reform focuses on a hierarchical of roles and responsibilities that are specifically assigned for different managerial positions in order to ensure the desired policies, regulations and legislations will be enforced. Plus, a mechanism to recognize the success and/or failure also needs to be considered as part of the good governance practices.

Effective functioning of primary health care:

There are a number of characteristics that must be sustainably established to ensure the delivery of good primary health care, including that provided to improve maternal health. These are summarized below.

- Active, accountable management by leaders who have been trained for the job, who understand their responsibilities and their authority, and whose continuation in the job is based on their facility's adequate performance against agreed quantity and quality targets.
- Effective local micro-planning that is based on reliable data and on sufficient resources being available to deploy to meet changing needs.
- The local community contributes to planning services and oversight of performance through surveys and having a representative group that meets regularly to advise the management.
- Appropriate facilities and equipment are available and are well maintained.
- Staff have clear job descriptions, have appropriate qualifications for their job, receive on-the-job training at regular intervals and are available in appropriate numbers.

- Financial support is provided on time in accordance with an agreed budget.
- The cost of services does not create a barrier to seeking services.
- Services are organized and delivered to meet needs. This may include the appropriate timing of centre based clinics, outreach programs, and flexibility to ensure that the health of the community is the primary goal of the service.
- The relationship of the primary health service with secondary level services is clearly defined and contractually based with regular supervision and support coming from higher level services.
- Referral mechanisms are clearly defined with patient welfare as the highest priority and are effectively implemented.
- Services quality is regularly assessed through processes of supportive supervision, peer review and community feedback.
- The reward system for management and staff members is linked to objective and regular assessments of the adequacy of services quantity and quality. Rewards include salary increments, training opportunities, promotion and public recognition.
- There is community-wide understanding of the role of their local primary health care service and trust in the services it offers.

3.1. Establish a strong mechanism for coherence and coordination for a result oriented management of HSR

- The establishment of a strong national committee that will lead the process, in combination with a clearly defined mechanism of roles and responsibilities, accountability at the initiation of the reform process will determine the course and success of the health sector reform. As equally important is the involvement of the provincial governor, the provincial authorities in supporting and engaging in the reform process. Therefore, to bring the staff of the MOH, of the line ministries and the provincial government on to the same page with the national leaders is one of the crucial areas of this pillar. The establishment of a National Commission on HSR will not only strengthen the commitment, coordination of all related ministries and development partners, it will also show a strong commitment from the Government to reach the MDGs *(see chapter on Management, Coordination and Operation for more details).*
- The appointment of an Officer in Charge (OiC) at national and provincial levels; the reform manager at provincial and district levels, will strengthen the implementation, oversight of the PM Decree on the HSR. It also aligns with the result oriented management principles.
- Set up HSR Secretariat that oversight the implementation of the HSR. The Secretariat is overall responsible for supporting the OiC; the National Commission and works directly with TFT and other staff of departments and centres under the MOH, other related ministries, development partners and provincial and district departments of health.
- Training on HSR, reform management will be provided to provincial and district level managers as they play a critical role for the success of the HSR implementation.
- It is equally important to inform and gain supports not just within the MOH, but also other ministries, the health service providers and the beneficiaries (such as the patients, the mother and children and general population) on the intention of the Government and the health sector to bring better, affordable and accessible health services to all.
- The existing Sector Wide Coordination (SWC) mechanism should be strengthened to support HSR Secretariat and the TFT for better coordination within MOH, coordination from central to provincial, district levels; coordination between MOH and other ministries and the DPs.

- Based on the objectives, expected results and health service status, develop criteria for selection of province, in conjunction with the identified needs for system strengthening. This will determine the provinces to initiate the HSR implementation.

a. Strengthen HSR management of the implementation of HSR

- Conduct planning at and for provincial level is a crucial way to ensure the success of HSR implementation as the planning will be based on the current situation, capacity and needs of the province. With support from central level, the plan will engage with DPs working in the province and with the Provincial Government to ensure funding and supports for the implementation. At first, the planning on HSR will start with focus on MNCH and PHC; for 2015, the planning should be incorporated to the annual planning of MOH, PHO and DHO; from 2016, the HSR should be part of the 5-year health sector development plan.
- Applying the "Three Builds" initiative, by decentralising management of HSR implementation is another appropriate approach to ensure effective implementation. As the planning process is decentralised, though with focus to the needs and resources available at the provincial and district level, the plan should still be within the framework of the HSR at national level and contribute to the common goals and objectives.
- From management point of view, it is essential to know who is responsible for what activities as the plan is implemented. Therefore, developing clear job description with functions and responsibility for members of the HSR Secretariat, the TFT at central level, or those at the Provincial Government, PHO and equivalent at district level is a measure to ensure effective implementation. This should also link with the performance based funding mechanism to manage quality of performance. This will also allow supports to be provided where and when needed.
- The beginning of One Window Service will start in phase 1 with the Cabinet of the MOH for both internal and external communication is another aspect of reform. The concept of E-management will be introduced through the transferring of paper based documents to an E platform at later stage. This will be followed by other electronic based management and communication mechanism.

b. Define clear reporting and feedback flow mechanism for effective oversight and support of the HSR implementation

- The M&E system for HSR implementation will be set up with the set of indicators as mentioned in annex 4 – M&E indicator matrix. The monitoring and report system will be established in order to have a regular flow of communication among all administrative levels and involved entities. This system will provide regular updates on the HSR implementation progress to the provincial and national commission on HSR, as well as help the managers to have timely interceptive action and decisions during the implementation process.
- There will be regular meeting mechanism between health centre to district, district to provincial and provincial to central level on different interval basis. The aim is to use this forum to report and update on the progress of the implementation; to submit and feedback on data reporting; to discuss on issues that occur and decide on solutions, intervention needed as well as issues that will need approval at higher level.
- The M&E framework, developed from the indicator matrix will provide a clear guidance of what to be reported, by whom and how often.
- The interlink between the HIS and the M&E framework, and the use of information from the system as evidences for planning, decision and policy making at all level.

c. Develop a cross-cutting mechanism for better coordination and Result Based Funding

- Result Based Funding is a complex mechanism that requires involvement across the health sector as a quality assurance of the performance of the staff. A mechanism will be developed, based on the TOR, the job description, through oversight, supervision to determine the quality of the performance. Linkage with the financial management is also required as to determine the funding mechanism – basic payment as well as incentive for good performance, or *vice versa.*
- A clear standards and guidelines will be needed to evaluate the performance of the staff, as well as regulation on financial allocation, human resource management will be needed.

In phase 1, attempt to develop a mechanism will need to be started, in collaboration with MOF as they decide on budget for salaries of health staff so that the policy on the mechanism will be feasible and actionable.

d. Strengthening regulatory enforcement

- The policy matrix has enlisted a numerous legislative documents either to be revised or to be developed. These documents are the requirements and the pre-requisite for a legally bound, successful implementation of the reform of the health system. Therefore, having a strong legal division in the MOH is crucial to ensure that the legislative documents are harmonised, aligned with national, regional and international requirements and standards.
- The legal division in MOH will need to work with concerned departments in MOH and line ministries to see that the required legislative documents are there to support the implementation of the plan.
- The approval process of the legislative documents will be expedited in order to have the plan implemented timely. This will require synchronised efforts from all departments as well as strong leadership of the MOH to move this process forwards.
- Other public health laws and regulations will also need to be revised and/or developed as necessary to be in line with the socio-economic development, such as law on alcohol control; regulations for private sector engagement etc.

Priority Area 4 – Health Service Delivery and Hospital Management

Expected Results:

- Basic Integrated service package focused on MNCH that meet national standard is provided at Village-Health centre and District level
- 30% of health centres and district hospitals have sufficient capacity and adopt a set of quality assurance measure
- Healthy Village Model is expanded to 50% of villages in the country

Primary health care is the cornerstone of health service delivery. In Lao PDR, the primary health care system has been fully established with service providers located at the village, health centre and district levels. Evaluations of their work suggest that their limited training and treatment options can meet only a very small proportion of local health needs. Adequate supervision and support of village health volunteers' work is not uniformly established.

The Government's health sector reform plan appropriately envisages primary health care improvement as the highest priority for the first phase of the reform. There are many facets to primary health care. MNCH constitute a significant proportion of primary health care and improvement of MNCH services is essential if the high priority for Government of achieving the MDGs is to be met by the end of 2015.

Plans and policies prepared by or for the Ministry of Health provide ample evidence that the Ministry has good information available about what needs to be done to provide modern, good quality maternal health services. There appears to be less information and capacity to effectively manage the implementation of these plans and policies.

- **Rationalize allocation of service arrangement through localized planning that is harmonized from central to village levels to ensure availability of services to the population**

Government decrees the priority given to maternal health improvement and meeting MDG 5

In Lao PDR, governmental priorities are announced in decrees. Health sector reform has the endorsement of the National Assembly and reaching MDGs by the end of 2015 is an issue of priority for the Government. The process of reform would be accelerated and prioritized by the issuing of a Prime Minister's decree that approve the plans for activities in phase 1 and defines the accountability of the Ministry of Health, Governors and Health Directors at provincial and district levels and Village Leaders for its achievement. *(Link with 3.1. in the planning matrix)*

Key managers' mobilization

The implementation of the reform is a significant management task that requires skilled and full-time senior staffing at the Ministry of Health. A position of Reform Manager or HSR Officer–in-charge (OiC) should be created with accountability directly to the Minister. An appropriately qualified and skilled person should be identified and appointed. The OiC would be given authority and responsibility for coordinating the planning and implementation of the intervention. An office and a small support team should be established for the Reform Office *(Link with 2.2 in the planning matrix).*

The OiC directly accountable to their Governors are appointed at provincial and district levels. These positions would be part-time and might be held by the provincial or district director of health. The local Reform Managers would be expected to work in close cooperation with the equivalent personnel at the central level.

Define a basic package of primary health care service

1. The Primary Health Care (PHC) policy has outlined services that are regarded as the package of PHC services.
2. The National MNCH strategy till 2009 has clearly defined the standard packages with minimum and optional services to be provided at different level of health facilities. Up to now, this the package of services so far has been delivered depended on the capacity, both human and financial, of the health facilities.
3. The national policy on free MNCH/under 5 services has been implemented in selected districts in all 17 provinces, under different guidelines, applying different methods.
4. The MOH is in the process of developing national standards for health facilities and the types of services the facilities should delivered.

Although the ultimate aim of the health reform is to deliver good, accessible services to all and all health facilities should be able to provide services that meet national and regional standards, in phase 1, in order to reach MDG targets, the focus is on PHC and MNCH. To enable health centres and district hospitals to provide harmonized, standardized services, the basic package of services will need to be revised, based on the existing guidelines and policy regarding PHC and MNCH services.

By 2015, the basic package of services should include:

5. Public health service: EPI, ante and post-natal care, birth assisted by TBAs or SBAs; family planning; nutrition related activities; sanitary and safe drinking water; prevention and treatment of malaria, dengue and other neglected tropical diseases.
6. Clinical services: institutional delivery; treatment related to pregnancy and child birth; integrated management of child illness including diarrhoea, ITR; common outpatient problems (e.g. respiratory infection, gastrointestinal illness…).

At the beginning, the priority is given to the list of services provided in the national MNCH strategy, including ANC, family planning, immunization etc. the services will be expanded based on the capacity of the health facilities at health centre and district levels. The MNCH services will be the minimum package of services.

Conduct implementation plans at the central and local levels with relevant approvals

Prior to planning, a the whole health facility network will be mapped out in term of geographical location, staffing, facility condition such building, water and electric supply, drug and medical product supply, equipment and is maintenance. Based on the outcome, the MOH then will determine type of facility and standard requirements to set up a standard health facility network.

A national level, the implementation plan including MNCH improvement plan should be developed at the central level with the support of Development Partners as appropriate. The plan must include identification of priority regions, situational analyses for target areas, planning and implementation guidelines and the funding, staffing, equipment and supplies strategies to be employed. This activity would be led by the Department of Planning and International Cooperation in conjunction with the OiC and the departments of Finance, Human Resources, Health Care, Hygiene and Health Promotion and drawing on guidance and advice from the ministries of Finance and Home Affairs and the Women's Union.

Once the national plan is prepared, provincial and district implementation plans should be conducted in the identified priority regions. These would include short term and long term interventions, financial and human resources, and equipment and supplies requirements and how they would be obtained and deployed. These plans would be developed by the local Reform Manager which should be the heads of the provincial and district health offices, in conjunction with the relevant Finance and Home Affairs, with the support of the Department of Planning and International Cooperation and Development Partners as appropriate. The implementation plans would be submitted to the district/provincial authorities for approval prior to submission to the Reform Manager at the Ministry of Health for incorporating the details into the overall plan. Where appropriate, micro-planning for integrated services can be conducted.

Plans adapted as indicated

The Reform Manager and Provincial Reform Managers initiate action in follow up to routine reporting or M&E reviews and all actions taken are reported to the Minister through the Reform Manager’s office.

Adaptations of plans or implementation methods (including resources issues) are introduced in consultation with local Governors, Health Directors and MNCH leaders as indicated. All proposed plan changes are reported through the Reform Manager to the Minister

Implementation commenced

An Implementation Workshop (1-2 days) is held for central and provincial OiC and key implementation managers to finalize and coordinate plans.

Short term and long term interventions requirements finalized with relevant managers and service providers at central, provincial and district levels (including availability of HRH, finance, supplies and equipment) and reported to Reform Manager's office.

Legislation, standards and guidelines

Law on health care, policies, legislation as well as guidelines and regulatory documents to ensure quality of services will need to be revised, with focus on effective delivery of MNCH services. Service delivery manual/guidelines; standard clinical procedures, rational use of drugs, treatment guidelines, the list of essential drugs… all will need to be revised and finalised.

The MOH will revise existing term and conditions and standards for health facility, together with regional standards to develop a hospital regime and health facility standards. These standards will be the baseline for the planning and development of health facilities and services in the implementation plans.

In line with the facility standards, the treatment guidelines and clinical standard procedures will need to be revised and relevant to the term and standards given to health centres and district hospitals.

- **Mobilization of resources (funds, skills, supplies, equipment)**

When the action plans are finalized, the Officer in Charge (OiC) works with Departments of Planning, Finance, Health Care, Human Resources and other relevant departments to identify new resources and resource reallocations needed for the implementation of the plans (national and in target provinces and districts). Proposed new resources and reallocations negotiated with Ministry of Finance and Ministry of Home Affairs and other relevant bodies and finalized.

- **Strengthen Primary care to improve access to health services.**

The MOH will develop a Hospital System Regime to clearly define types of services that different types of hospitals at different level can provide. Standards for capacity of health centre and district hospitals will need to be finalised, complete with standards for infrastructure, staff, and equipment. Other issues will need to be considered are catchment areas or population, criteria to determine the number and skills of staff needed for health centres and district hospitals, in phase 1. Later on, standards will be given to provincial and central level hospitals.

In order to identify areas (geographically, technically) that need extra efforts and investment, a situation analysis will need to be done to identify gaps of MNCH services, the staffing situation, the current capacity of health centres and district hospitals regarding location, equipment, and infrastructure such as water and electricity supply, room for delivery (1.1.2.1; 4.1.1.1; 4.3.1.1). This activity will be conducted the prior for planning. Based on the findings of this analysis, the provincial and district plans will consider these factors and plan accordingly so that limited resources can be coordinated to support where improvement of MNCH needed most.

Outreach, mobile services

As many parts of Lao PDR are mountainous with limited road access, the mobile/outreach services will be considered as one way of service delivery in present time, while the health facilities improving and expanding its services to meet the needs of its population. The baseline information will provide evidence to determine what type of services, who can deliver and how to deliver the mobile/out-reach services. The mobile team can be formed at provincial or district level. Another alternative could be to identify and support some "regional hospitals' of which these original provincial hospitals will have the capacity to set-up a mobile team to cover integrated basic package of services to remote, rural

communities. The mobile team will also be part of the supportive supervision, which together with a well-defined mechanism, is crucial to guarantee standards of services. The key to a successfully mobile service is good coordination, clear role and responsibilities of those who provide the services and the communities that receive the services.

At village level, expanding the healthy village model include deployment of village health workers (VHW), step-wise replacing the village health volunteers (VHV). The aim is to address the needs of the community, mostly those that are hard to reach. In most scenarios, the VHW will provide the public health services of the basic package. In areas where reaching any health centres timely is an issue, the role of the VHW is even more crucial, hence additional treatment should be included in the service delivery . The first step into this action is to get information on the current situation of the VHV, together with type of villages (under or above poverty line); the health service delivery capacity of the health centres, the districts. This will enable the MOH and provincial authorities to determine where to prioritise the allocation of VHW as well as the type of training they should receive.

Expand to the primary health care comprehensive service package

The process of developing and introducing the package should be undertaken around the mid- point of Phase 1 of the reform (Q2 2014). There are many Lao PDR policies and reports that define the basis of the primary health care package of services. Core services for primary health care always include: MNCH, EPI, communicable disease detection and ongoing management, diagnosis and treatment of minor ailments, the provision of essential drugs, health education and health promotion, and practical nutritional advice. Particularly for urban areas where incidence is higher, the basic package should contain the activities for the prevention, detection, diagnosis and ongoing management of the most common non communicable diseases such as hypertension and diabetes. As the capacity of primary health care workers is developed, support for community provision of rehabilitation services and for the initial management and ongoing maintenance of severe mental illnesses (such as schizophrenia) are included in the package.

Applying the step by step approach advocated in this paper, led by the Reform Manager and the Department of Planning and International cooperation working with the departments of Health Care, Hygiene and Health Promotion, Communicable Diseases, Food and Drug, Finance, Human Resources, Medical Products and Supply Centre and other relevant units, the Ministry of Health should progressively review and further develop relevant policies and plans in these primary health care fields to inform the planning and implementation of improved services from 2015. Furthermore, a system should be set up to monitor the use and maintenance of health facility equipment and supplies.

Community informed about intended changes

Use of the health facilities by the population is a driving factor to sustainable improvement of health services. Informing the population on the intended changes at their local health facilities using plain language (including ethnic language translations) is crucial. The messages are prepared by the HSR unit for public release through mass media with commentary by Minister, Governor.

More specific, media kits on “How to explain the improved maternity services to the community and why we should use them” in relevant languages prepared and distributed to Village Leaders.

Community should also be kept informed of the improvement and achievement as reported through the M&E system and reporting. By Q4 2014, consideration should be given to making a TV documentary on the intervention and its achievements with the aim of increasing the community’s knowledge and their adoption of good maternal health practices.

As the improved services are available at health centres and district hospitals, the village heads and local authorities should take part in raising awareness among the villagers and ensure the services are used by informing and mobilizing the villagers to use the services.

Supportive supervision is an essential tool to quality of services. In PHC, supportive supervision should be provided to VHW as well as to clinical staff health centres by the district/ or provincial team. And provincial hospitals should supervise the districts. The key point in supportive supervision is to have a clear standard of services, with guidelines, standard procedures… and both parties – the supervisors and the supervised have the access to and similar understanding of the regulatory documents. The supportive supervision should be planned with the managers of the health facilities and heads of local health offices to ensure that the supervisor's recommendations will be followed up and adapted.

- **Strengthened referral system and accessibility**

For a referral system to be effective, it needs to be a part of an established working relationship between health care providers. The act of referral must reflect the best interests of the patient, not the convenience of the provider. The referring service needs agreed ways of connecting with the receiving service to ensure that the referral will be accepted and treated appropriately. Ideally this would be based on a negotiated and agreed relationship between the levels.

There also needs to be adequate capacity at the higher level to provide informed guidance and supervision. This relates both to providing feedback on the issues relating to the patients referred and to maintaining a supportive relationship so that referrals are appropriate and reserved for those patients who genuinely need the higher level service. With support and supervision, the primary care service can become more skilled in delivering care locally as well as better able to determine the level of risk faced by a patient. A good clinical relationship between the levels of care is essential for patients to be safely referred back to the primary care provider for ongoing management of their condition.

Trust between levels provides the basis for priority being given to requests for assistance or for transfer of patients (either to a higher level or back to the primary care provider).

For a referral system to function it must of course have access to appropriate, reliable, safe and affordable transport for patient transfer. At the village level, this may call for an organized arrangement in which the village leader and the village health worker take responsibility for gathering community commitment for providing transport for people in need. Similarly, at the health centre and district hospital level, where an ambulance may not be available, it is essential for the facility to have arrangements in place for urgent patient transport.

Information sharing about treatments and outcomes is a two way necessity. A patient being referred to a higher level should arrive with the receiving centre having good information about the assessment made and treatment already given as part of the explanation for the referral. That could be by written letter or by phone call in an emergency. Similarly, the receiving centre has an obligation to provide the referrer with information about the outcome of the management of the patient by their service.

One measure of the effectiveness of referral systems is the extent to which they become two-way with downwards referral to lower levels as appropriate (e.g. where experts can work with the primary health care staff to provide needed services and supervision).

- **Improve hospital management for better quality and efficiency of services**

The Department of Health Care, MOH has been drafting and revising numerous documents related to curative service delivery. These documents cover health facility standards (hospital regime); treatment

guidelines focusing on MNCH services, based on the National MNCH Strategy till 2015. The MOH also try to implement the 10 Minimum Requirements (MR) as a way to improve the standard of services.

In parallel with introducing strong guidelines and standards for quality of service, supportive supervision is the key tool for quality assurance. A supportive supervision mechanism will be decided between the ministry, provincial health authorities and provincial hospitals. The mechanism should base on the situation of the province in term of number of staff, geographical condition, training facilities and capacity. This will be discussed and elaborated further so that the provincial supportive supervision systems will reach the common aim: to ensure that health workers adhere to the national standards and guidelines and hospitals provide supportive working environment for the health workers to perform their tasks. Other issues will also be included as part of the supportive supervision. These include plan for training of health staff on communication skills to improve the client-service provider relationship; a mechanism to receive and response to feedback from clients/patients in order to improve the quality of services at health facility level. Moreover, in areas where many different ethnic groups reside, some measures to be taken to encounter and accommodate their cultural practices, customs so that they will receive the needed services, especially in MNCH services.

- **Ensure uninterrupted supply of drugs and medical products.**

The main areas of work include: improve policy and regulatory system to control drug quality; routinely revise the essential drugs list; there are pharmaceutical trained staff to be responsible for management drug supply at facilities; strengthen the roles and function of drug and pharmaceutical committees at central and provincial levels to assure rational use of drugs by health practitioners.

At systematic level, the procurement and chain management of medicines and medical devices need to be unified at central level.

Priority Area 5 – Health Information System (HIS)

The improvement of the HIS is based on its utilisation. In principle, a good HIS should be able to provide reliable evidences for planning, for managers to make decisions, policies that are responsive and timely with the health situation. The HIS should be unified as one with the MOH is the official source of information on health. That also creates the needs to have an exchange mechanism of existing information systems with the national indicators is the common reporting indicators.

Operational medical record systems need to be established with sufficient data to ensure safety in continuity of care and maintaining records of immunisations and treatments given. Good records are needed to make assessments of quality of services provided and the needs of the community.

The important balance is between the minimal level of data required to successfully plan, manage and monitor the primary health care services and the skills and resources available to reliably collect those data. Once gathered, the data need processing, useful reports need to be prepared and managers and supervisors need to take action.

Expected Results:

- Overall M&E framework and a standard set of national indicators are identified with proper data collection, analysis, and utilisation management
- Baseline for HSR is developed
- A compulsory birth registration is introduced
- % of public health facilities able to provide statistical reports timely and accurately

5.1 Standardise and harmonise the health statistics routine reporting system:

Set-up a set of standard national health indicators with clearly defined definition and means of collection and measure will help track the health system development and reform progress. A strong set of national health indicators will reduce burden of over collecting information, especially for sub-national levels. The system will be computerised, starting at central level with advanced information technology (IT) inputs and continuous supports for data processing and analytical capacity. Moreover, this set of national indicators will be aligned with internationally collected indicators for the health sectors. This would help Lao PDR able to report internationally on standard health indicators, as well as it serves the purpose of comparing trends and data globally and regionally.

Routine data recording, collection and reporting mechanism will be standardised, including frequency of reporting. Detailed guideline on how information should be recorded, collected and reported will be distributed to all the data entry entities. Data auditing and quality assurance measure also to be applied after the first year of report is completed.

5.2 Civil registration and vital statistics system:

CRVS especially for birth and death statistics plays a crucial role in the national statistics to the government in general, and for the health information system in particular. The current lack of a routine formal procedure to record and report on these data creates a critical gap in the information system, especially for understanding of trends and scopes of any of the health issues, especially for MDGs 1, 4, & 5. After standardised, unified forms for birth and death registration and the computerised reporting system is finalised and in place, the system will be piloted in selected sites before expanding for nationwide application.

A crucial element to have the CRVS in Lao PDR is the combined efforts and involvement from both, the MOH and MOHA. Initial steps have been taken between the two ministries and further collaboration will determine how the two ministries will work together to set up a functional CRVS system.

5.3 Information and technology:

Information and technology often go hand-in-hand, especially in reporting system. Upgrade the health information with IT and computerised system will not just reduce the workload for an already stretched capacity of the health sector, it also will help reduce human errors thus improve quality of information, shorten the data processing and analyse time. With the health reform, a computerised reporting system, data base will be installed, together with the use of mobile phones and computer programmes that has been proven appropriate and useful for management at different types of health facilities and public health purpose.

5.4 Use of information:

Finally, the use of information provided through the health information system is the main cause for improvement of the health information system. Reports produced from the health information system will be used for planning, policy and decision making as well as to inform general population, development partners on the status of the health service, the status of the health of the Lao population and the progress of the health sector reform process.

PHASE II: 2016 - 2020

Objective:

1. *Ensure that essential health services of reasonably good quality are accessible and utilised by majority of the population*

Specific Objectives:

2. *Improve access to basic health care and financial protection*

Phase 2 will continue the momentum of phase I, implying lessons learnt and successes identified in the assessment of phase I. The implementation of phase II will focus on further improving the quality of health services, especially at primary care level, and to some extend to provincial level. The implementation of the PM Decree on health insurance will be expanding which will increase the coverage for financial protection amongst the population, especially for those living in rural, remote areas.

Priority area 1 – Human Resources for Health

Objective:

By 2020, all health centres will have been staffed in accordance with the health coverage plan.

- Health Centres will have at least mid-level health workers including at least one midwife.
- District and provincial hospitals will have at least the minimum staffing level and specialists defined in the health coverage plan.

Phase 2 will focus on adjusting the production of health workers to the need of the country in term of quantity as well as improving quality. In addition to continuation of the interventions in Phase 1, training capacities of the health profession education institutions will be adjusted to the needs of the country in terms of numbers and skill mix. Interventions will be made to improve the performance and productivity oh health workers.

Later on, the work will focus on ensuring the access of all population to skilled health workers, phasing out unskilled or low level cadres. Improved quality, performance and productivity will be emphasized. Adequate resources will be allocated to sustain the health workforce.

Continuous training for health staff, especially those working in primary care level, will focus on providing updated knowledge and skills for those working in far and remote areas. Bachelor and post-graduate training for health managers will be set up.

Supportive supervision and upgrading training for village health workers will be continued in phase II. A mechanism will also need to be developed to manage this workforce with appropriate type of contract and responsibilities. When the number of skilled health workers increases, village health workers will be gradually upgraded or replaced by skilled health workers, the systematic upgrading and expansion of qualified health workers will require detailed planning of training sites. Staff at health centres and district hospitals needs to strengthen their capacity to supervise the lower level service providers. In-service training might be a mean to increase capacity.

Priority area 2 - Health Financing

The aim of health financing from phase 2 are:

- To maintain a regional average level of the government expenditure for health.
- To increase coverage of the health insurance to 80% through effective implementation of the national decree on health insurance.
- An effective financial management is set up and used cross the Ministry.
- Out-of-pocket expenditure is at 35% of total health expenditure.

In phase 2, government spending on health should increase steadily through general tax revenue and payroll tax. Compulsory contributions to social health protection schemes by households who have the capacity to pay should be enforced. Regulations and guidelines on private investment in health will be developed. Donor funding should be more predictable.

The focus of this phase is to expand population coverage and to consolidate different social health protection schemes into bigger pools, including enforcement of the legislation on compulsory enrolment for SASS and SSO and merging the two schemes. For informal sectors, government will subsidize the premium, including full subsidy to the poor and other disadvantaged groups. By the end of this phase, the population coverage should reach 80% and all the poor in the country will be covered by the schemes. Out of pocket payment, as percentage of total health expenditure, will reduce to 35% by the end of this phase. Furthermore, government will continue the efforts to allocation more funds to rural areas and to strengthen the integrated service delivery network including primary to secondary and tertiary care, and thus improve quality of services.

While expanding population coverage by the social health protection schemes, benefit packages should also be enlarged to facilitate the efforts of enrolment in the schemes. Co-payments for different services, medicines and by different people may vary in order to reflect the priority interventions, to reduce moral hazard, to direct patient flow to different levels of facilities and to ensure the financial access and risk protection for the poor. As the benefit package only covers the direct cost for health services, safety net programs, such as cash transfers, conditional cash transfers, voucher schemes and other means, are important for the poor to have access to needed services.

Coordination among different provider payment mechanisms and alignment of the incentives need to be considered. The real cost of services should be reflected in the price paid to the facilities. The revenue from drug revolving fund needs to be revisited, and appropriate adjustments may be needed, as more funds from social health protection schemes are available to support the operations of health facilities, particularly at the health centre and district hospital levels.

Priority area 3 - Governance, Organisation, and Management

Expected Results:

- New national health plan reflects and supports the health system reform.
- Performance based payment/ funding policy is being introduced and piloted.
- Public-Private-Partnership (PPP) implementation is initiated.

Phase 2 will continue revision of laws, regulations and other policies regarding other areas of the service package.

The role of the national commission for HSR will continue its role in overseeing the implementation through effective coordination, guidance and decision making process. Evidence-based planning and decision making will be the norm of management.

The role of provincial government will continue to grow with more autonomy and accountability. Provincial funds for HSR should be considered amongst provinces that have additional income. District authorities will take the responsibilities to coordinate and manage the reform process.

Result Based Funding (RBF) will be considered and preparation for apply RBF as a management tool will take place, as the initiation of these approach to effective management should be starts around 2020.

Policy towards PPP and hospital autonomy will need to be developed, with careful consideration based on the interest for the welfare of the users of health services. Either PPP or hospital autonomy should be treaded carefully; as lessons from neighbouring countries (Vietnam, China) show that managing these models of health financing and service delivery will need strong regulation and enforcement, if to put the welfare of the Lao population at first.

Priority area 4 - Health Service Delivery and Hospital Management

Expected Results:

- Expand health service package including major non-communicable diseases intervention to be provided nationwide
- 60% of all health facilities adopting the quality assurance measures

Phase 2 will see the continuity of expanding availability of quality health services, especially from health centres, district hospitals, aligning with increased needs and expectations of the people. It is necessary to improve the network of service delivery in order to increase the responsiveness of the health sector for better access to basic healthcare for all. All the health centres will also have a reasonable catchment area with an appropriate size of the population to serve, as well as consideration of geographic condition. Where outreach services and/or mobile services are required, the integrated services, both preventive and curative will be delivered on regular basis, with proper follow-up and referral as patient recording and health information is improved, as well as the referral system. During this phase, the supervision system should be well institutionalized and functioning. A referral system among different level service providers should be further improved to meet the needs of the operation of the social health protection schemes. The quality assurance system including in-service training will have been put in place at the health centres, district hospitals, and provincial hospitals. More clinical treatment guidelines have been developed and used in a majority of these hospitals. District hospitals and beyond should have establish an internal system for quality assurance and auditing. It is expected that over 60% of health facilities adopt quality assurance measures.

The government should also develop appropriate policies and regulations to manage the autonomy of hospitals, especially at the provincial level and above, as those hospitals with autonomy may not necessarily serve the interest of the public, but rather their own interests. In addition, while the government needs to encourage the development of public and private partnership so that the capacity of service delivery in the country can increase in response to the increased demands for quality services, it is imperative for the government to develop appropriate legislations including accreditation and information reporting for these public and private partnership institutions. Furthermore, adequate mechanisms of monitoring and supervision for targeted private service providers including private clinics and pharmacists need to be put in place accordingly.

In phase 2 and 3, when ongoing care is needed, it becomes the responsibility of the primary care service, working in conjunction with the higher level providers. This is particularly important for periods of rehabilitation and also for the growing prevalence of non-communicable diseases where the health problems are chronic and need continuing care. In urban regions, the potential of "Shared Care" programs (for non -communicable diseases - NCD) could be explored. These programs will bring primary care and specialty care providers close together to collectively work on the management of patients with specific conditions that require on-going maintenance and regular reviews by specialist providers. The effective management of patients with diabetes provides a good example of this form of care.

Priority area 5 - Health Information System

Expected Results:

- 90% of public health facilities can provide timely and accurate statistical reports.
- The health information is used at provincial and district levels for planning, policy and decision making process.
- ICT system for public health facilities is introduced as a tool to improve service provision.

In phase 2, the national health information system in Lao PDR will be further developed. Adequate IT technique should be applied into the reporting of service use and expenditure, and disease morbidities and mortalities (e.g. web-based key communicable disease reporting). Civil Registration and Vital Statistics (CRVS) should be expanded into the coverage of all births and death registration across the county. The quality assessment of routine data collected from all the health facilities needs to be further developed through data auditing and other measures by the national health statistics division in the MOH. Capacity of data analysis and use will be further increased. While a number of nationwide surveys associated with health and healthcare may continue, the Ministry of Health ought to streamline national household health surveys by setting up regular national health surveys, for example, every 3-5 years, for population-based data collection to monitor and evaluate the impacts of the health sector reform.

PHASE III: 2021-2025

Objective:

- *To reach universal health coverage.*

Phase 3 is expected to complete the health sector reform with good health services being effectively delivered to the population, with the risk to people's health well covered by social protection, delivered by an appropriately trained workforce whose efforts are adequately rewarded and encouraged. Health facilities are to be rationally distributed, adequately equipped and maintained and information systems are to be well established to support services delivery and understanding of achievements.

Priority area 1 – Human Resources for Health

Expected Results:

- X% of health facilities have a proper health workforce according the National Standards.
- Performance Based Payment mechanism is applied nationwide.

Phase 3 is expected to complete the health sector reform with good health services being effectively delivered to the population, with the risk to people's health well covered by social protection, delivered by an appropriately trained workforce whose efforts are adequately rewarded and encouraged. Health facilities are to be rationally distributed, adequately equipped and maintained and information systems are to be well established to support services delivery and understanding of achievements.

By 2025, Lao PDR will have sufficient and sustainable health workforce, which is skilled, motivated, supported and well distributed in order to ensure access to services in achieving universal health coverage. This phase will focus on further development of health workforce, ensuring that all population have access to skilled health workers, while phasing out unskilled or low level cadres through bridging programmes. It will also put an emphasis on the improvement of quality, performance and productivity of health staff across levels of health facilities in the country.

In this phase, continuous professional development opportunities will be provided in a systematic way. In-service training and continuation education should be a common and routine practice for health professional at all levels. Performance based payment mechanisms will be expanded, in accordance with overall changes in provider payment mechanisms. Health management capacity will be well fit into the needs of expanded network of health care and social health protection schemes. In addition, relevant medical professional associations and societies will have been well established in the country to play an important role in developing norms and standards for health service delivery, as well as self-regulation of different categories of health professionals.

Priority area 2 – Health Financing

Expected Results:

- Government health expenditure from domestic sources is 3-4% of GDP.
- Out-of-pocket expenditure (OOP) is at 30% of total health expenditure.

Continue the expansion of population coverage by the social health protection schemes, extend service benefit package, and consolidate the different schemes will be the focus of this phase. This phase will also start a single pooled fund for health insurance, with compulsory participation for all. The funding sources consist of general taxation, payroll tax, and household contributions to social health protection schemes, external funds and out-of-pocket payment. The total funding available for health care in Lao PDR ought to increase significantly and government funding for health will reach at least 3-4% of GDP. The service benefit packages offered by different schemes should be aligned with increased government subsidies to the scheme for informal sectors. The service package should include health promotion, preventive and clinical services with essential medicines, as well as rehabilitative interventions. Different cost sharing levels by the patients will be applied to different level of facility services, different types of services and medicines with exemptions for the disadvantaged population groups.

In addition, service providers will be paid by the pooled fund through a set of carefully designed mixed provider payment mechanisms, which encourage good quality, adequate quantity and system efficiency. In this phase, the system should take the full advantage of the negotiation power as the single payer.

Priority area 3 – Governance, Organization, Management

In Phase 3, the government may need to adjust the structure of the service provider system, resource requirement (such as the level of skills, technologies and medicines) and performance targets, as the needs of, and demands, for healthcare will increase significantly.

Priority area 4 – Health Service Delivery and Hospital Management

Expected Results:

- Comprehensive service package to fit the health needs of all population is implemented.
- Standardised service provision and quality assurance are conducted across the country.

The organization of service delivery may become more complex, as an increasingly number of hospitals will provide sophisticated services to the people, using more high-tech equipment and medicines. With the application of computerized system in all health facilities, the management of service delivery at each level should be more standardized, in terms of service provision and quality assurance. All this needs continuous development of capacity of organizing and managing service delivery at all administrative levels. In addition, responsiveness in service delivery at all levels of health facilities will have reached a high level that would satisfy the service clients. The accountability of health facilities and health staff in these health facilities to their constituencies will also be greatly increased by raising service quality standards and improving staff attitudes.

Priority area 5 – Human Information System

Expected Results:

- Most health facilities apply a standardised electronic information system and exchange data with different sectors.
- ICT is applied for empowering patients and better service provision.

In Phase III, while the government will continue to strike to improve the CRVS, routine facility-based health reporting system, population-based surveys, and capacity of data analysis and use, the system needs also to bring the social health protection scheme into the system, as the expanding of universal health coverage will be scaled up.
By this period, the HIS in Lao PDR will be able to provide enough information and evidence for the Ministries, the Provincial and District Governments to plan the health system to deliver health services that satisfies the needs of the population with adequate financial and human resources.

LEADERSHIP, COORDINATION AND OPERATIONAL STRUCTURE FOR IMPLEMENTING HEALTH SECTOR REFORM

➢ Structures

The National Commission for HSR

Lao's health system reform process should be led by a central government HSR commission chaired by the Deputy PM responsible for social development and co-chaired by the Minister of Health and Minister of Finance. The membership of the HSR commission should consist of key line ministries such as the MOH; MPI; MOF; MOHA; NA and other related ministries. The National Commission's roles include providing policy and strategic guidance for the development and submission of legislative and strategic documents for approval; approving implementation plans, budgets and M&E reports; coordinating related sectors to support the implementation.

Another important role of the commission is to address and response to the provincial governments in support and supervision the management of the provincial authorities to their localised action plans. The implementation of the PM Decree on the HSR Framework and its plan for phase I will be oversight by the commission and the provincial authorities will report to the commission on the progress of the provincial implementation through the monitoring structure.

The commission should meet biannually to review the progress of HSR implementation and decide on the way forwards.

It is imperative to establish similar leadership and coordination mechanisms at provincial level in order to hold local governments accountable to the targets and deliverables set out in the health sector reform plan. The provincial health committee models can be a strong foundation for the health system reform as normally, the committee is chaired by Vice Provincial Governor responsible for social development, and consist of senior officials from provincial departments of planning and investment, finance, health, education, and other relevant ones. The Committee's TOR will need to be revised to integrate and adapt the requirements for HSR implementation. The provincial leading group should take main responsibilities of implementing the health reform plan and annual operation plans in their areas. Equally important is the establishment of a similar leading group at the district level directed by the district governor with key offices relevant to the health sector reform in the Lao PDR. Village chiefs and the village health committees should also be invited to engage the process of health sector reform, as they can also play a pivotal role.

The HSR Secretariat

Under the leadership and auspices of the National HSR Commission, the secretariat, consists of heads or deputy heads of departments in the MOH. The secretariat is responsible for the development and implementation of the health system reform. The secretariat needs to play an active role in coordinating multi-sectors and promoting cooperation within the government agencies at different levels, and with development partners. The secretariat should also be given clear mandates and responsibilities in the process of implementing the health system reform strategy. The responsibilities may include to: 1) take part in providing guidance to the provincial HSR planning process; 2) seek consultations and commitment to the provincial draft plan with other sectors, 3) coordinate with development partners engaged in health development in the province, and 4) provide secretarial support to the National Commission and the OiC to oversight the implementation of HSR process. The secretariat should be accountable to the central National Commission and the OiC.

The Technical Focal Points Team (TFT)

Set up during the development process of the HSR Framework and appointed by the Minister, the focal points team consists of members from departments and centres under MOH, who are technically strong and decision making responsible in the specialty areas of their work. The focal points have been working together to develop the planning matrix in order to achieve the common expected results for each of the priority areas.

A part from taking the lead and action for the technical planning at national and provincial levels, the focal points team will act as a think-tank, a technical advisory group for implementation of the HSR process. The focal points team also act as advocate of HSR and support their colleagues in and outside the MOH during the initiation and implementation of the reform process.

The TFT may consist of several separate teams as required by the priority areas, which could coordinate the formulation and implementation of different national policies and regulations for the planning and implementation of the HSR.

➢ Coordination

The reform of Lao's health sector to achieve the targets of Health MDG by 2015 and universal coverage of essential healthcare by 2025 would not be possibly successful without effectively aligning cooperation across government agencies at different levels and with development partners. Under the current fiscally decentralized management system, it is critically important to get provincial governments actively engaged in the process of developing and implementing the health system reform plan in order to obtain the "buy-in" of the health sector reform in Lao PDR by different level governments, particularly provincial governments, and other relevant sectors. In addition, special attention should be paid to appropriate mechanisms that provide adequate incentives to health facilities and professionals for their provision of quality service.

A coordination mechanism will need to be set up, oversight by the National HSR Commission. The Ministry of Health, with assistance from Sector Wide Coordination Mechanism (SWC) will organise regular meeting between the MOH, other line ministries such as MOF, MPI, MOHA, DPs to address cross-cutting issues at national level. Similar mechanism will need to be set up at provincial and district level, in conjunction with their line at national level. Communication should also be set up between central, provincial and district levels.

Each of the line ministries will also need to consider incorporating their area of responsibility that can work in collaboration with the health sector and contribute to the outcomes of the SHR process. Potential actions for consideration include:

(1) *Ministry of Education*:

- Incorporate health education courses into curriculum from the primary school to senior high school;
- Build toilets and provide safe drinking water in all schools;
- Implement school-based de-worming programme
- Implement nutrition supplements for all school children

(2) *Ministry of Planning and Investment*

- Coordinate the development plans with other social sectors
- Coordinate and facilitate inputs/assistances from development partners to the health sector
- Coordinate the planning and monitoring of capital budget through public investment programs submitted by the Ministry of Health
- Oversee the mid-term evaluation of 7th NSEDP and the health reform plan
- Strengthening the targeting mechanism to ensure health services reach the poor

(3) *Ministry of Finance*

1. Ensure adequate financial resources allocated and distributed timely to the health sector as plan
2. Monitor local government budget allocation to the health sector
3. Develop alternative means of resources, e.g. sin-tax policy

4. Strengthen financial management

(4) *Ministry of Home Affairs*

1. Develop appropriate rural salary incentive policies
2. Ensure adequate quota allocated to the health sector at different levels and different provinces
3. Working together to strengthen civil service structure for effective service deliver

4. Involve and work with MOH in introducing the CRVS data collection and reports.

In addition, the national assembly (NA) is expected to play an important role, especially in supporting the government agencies to develop and pass relevant registrations and regulations that can facilitate the implementation of the health sector reform strategies and policies proposed in this document.

➢ Initiation steps for implementation

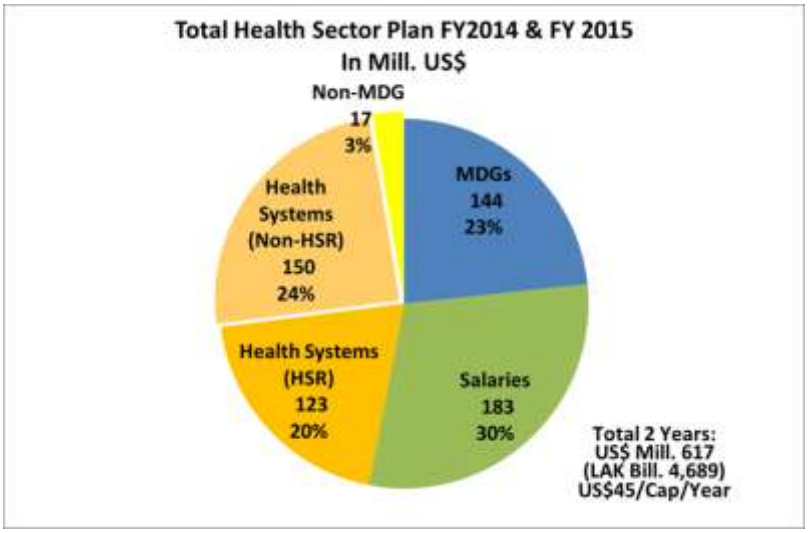
- Prepare and submit for the PM Decree regarding the HSR Strategy, HSR Framework and its structure
- Establish the National Commission, the HSR unit, the Provincial and district Committee
- Appoint the OiC at National and Provincial level
- Identify needs for HSR interventions
- Develop criteria for selection of provinces that initiate the HSR implementation
- Conduct provincial annual action plan in selected provinces

COSTING and FUNDING REQUIREMENTS

See annex 3 for details

- Costing for the first phase of the Health Sector Reform Strategy (FY 2014-15)

- Methodology used for HSR costing: Costing FY2013/14-FY2014/15 is based on the main costing exercises performed in the health sector over the past 4 years including 3 sector costing (MDG health, HSD plan, MBB), and 15 sub-sector costing exercises. Priority interventions with direct impact on the achievement of health MDGs and associated health systems costs were identified and costed.
- The total public health sector costs of the first phase of the Health Sector Reform, including the new salary grids, is estimated at US$ Million 617 or LAK Bill. 4,689 (US$45/cap/year) for the 2-year period of 2014-2015. The priority interventions directly related to the HSR strategy represent roughly 73% (US$vMill.450).

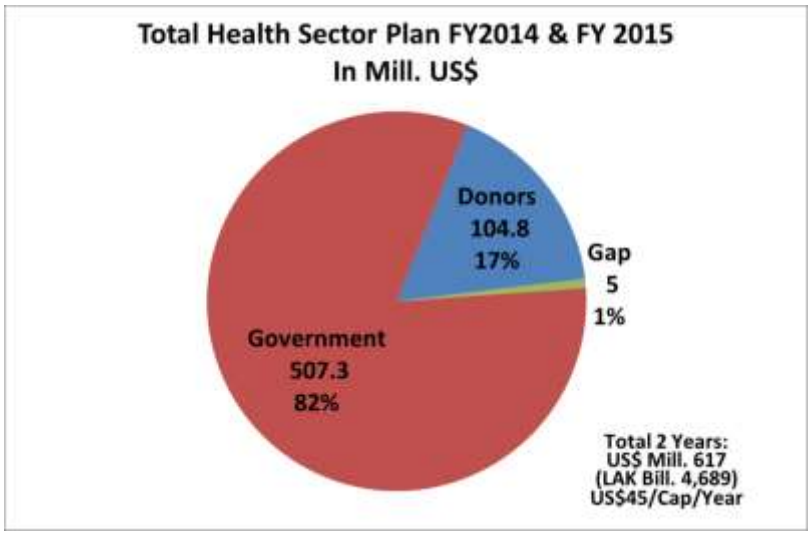


- On a yearly basis, this represents US$45 per capita, still well below the estimated US$58 needed to reach MDGs based on 49 Low-Income Countries.
- The above public health costs represents 9.4% of the General Government Expenditure (GGE) Plan and 2.3% of the GDP
- 23% of this amount is directly related to the health MDGs (9% for MDG 4, 9% for MDG 5, 7% for MDG 6, 5% for MDG 7 and 2% for MDG 1), 30% for salaries including new staff required, 44% for health systems in general (41% for human resources, 19% for service delivery and 6% for the expansion of social health protection) and 3% for non-MDG interventions.
- 80% of the costs of the 1st phase of HSR are for recurrent expenditure and 20% for investments
- Total health cost for the 1st phase of HSR is split into US$ Mill. 292 in 2014 (LAK Bill. 2,222) to US$ Mill. 325 in 2015 (LAK Bill. 2,467)
- This is almost 3 times the planned funding for the FY2011/12.

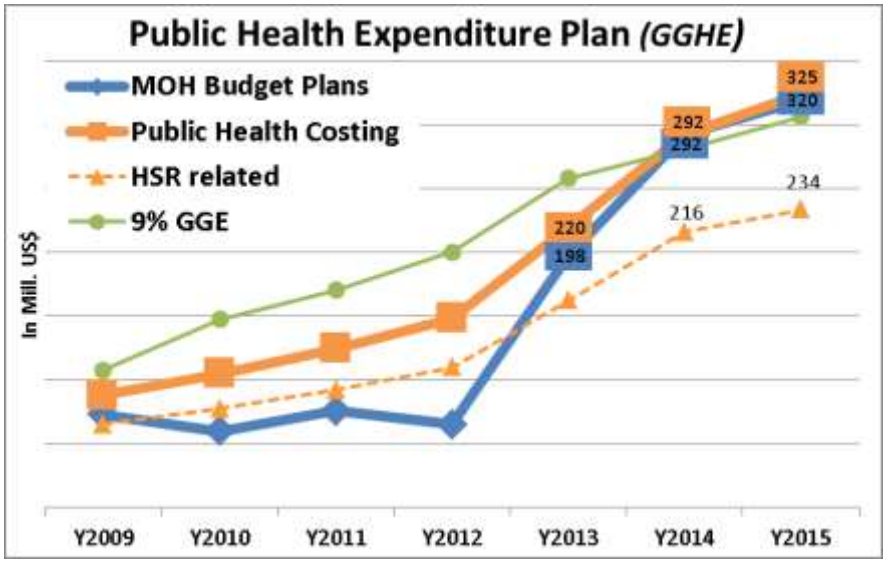
- Funding requirements for the first phase of the HSR Strategy (FY 2014-15)

- Acknowledging the importance of health for the well-being, prosperity and economy, the Lao Government has committed to allocate at least 9%of the GGE to the health sector.

- For the 2-year period of FY2014 and FY2015, US$ Mill. 612 are initially expected by the Ministry of Health (MOH) for the health sector (from public sources, i.e. Government and Donors), just above the 9% of the GGE.



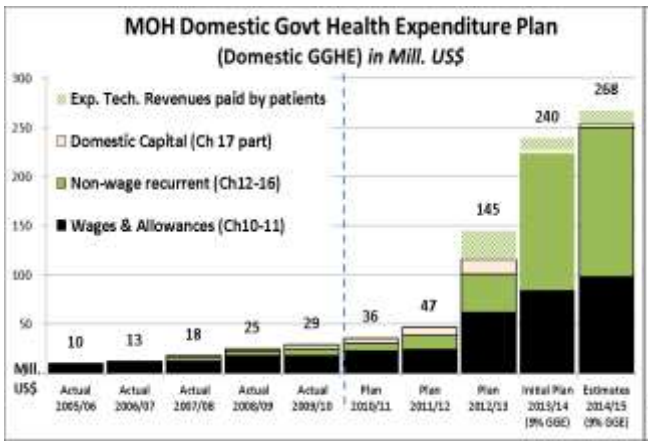
- Expected Domestic Government budget for Health reaches US$ Mill. 240 for FY2013/14 (LAK Bill. 1,822) and US$ Mill. 268 for FY2014/15 (LAK Bill. 2,033)
- If effectively released, this amount should be sufficient to fully finance the 1st phase of the Health Sector Reform

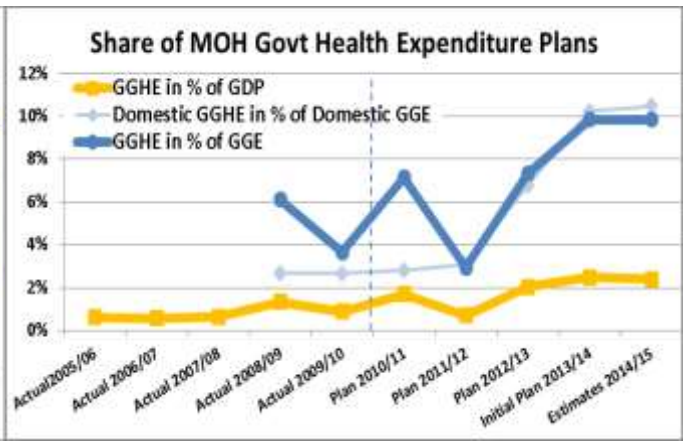


- Trends in total government funding for health in Lao PDR

- Acknowledging the very low Government funding for health, especially for non-wage domestic recurrent costs, the Government of Laos has been planning a very high necessary increase in the level of Domestic Government Expenditure for Health over the past two years.
- The approved MOH Government Health Budget planned for FY 2012/13 is at Mill. US$ 210 or LAK Bill. 1,689(including US$ Mill. 134 in domestic budgets, US$ Mill. 12 technical revenues paid by patients and US$ Mill. 65 from donors), standing at 7.3% of GGE. This is a welcome threefold increase compared to the budget of the previous years. The budget is equivalent to 2% of GDP (1.4% from domestic sources).

- With the commitments to meet at least the targets of 9% of GGE for health, the MOH drafted an initial budget FY2013/2014 in line with the costing needs at Mill. US$ 308or LAK Bill. 2,343, slightly above the 9% of GGE and equivalent to 2.5% of GDP (1.9% from domestic sources).





- Comparisons with other countries

- Compared to other countries in the region, Lao PDR was ranking in 2010 at the lower end for 3major macro-economic indicators:1) GGHE in per capita amount; 2) GGHE as % of GGE; and 3) GGHE as % of GDP. In 2015, with the Government commitments for health, Lao PDR is expected to catch up on these key indicators.

Regional	US$ / Capita			Domestic GGHE			Total GGHE		
Comparisons (Y2010)	GDP	GGE	THE	US$/cap	% GGE	% GDP	US$/Cap	% GGE	% GDP
Myanmar	871	215	17	2	1%	0.2%	2	1%	0.2%
Lao PDR (2010)	**1,073**	**264**	**27**	**5**	**3%**	**0.5%**	**11**	**4%**	**1.0%**
Cambodia	795	161	45	16	10%	2.0%	17	10%	2.1%
Viet Nam	1,211	403	83	29	7%	2.4%	31	8%	2.6%
Mongolia	2,207	823	120	60	7%	2.7%	66	8%	3.0%
China	4,358	981	221	118	12%	2.7%	118	12%	2.7%
Thailand	4,614	1,058	179	134	13%	2.9%	134	13%	2.9%
Malaysia	8,373	2,218	368	204	9%	2.4%	204	9%	2.4%
Lao PDR (2015 9% GGE)	**2,027**	**491**		**35**	**10%**	**1.7%**	**44**	**9%**	**2.2%**

WHO NHA data General database (last accessed 20 Nov. 2012)

- Conclusions

- The Domestic budget for health, if approved as requested by MOH, should be sufficient to finance the first phase of the Health Sector Reform.
- Key focus would then be on ensuring that:
  - the requested MOH budgets are effectively approved and disbursed by the Ministry of Finance and Provincial authorities
  - the budgets from Government and Donors are disbursed on time (predictability) and with sufficient flexibility in use
  - the MOH, PHOs and DHOs are able to take on the challenge to manage this high increased in budgets (planning, budgeting, financing, accountability, reporting)

Additional explanations:

- This cost and funding requirements for the priority interventions directly related to HSRis much higher than the initial draft of HSR costing FY2013-15 submitted in December 2012.In terms of costs: (1) adjustments in salary wages based on MOF index; (2) inclusion of priority MNCH investments, placement of new personnel in rural areas; (3) inclusion of administration and technical assistance costs; In terms of funding: initial costing FY2013-15 based on partial domestic budget FY2012/13 approved in Nov.2012 at US Mill.89 compared to full budget approved at US$ Mill.145
- The difference between the funding requirements for the 1st phase of the HSR (US$ Mill 292 for FY2103/14) and the MOH budget plans (US$ Mill. 308 for FY2013/14) is in the donors funding plan (US$ Mill. 52 in HSR based on previous years' disbursements versus US$ Mill. 65 in MOH budget plan)

Health Sector Reform

M & E Framework

2013 – 2025

MONITORING AND EVALUATION

(See annex 4 for the indicator matrix)

• Monitoring and Evaluation (M&E) Concept

M&E is part of the cycle of the management of program interventions. M&E provides a feedback loop to assess how the plans are being implemented. While there are different frameworks for indicator selection, using the logical approach to program management and planning, the commonly agreed framework, input-process-output-outcome-impact will be used. The framework reflects measurements of the operational results (based on inputs) and developmental results (based on outputs, outcome and impact) of the interventions, thus presenting a countrywide picture of how the health service system operates.

The various components of the framework with the corresponding M&E activity to be done are as follows:

- **Inputs:** At the Input level, monitoring will measure the degree of National Action improving the health services in the Lao PDR. Measurement will be done through an inventory of expenditure on health; human resources and policies made supporting the health sector reform and improvement of health services.
- **Process:** Process indicators are immediate results of activities or specific interventions.
- **Output:** Output data will show the extent of implementation direct results of different health related intervention under different priority areas.
- **Outcome:** Outcome data shall measure changes in behaviour, practices or skills that happen as a result of program interventions. These data shall be collected by assigned agencies and organizations as part of national surveys, special research, and surveillance activities**.**
- **Impact:** Impact data will assess health status and the overall burden of disease to the country. The disease burden shall be measured among those target population or general population as in case of the universal health coverage.

Figure 1: Level of M&E measures

Input	→	**Output**	→	**Outcome**	→	**Impact**
Health Financing		Service accessibility and readiness		Coverage of intervention		Health Status
Health Workforce		Service Quality and Safety		Risk Factors and Behaviours		Financial Risk Protection
Infrastructure		Effectiveness		Efficiency		
Information						
Governance						

For the HSR process, the M&E aspect will be covered under the M&E Framework (annex 3) and is part of the governance and management pillar.

• Use of M&E

Collecting data for M&E, as its ultimate goal is for improving the implementation of interventions. The M&E system should have a clear plan on how to use and disseminate information. Information generated by the M&E activities should be used for planning improvements on existing interventions. The main purpose of the use of the M&E system in the HSR process is to collect evidence of effective

approaches in implementing the HSR action plan for consideration of further expansion and multiplication. The annual review and periodical evaluations will not just determine whether or not the intended objectives and goals have been achieved, but it will also identify shortcomings, challenges and how to overcome them. These lessons learnt then should be applied for the next cycle of implementation.

The routine monitoring reports should be disseminated to all involved stakeholders and the recommendations for improvement should be discussed and further action to be agreed upon. Furthermore, the review and evaluation reports should be widely distributed with its format adapted to different audience, including the beneficiaries – general population. At the end of each phase, an assessment will be conducted to determine whether the objectives are achieved and what will/should be carried on in the next phase. Lessons learnt from this type of assessment will provide inputs and evidence for further improving the planning and execution of the HSR.

- ## Monitoring and Evaluation Framework of the Health Sector Reform Implementation

It is imperative to track the reform progress and assess the impact of policy interventions implemented in the process of the reform, in order to adjust relevant policies and interventions for better outcomes. Based on the approved reform strategy and implementation plan with a set of targets and milestones, a framework with key indicators for Monitoring and Evaluation (M & E) should be developed as a tool to track reform progress and outcomes. In order to monitor and evaluate the performance of the health sector reform at different levels and in different geographic areas, the Lao health information system needs to be further developed and strengthened in the different phases during the reform process. The M&E Framework have identified a set of indicators to measure different part of the process. Most of these indicators are part of the health information system's indicators and help monitoring the priority and population coverage.

M&E framework is for the health system and the health sector reform as whole, it doesn't replace the management of different health related interventions.

Data collection, data sources

Most of the data that feeds in the M&E Framework should be collected by the national HIS routine reports as well as by other sources of information (surveys, census) for outcome and impact levels. As currently the routine reporting system can't provide all the information need, a baseline data collection will be conducted at health centre and district hospitals, as well as at the village level in order to have a comprehensive assessment of the situation of the service delivery situation in the country, including information on human resource, infrastructure, service delivery status…

For input and output/process indicators, most of the day will come from the routine reporting of the HIS. Others will come from the routine reports that submitted monthly from district to provincial authorities. For outcome and impact level indicators, data sources for most data will come from the facility reports of the routine report, many other data will need to be collected through special surveys and surveillance.

The information will be collected on every six months, for output/process indicators and on annual base for many of the input, outcome and impact indicators. Others collected through surveys will be collected on longer intervals. How often these data will be collected and how will be determined by data collection guidelines which will be developed during the initiation of the HSR implementation.

Annual report on the progress based on the data analysis will be circulated to all concerned stakeholders.

Monitoring progress

Routine monthly progress reporting introduced as part of implementation with reports going to District Governors, Provincial Governors and through the Reform Manager's office to the Minister. Consolidated reports to be sent to the Minister within 10 working days at the end of each month. The content of the routine reports is stipulated in the intervention plan and covers key inputs, processes and outcomes including such matters as changes in antenatal care (ANC), postnatal care (PNC) and skilled assisted birthing, health promotional activities, number of births recorded, number of maternal complications and deaths. The report will also contain explanations of changes and relevant actions already taken.

The OiC together with the focal points at the MOH should have quarterly meeting with the provincial HSR managers to update the implementation progress and to discuss on issues that need further actions from higher level.

Detailed monitoring and evaluation (M&E) quarterly reviews of implementation and outcomes are established and undertaken in a rotating sample of intervention sites by a team comprising central and provincial experts and DP reps as relevant. Reports are presented to Reform Managers with recommendations for action. A summary report on findings and remedial actions taken is provided to the Minister within one month of each review. The structure of the detailed monitoring is stipulated in the implementation plan.

Evaluation of the way in which the first stage of the health reform is implemented

The second goal to be achieved from initiating of the health reform program with focused activities to improve maternal health by the end of 2015 is to develop and refine the ways of managing the implementation of health reform over the next seven years.

The maternal health improvement intervention is just the first of many specific interventions to follow as parts of the health reform process. To provide objective information on the effectiveness of the processes used, an ongoing "formative evaluation" should be established from the planning stage of the maternal health intervention and continue until its conclusion in 2015. It would review steps taken, issues confronted and how they are managed in order to provide the Ministry and governments concerned at all levels with valuable information on the most effective ways of managing the ongoing reform.

Formative evaluation examines process not outcome. It is not an evaluation of the changes achieved in maternal health but rather evaluates the effectiveness and efficiency of the management processes used to design and implement this first stage of health reform. Its findings should guide government in strengthening the implementation of health reform.

Technical assistance will be needed. One or more Development Partners would make a valuable contribution to the reform process by providing such technical assistance. Using an independent source to undertake the evaluation should strengthen both its methods and its objectivity.

The formative evaluation team would make progress reports to the Reform Manager with recommendations on overcoming problems and obstacles to reform implementation that are identified. By the start of Q3 2015, a report on the formative evaluation should be presented to the Minister with clear recommendations for the organization of the delivery of the next stages of the overall health reform.

Health Sector Reform Framework -

ANNEX

2013 – 2025

Annex 1 Policy Matrix on Health Sector Reform in Lao PDR

Policy Areas and Medium Term Objective		Policy Actions by end 2014	Policy Actions by end 2015
Human Resource for Health			
1.1	**Increase deployment of skilled health workers to rural and remote areas, including increasing of quota**	○ MOH Instrument (such as action plan) for implementing 'National Health Personnel Development Strategy Plan till 2020' ○ Decree on quota on health staff based on the projected staffing needs ○ Prime Minister Decree on Deployment of Village Health Workers	Amendment of the Law on Health Care Article 55 (Duties of Rights of MOH –'To establish and enforce the comprehensive health and systematic policies in effort to develop and secure human resources for health')
1.2	**Increase deployment of skilled health workers to rural and remote areas**	• MOH Order/ Decree regulating employment	
1.3	**Enhance the capacity of health professional education and training**	○ Ministerial Strategy/Policy on Health Professional Education and training including continuing training ○ MOH Decree on setting up medical training unit in selected provinces, including its roles and functions ○ A MOH Decree on Registration and Licensing of health workers	Amendment of the Law on Health Care Article 5 including enhancing the capacity of health professional education and training
1.4	**Improve HRH information system**	• MOH Decree to approve the revised information requirements and methods of data collection	

Policy Areas and Medium Term Objective		Policy Actions by end 2014	Policy Actions by end 2015
2. Health Financing			
2.1	**Increase government domestic spending on health**	• National Assembly Decree and Prime Minister Decree to: ➢ specify that 9% of GGE is allocated to the health sector and if it excludes ODA and TR then not less than 6% of domestic GGE; • to ensure a minimum funding allocation in line with MOH budget plan	
2.2	**Improve resource allocation focusing on the district health system**	○ Prime Minister Decree on Free MNCH ○ MOH Decree on allocating NTW funding to HEF and Free MNCH/Under 5 services	Enacting Law on Health Care including State's duty on attaining universal health coverage
2.3	**Improve coordination of funding flows to the health sector**	○ Aid effectiveness policy ○ MOH Decree on harmonising all funding sources for health to HSR and to the health sector annual plans	
2.4	**Improve oversight and financial management and tracking of funds in the health sector**	➢ Review of Decree 03 and 53 ➢ Budget Law, Accounting Law, and others ➢ MOH decree to develop NHA institutionalization plan and establish the NHA team (composed of members from MOH, MOF, MPI, LSB, NIOPH, UHS) ➢ Review charter of accounts for health	
2.5	**Adopt appropriate Provider Payment Mechanisms (PPM)**	➢ PM Decrees 03 and 52 revision (on-going) ➢ MOH Decree on governance arrangement for the National Health Insurance Bureau and its branches	MOH Decree on phasing out of the Drug Revolving Funds through Government Funding and expansion of social health protection schemes

Policy Areas and Medium Term Objective		Policy Actions by end 2014	Policy Actions by end 2015
3. Governance, Organization and Management			
3.1	**Establish a strong mechanism for coherence and coordination for a results oriented management of the HSR**	➢ Revise the current legislation on MOH and provincial authorities on their duty, functions and responsibilities to support the focused approach of HSR. ➢ PM Decree on HSR strategy, structure and responsibilities of involved managerial officials at central and provincial levels; endorsing the plan for Phase I	Amendment of 'Law on Health Care' or Enactment of decree on Health related organization's management including below contents (duties, role description, implementation, supervision, monitoring, evaluation of health interventions etc.)
3.2	**Strengthen HSR management of the implementation of HSR**	1. A formal MOH directive assigning individuals and their roles and functions for supportive supervision	
3.3	**Define clear reporting and feedback flow mechanism for effective oversight and supervision of the HSR implementation**	➢ Develop a result based planning and management policy ➢ MOH Decree on the M&E system	
3.4	**Develop a cross-cutting mechanism for Performance Based Funding (PBF)**		Policy on PBF and PM Decree approves the policy with clear roles and functions of involved ministries

Policy Areas and Medium Term Objective		Policy Actions by end 2014	Policy Actions by end 2015
4. Health Service Delivery			
4.1	**Rationalise allocation of service arrangement through localised planning that is harmonised from central to district levels to ensure availability of services to the population**	2. MOH Decree on the criteria for selecting the provinces to initiate HSR	
4.2	**Strengthening referral system and accessibility**	➢ Revise current MCH legislation to meet regional (ASEAN) and international standards ➢ Amend 'Regulation on Maternal and Child Health' or ➢ Enact Law/Decree on Maternal and Child Health including below contents (responsibility of state and local government, development and coordination of service plans etc.)	
4.3	**Improve health legislation coverage on community health**	➢ Reviewing current community health legislation comparing with international standards and other countries cases and drawing the legislative requirements ➢ Develop and get approval of a Policy on community health services ➢ Amend of 'Law on Health Care' or Enact Law/Decree on community health care including below contents (establishment of provincial public health and medical care plan, official tasks of public health clinics,	MOH Guideline on utilization of health facilities, charges, equipment of public health clinics and health centres in provincial and district level

		appropriate disposition, referral system , emergency care etc.)	

Policy Areas and Medium Term Objective		Policy Actions by end 2014	Policy Actions by end 2015
4.4	**Improve hospital management for better quality and efficiency of health care services**	3. Develop a policy on quality assurance of health care	
	4.4.1. Improve quality of health care services with focus on MNCH, basic package of service	➢ Revise current MCH legislation to meet regional (ASEAN) and international standards ➢ Amend 'Regulation on Maternal and Child Health' or ➢ Enact Law/Decree on Maternal and Child Health including below contents (responsibility of state and local government, development and coordination of service plans etc.)	
4.5	**Improve regulatory capacity on drug, pharmaceutical, and essential medicine**	1. Revise current drug regulatory system to meet with regional (ASEAN) and international standards 2. MOH Instruction on financial and drug management reporting forms and reporting system	
4.5	**Ensure uninterrupted supply of medicines and medical products**	- Getting approval for the revised National policy on infrastructure and medical technology and medical technology - Revise the National Policy on Medicine - MOH Decree on Roles and Responsibility PHO and	A MOH decree on pooling funds for a list of life-saving essential medicines that will be fully subsidized

		DHO in assuring uninterrupted supply of drugs, medical products, including vaccines.	

Policy Areas and Medium Term Objective		Policy Actions by end 2014	Policy Actions by end 2015
5. Health Information System			
5.1	**Improve the routine national health information system, covering all the MDG targets**	4. Developing National health information system as well as developing strategy and application of sub-national level health management information system	Enactment of Law/Decree about Health Information including below contents (Policies toward management of statistic and information on health and medical services, facilitation of health information, dissemination and expansion of health information)
5.2	**Develop Civil Registration and Vital Statistics**	5. Decree of the Prime Minister about Civil Registration and Vital Statistics	
5.3	**Strengthen information standard and exchange of information amongst different reporting systems**	6. Creating the Health Information and Statistics Policy 7. Se-up a page about Health and Diseases Statistics in MOH website 8. MOH Guideline on Standardization of information on health and medical records	

Annex 2 HEALTH SECTOR REFORM FRAMEWORK – STRATEGIC PLANNING MATRIX

HSRF PRIORITY AREA1. Human Resources for Health			Targets/ Milestones	Legislative requirements	Responsible parties	HSRF Reference
Expected Result: • *All health centres will be staffed with at least one mid-level midwife/or community midwife* • *All trained health workers will be recruited to public health facilities.*						
1.1	**Improve employment capacity**					
	1.1.1	Accelerate deployment of health personnel for essential health services with particular attention to remote areas	Recruitment increase to 5000 in 2014, 3000 in 2015 and return to 2000 from 2016 onward.	MOHA commits to increase significantly the quotas as recommended by MOH	MOH: DHP, DTR,DHC, DPIC, DOF MOHA	
	1.1.1.1	*Develop a strategy for negotiation with the MOHA concerning request for accelerating recruitment according to essential health service requirement*	*Detailed plan for allocation of staff including associated cost and logistic presented to MOHA for approval*	*MOH Decree*	*MOH: DHP; DTR, DPIC, DOF*	*Link with Nat't standards on health facilities*
	1.1.2	Confirm health staffing needs at facilities level in villages, district and provincial levels to ensure sufficient number and skill mix required at all levels with particular attention to maternal health services required to accelerate the reaching of MDG5	The guidelines stipulate the minimum number and basic skills required of personnel in remote, rural and urban locations for respective level of health facilities		MOH: DHP, DHC, DTR	
	1.1.2.1	*Conduct mapping of health centre and staff to assess the staffing situation (number and skills)*	*2014, mapping result is completed*		*MOH: DHP, DTR, DHC*	*Link with 4.1.1.1; 4.3.1.1*
	1.1.2.2	*Revise the HRH projected staffing estimates based on updated staffing norms for all health facilities*	*Completed by end of 2013*		*MOH: MOP, DTR*	
	1.1.3	Define the functions of the VHW and determine their deployment in the health system and design appropriate	Draft decree is developed by 2014, including scope of service, supervision arrangements, training	PM Decree	MOH: DTR, , DHP, DPIC; DOF; HSR unit MOF;	

		training in accordance with their expected functions	requirements, and remuneration.			
	1.1.4	Recruit non-medical staff with accounting/financing background for financing / accounting positions			MOH: DHP, DPIC, DOF Province: PHO, Governor's office	
1.2	**Increase deployment of skilled health workers to rural and remote areas**					
	1.2.1	Monitor implementation of policies and employment regulations that promote educational opportunities and hiring practices to ensure gender equity and ethnic diversity.	10-15% of student recruitment nationwide is from the remote areas and ethnic minorities	MOE decree is available	DTR and UHS	
	1.2.2	Provide incentives and other forms of support for personnel working in rural and remote areas	Provinces include remote area incentives in personnel budget	MOH and PM decrees are available	DoF, DHP, DPIC/MOH; MOF;	
	1.2.3	Review and revise job descriptions for all health professions to adjust for health reform initiatives.	Q4 2015 all posts have job descriptions		MOH: DHP, DHC MOHA	
	1.2.4	Ensure that incentives in place reward the performance of health workers	FOR 2020 - 2025			*Link with the SBA plan by MOH/UNFPA*
1 .3	**Enhance the capacity of health professional education and training**					
	1.3.1	Strengthen the capacity of all training institution to provide quality education	Systematic teachers and preceptors training implemented with support of EDC.			
	1.3.2	Strengthen the education capacity of clinical training settings to ensure provision of quality education programs	By Q4 2015, 8 provincial hospitals with health training institutions have the medical training unit (MTU) established	MOH decree adopted	**MOH: DTR,** DHC, Provincial hospitals	
	1.3.2.1	*Strengthen the education development centre and ensure its sustainability*	*Core team expanded to enable implementation of EDC national functions, (6 additional professional staff by end of 2014)*			

	1.3.3	Revise curriculum for all categories of staff to address required competencies and emerging functions	Competencies will be available for three disciplines. The other disciplines by mid-2014. Curricula will be revised by the end of 2014			
	1.3.4	Strengthen Continuing Professional Development (CPD) at provincial and district level linked to requirement for registration and licensing.	Pilot phase report available Begin expansion in phase II.	Decree concerning Registration and licensing		
	1.3.5	Introduce National Exam for the assessment of graduates	2014 will start national exam for nurse		MOH: DTR, DHC, DHP, UHS	
	1.3.6	Introduce licensing system	Licensing system is in place by 2015		MOH: DTR, DHC, DHP, UHS	
	1.3.7	Strengthen Health Professional councils for all disciplines as authority for setting quality standards, licensing of health personnel and accreditation of training institutions.	Development of required legislation and capacity building completed by 12/2014		MOH: DTR, DHC, DHP, UHS	
	1.3.8	Strengthen the capacity of all training institution to provide quality education	Systematic teachers and preceptors training implemented with support of EDC.			
1 .4	**Improve the HRH information**					
	1.4.1	Expand HRH data to capture all health workforces, including private and other sectors.	Comprehensive information on public sector by end of 2015 Phase II will include information on the private sector		MOH: DHP	
	1.4.2.	Develop HRH information and capacity for data collection and interpretation at provincial level	Q4 – 2015 All relevant staff at provincial level have been trained.		MOH: DHP Province: Governor's Office, PHO	
1.5	**Strengthening HRH governance capacity**					
	1.5.1	Enhance the capacity of the MOH to engage all relevant stakeholders in the development and implementation of	Data base of stake holders and their areas of concern and contribution documented and applied.	Enhance the capacity of the MOH to engage all relevant stakeholders in the	Data base of stake holders and their areas of concern and contribution	

		the HRH strategies		development and implementation of the HRH strategies	documented and applied.	
	1.5.3	Develop and strengthen professional council to be able to regulate health professionals	Priority for strengthening Professional councils for Medicine, Dentistry and Nursing. (Phase 1)	Develop and strengthen professional council to be able to regulate health professionals	Priority for strengthening Professional councils for Medicine, Dentistry and Nursing.	

PRIORITY AREA 2. Health Financing.		Target	Legislative requirement	Responsible party	HSRF Reference
Expected Results: • *Not less than 9% of General Government Expenditure (GGE) is allocated to the health sector* • *All MNCH (under five) services are free of charge to users, nationwide* • *Social Health Protection coverage of the total population is 50% and of the poor is not less than 70%* • *Out of pocket payment is less than 40% of Total Health Expenditure* • *General Government Health e Expenditure (including ODA channelled through the government system) is efficiently managed and monitored at all levels*					
2.1	**Increase government health funding from domestic sources in order to make basic health service available and accessible**	MPI and MOF allocates under the National Socio-economic Development Plan sufficient funding for the health sector in line with the agreed priorities of the Health Sector Reform	National Assembly Decree passed and PM Decree required	**MOF** and **MPI** use the overall fiscal space to redress the funding gaps for health priorities; by giving health more priority in the national development agenda NA, PMO, MPI, MOF, MOH	

	2.1.1	Increase and secure throughout phase two of the reform sufficient domestic resources for health	• Not less than 9% of GGE is allocated to the health sector by 2013 • 2.5% of Total Health Expenditure as a share of GDP is reached by 2015	National Assembly Decree passed and PM Decree required	NA, PMO, MPI, MOF, MOH	HFS, HF1
	2.1.1.1	*Reach common technical agreement between government entities (NA, PMO, MPI, MOF and MOH) on the categories used to calculate General Government*	Common agreement on the categories included under GGHE agreed before the start of the 2014-15 fiscal year			

		Health Expenditure (GGHE)				
	2.1.1.2	*Prepare and pass PM decree establishing allocation of 9% of GGE to the health sector*	PM decree approved before start of 2014-15 fiscal year on allocation of not less than 9% of GGE to the health sector of FY 2014-2015	MoH Decree	MOH, MPI, MOF, MOJ,	HFS
	2.1.1.3	*MOF to designate a liaison officer to be assigned to the DOF MOH to support the budgeting process (improve overall and quarterly budget plans and reports)*	MPI and MOF staff involved in the development of budget plan (update the overall plan including quarterly plan and reporting) FY 2014-2015	Decree MOF, MPI and MOH	MOF,MPI, MOH	
	2.1.1.4	*MPI and MOF allocate 9% of GGE to the health sector for fiscal year 2014-2015.*	Not less than 9% of GGE allocated to the health sector	PM Decree	MPI and MOF	
	2.1.1.5	*MPI and MOF ensure that there is a minimum funding allocation for each quarter in line with the MOH budget plan (so that funds can be absorbed by the MOH along the fiscal year).*	MOH has sufficient funding for implementation of the annual action plan	PM Decree	NA,PMO,MPI, MOF, MOH	
2.2		**Improve resource allocation focusing on the district health system**	Budget allocated to the district health system increased	PM Decree	NA, PMO, MPI, MOF, MOJ, MOH	
	2.2.1	Allocate sufficient resources for scaling up MNCH services through Free MNCH/U5 schemes and HEF	Q4. 2014, Free MNCH/U5 services are provided nationwide through a combination of Government and ODA funding sources	Approval of PM Decree on Free MNCH	*MOJ,MOH, PMO*	
	2.2.2	Prioritize the use of NT 2 funding to HEF and Free MNCH/U5 schemes		PM Decree*,* HSR, HFS	MOH (DOF, DPIC, MCH Centre)	
	2.2.3	Increase non-wage recurrent budget (chapter 13) allocation to health centres, district hospitals and district health offices (including funding for outreach activities) by ensuring an efficient balance across the government budget chapters.	*Sufficient budget for HC,DH and DHO for the implementation of activities (including budget for integrated outreach activities) available and increased every year*	HSR, HFS	MoH (DOF), PHO, DHO	
	2.2.4	Allocate funding to provinces and districts in line with the disease patterns,	*Formula and budget norms are approved and implemented*	PM Decree*, MoH Decree*	MOH, MOF	

		demographic characteristics and poverty levels (includes the development of an allocation formula/budget norms)				
2.3	**Improve coordination of funding flows to the health sector**					
	2.3.1	Align and harmonize all funding sources (including provincial, district and donor funding) to the Health Sector Reform Strategy and Planning Matrix; and to the health sector annual plans	Health sector budget aligned to the Health Sector Reform priorities and to the health sector annual plans according to MoH Decree on management of annual budget plan	MOH Decree; and aid effectiveness policy	MOH (including all departments), MOF, MPI, MOFA and provincial and district authorities	HFS, HF1
	2.3.1.1	*Establish a joint budgeting process for government entities (central, provincial and district levels) and development partners to the health sector aligning all budget sources to the Health Sector Development Plan and annual plans*	*Decree issued by government for the unification of the budgeting process*	PM Decree*, Gov Decree for establishment of budget and implementation plans*	MOH (including all departments), MOF, MPI, MOFA and provincial and district authorities	
	2.3.1.2	*Establish a common system for expenditure reporting by development partners*	-Majority of donors using a common system for expenditure reporting, consistent with the major government expenditure categories - All funding bodies reporting through a Single Window (including the development of a common database shared between MPI and MOH)	*MoH Decree, MPI Decree*	MPI and MOH, DPs	
	2.3.1.3	Encourage development partners to progressively move away from project funding and towards targeted sector support and or provincial programme approach	*By FY 2014-2015, support to the health sector through programme approach increased*	*MoH Decree, MPI Decree*	MOH, MPI and DPs	
2.4	**Improve oversight and financial management and tracking of funds in the health sector**		MoH Decree on management of annual budget plan in place	Budget Law, Accounting Law, and others	**MOH, MPI, MOF**	
	2.4.1	Strengthen financial management	MOH Decree on management of	Budget Law, Accounting Law,	DoF, PHO, DHO	

		practices to improve efficiency, transparency and accountability	annual budget plan in place	and others		
	2.4.1.1	*Update financial regulations (amend decrees 03 and 52) to clearly define how health facilities should use different sources of revenue (i.e. user fees, drug revolving fund, free MNCH/U5 and other Social Health protection schemes) by clarifying what type of costs should be paid by supply-side budgets and what by demand-side budgets (User Fees /SHP schemes) and establish a clear regulation process of User Fees (who has authority to define the rates, what periodicity to review, and on what basis – e.g. costing reviews, inflation rates))*	*Approval of reviewed versions of Decree 03, 52*	Review of decrees 03 and 52	MOH (DoF), MOF,MPI, MOJ,PMO, State Audit Authority,	
	2.4.1.2	*Develop and implement guidelines for accounting and reporting of funds to health facilities (including training and supervision) in line with the updated financial regulations and the charter of accounts (to ensure consistency in the costs charged to the different budget lines across spending units). Different guidelines to be developed for Health Centres and for hospitals. Guidelines to be in line with the budget law, accounting law, regulations of Social Health Protection schemes, and chapter 4 of HMIS reporting form.*	*Accounting and Financing guidelines developed and implemented by all levels*	*Budget Law, Accounting Law, and others*	*MOF, MOH - DOF in collaboration with MOF and Provincial and District authorities (health and finance) and State Audit Authority*	
	2.4.1.3	*Audits to take place regularly (according to the accounting law)*	*Auditing report*	*Auditing law*	*State Audit Authority, MOH, PHO, DHO*	
	2.4.1.4	*Agree with MOF on a more adequate chart of accounts with specific health*	*Chart of accounts of health sector reviewed, and*	*MoH Decree*	*MOF, MOH, Provincial and District Administrative*	

		budget lines (social health protection subsidies, Free MNCH/U5, allowances for staff in remote areas, remove donors funding from chapter 17 and allocate it by chapter)	*endorsed*		*Office*	
	2.4.1.5	*Ensure that allocations for Free MNCH services do not overlap with those of SASS, SSO, CBHI and HEF (e.g. no double payment to the same provider for MNCH services)*	*PM Decree on Free MNCH approved*	PM Free MNCH decree	*MOH: DOF* *PHO, DHO*	
	2.4.1.5.1	*Free MNCH/U5 scheme pays for MNCH/U5 services in the benefit package and the Social Health Protection (SHP) schemes pays for the other health services (in line with their benefit packages)*	*PM Decree on Free MNCH approved*	*PM Decree*	*MOH, PHO, DHO*	
	2.4.2	Institutionalize National Health Accounts (NHA) in order to provide accurate and timeliness health expenditure information (yearly)	NHA reviews conducted on a yearly basis and used for policy and planning	MOH decree to develop NHA institutionalization plan and establish the NHA team (composed of members from MOH, MOF, MPI, LSB, NIOPH, UHS)	MOH, MOF, MPI, LSB, NIOPH, UHS)	
	2.4.2.1	*Develop institutionalization plan and establish NHA team*	*NHA team trained, action plan developed*	*NHA team established*	*NHA team*	
	2.4.2.2	*Conduct yearly National Health Accounts reviews*	*NHA report yearly*	*MOH Decree*	*NHA team, MOH*	
	2.4.3	Ensure that there are integrated annual operational plans by districts and provinces and that these plans reflect expected results, programme areas, activities and government budget chapters				
2.5	**Adopt appropriate Provider Payment Mechanisms (PPM)**					

	2.5.1	Assess existing PPM (capitation, case-based payments, fee for services) and adopt appropriate ones as well as levels of payment across health facilities, including those contracted through Social Protection Schemes	Results of assessment of existing provider payment mechanisms available and disseminated	MoH Decree	MOH and MOLSW	
	2.5.1.1	*Conduct costing study of health services at all levels (from health centres to central hospitals)*	*Results of costing study available and disseminated*	*MoH Decree*	MOH and MOLSW	
	2.5.1.2	*Based on costing study, assess appropriateness of PPM and payment levels and revise accordingly*	*If recommended by costing study and review of PPM, revise payment levels and mechanisms*		MOH and MOLSW	
	2.5.1.3	*Review user fees (range of services and fee schedule based on costing study)*	*If recommended by costing study, revise user fees range of services and schedule*	*PM Decrees 03 and 52 revision (on-going)*	*PMO, MOH, MOF, MF*	
	2.5.2	Prepare for stepwise phasing out of Drug Revolving Fund (DRF) to be replaced by government funding (to provide for essential medicines in public health facilities) and through the expansion of social health protection schemes		MOH Decree	MOH, MOF, MPI	
	2.5.2.1	*Conduct assessment of how to phase out DRF*	Q4. 2015: Preparation for phasing out completed	HFS	*DF, DPIC, DC, FDD, TA*	HFS, HF2
	2.5.2.2	*Initiate implementation by including the costs of Reproductive Health and MNCH related medicines (based on the essential drugs list) in the government budget to health facilities (full implementation of entire essential medicines list to take place in phase two)*			*MOH, MPI, MOF*	
2.6	**Develop Social Health Protection Schemes (SHP) in areas where basic services are accessible**		Out of pocket payment is reduced to less than 40% of total health expenditure			

	2.6.1	Develop and implement an operational plan to merge all existing SHP schemes through the National Health Insurance Agency			MOH, MOF, NHIB, MOLSW	HFS
	2.6.1.1	*Develop the governance arrangements for the NHI Bureau and its branches. This includes the development of the institutional management structure, definition of mandate and roles, drafting of TORs for the divisions and branches and job descriptions of the staff*	*NHI Bureau and pilot branches at provincial level fully functioning by 2015*	*MOH decree*	*MOH, provincial and district authorities, PHO, DHO, MoLSW,MoF and MOHA*	
	2.6.1.2	*Develop and implement a common IT plan/database for all schemes*	*New database is developed and piloted by 2014*		*MOH and MOLSW*	
	2.6.1.3	*Based on costing study (2.5.1.1) review if necessary contribution and payment rates for SHP schemes (linked to 2.5.1.2)*	*New contribution and payment rate are approved – depending on costing study results and negotiations between the NHI Bureau and providers*		*MOH and MOLSW*	
	2.6.1.4	*Develop and implement a plan for the harmonization of the benefit package across all schemes*			*MOH and MOLSW*	
	2.6.1.4.1	*Review guidelines of all SHP schemes on benefit package and harmonize them under the NHI Bureau*	*Common benefit package established*	*Specific regulation*	*MOH and MOLSW*	
	2.6.1.5	*Develop a plan for provider management, including an accreditation system*			*MOH and MOLSW*	
	2.6.1.5.1	*Design and establish a quality assurance mechanism to monitor the quality of health services national accreditation system of service providers (including an appeal's mechanism for reporting abuses through an identified representative of the schemes)*	*Move on a step by step approach to an accreditation system*	*Standard requirement*	*MOH and MOLSW*	
	2.6.1.5.2	*Create an appropriate evaluation*			MOH and MOLSW	

		mechanism and relevant incentive structures (to prevent moral hazard, and incentivize ethical standards)				
	2.6.1.6	*Transfer responsibility for coordination and management of Free MNCH/U5 scheme to the NHI Bureau with a view of integrating it to the other schemes*	*Free MNCH/U5 scheme is integrated into the NHI system by 2015*	*PM Decree*	*MOH (DOF, DHP,DHC, MCHC)*	
	2.6.2	Expand coverage of SHP schemes in line with the additional funding to be allocated to the health sector (9% of GGE)	50% of the population covered by social health protection schemes in which 70% of the poor is covered (the poor will be covered through HEF and Free MNCH/U5 schemes)		MPI, MOF, MOH, MOLSW	
	2.6.2.1	*Create a plan for managing eligibility, enrolment and membership*			MOH and MOLSW	
	2.6.2.1.1	*Develop and implement a monitoring tool to track memberships by each SHP scheme*	*Membership database*		*MOH and MOLSW*	
	2.6.2.1.2	*Conduct regular campaigns for increasing awareness (all schemes), enrolment (mainly SSO and CBHI) and utilisation (mostly for HEF)*	*Increase enrolment and avoid drop out*	*Communication strategy*	*MOH and MOLSW*	
	2.6.2.2	*Operationalize subsidies for the poor (100% of premium) and people in the informal sector (50% of premium) according to the NHI decree*	*100% of all poor and 50% those in the informal sector in the country are covered through a Social Health Protection scheme by 2015*		*MPI, MOF, MOH, MOLSW*	

HSRF PRIORITY AREA 3. Governance, Organisation, and Management	Targets/ Milestones	Legislative requirements	Responsible party	HSDF Reference

Expected Results:

- *The HSR has a strong structure from central to provincial/district levels, lead by the Minister of Health and accountable to the Government of Lao PRD*
- *Legal framework required for the implementation of the reform process is developed, processed and approved timely*
- *HSR implementation is result oriented and jointly planned, funded by both government and development partners*
- *The HSR process is regularly monitored and supportively supervised.*

3.1	**Establish a strong mechanism for coherence and coordination for a results oriented management of the HSR**		2014,Q, an official governance mechanism is in place			
	3.1.1	Prepare and submit for the Prime Ministerial Decree that authorises endorses objectives and expected results of phase I of the health sector reform and specifying the responsibility and accountability of the ministry of health, provincial and district governors for its achievement.	2014, the Decree is signed and issued	PM Decree endorsing the HSR Phase 1 framework and its implementation plan.	Minister of Health, DPIC	
	3.1.2	Establish the Central HSR Level Steering Committee leading with the function as defined in the PM Decree, including multi-sectoral and development partners coordination	2014, the Central HSR Steering Committee is officially established		Minister of health and the ministries (MOH, MOF, MOHA, MPI)	
	3.1.3	Appoint an officer-in-charge (OiC) at national and provincial levels to lead and direct the implementation of the health sector reform directly accountable to the Minister of Health (HSROiC) and provincial governors	2014, an officer in charge is officially appointed	A PM decree appointing the OiC with full duty and responsibilities at MOH and at provinces.	Minister of Health	
	3.1.4	Establish a HSR Unit within the MOH which is accountable to the HSROiC.		A ministerial decision on the roles and responsibilities, functions of the HSR Unit		
	3.1.5	Appoint a OiC role at provincial and district level as additional task for health sector directors or those with appropriate qualification	2014,TOR of OiC at provincial and district level will be drafted	PM or Provincial Governor decree if needed to assign the manager for HSR at provincial and district level	Concerned ministries, provincial and district governance	
	3.1.6	To strengthen the capacity of the TFT as think-tank and technical advisory group to execute the implement the HSR planning matrix	TOR of TFT is revised according to their roles in the implementation phase		MOH: OiC, HSR Secretariat, DPIC	
	3.1.7	Train the managers of the provincial and	By 2014, provincial and district		MOH – Cabinet, DHP, DHHP	

		district on the HSR implementation plan and raise their awareness on the expected contribution from them	managers have received the training from MOH on the HSR implementation plan.		DPIC, DHP, DHC DHO, Provincial Governor's Office	
	3.1.8	Advocate for understanding and ownership of SHR within the health sector.	2014, All staff of MOH and provincial health entities are informed of the HSR.		MOH: Cabinet; HSR Unit, TFT	
	3.1.8.1	*Develop a communication strategy to advocate for HSR internally and externally in order to raise ownership and support.*	*Communication Strategy is approved and endorsed by 2014*		*MOH: Cabinet, DPIC*	
	3.1.8.2	*Organise workshop linking HSR and change management for managerial and central level staff*			*MOH: Cabinet, heads of depts..; HSRSectrariat, TFT*	
	3.1.9	Set up coordination mechanism within MOH and between MOH with other line ministries, DPs	A coordination mechanism is approved by the national commission	MOH Decree	MOH: Cabinet, DPIC, HSR unit	
	3.1.10	Develop criteria and select provinces to initiate implementation accordingly	Provinces is selected and receive support to implement	MOH decree on the list of provinces	MOH: Cabinet, DPIC, HSR unit	
3.2	**Strengthen HSR management of the implementation of HSR**					
	3.2.1	Ensure the planning is properly conducted at sub-national levels with resources secured and allocated			MOH : DPIC; HSR Unit, TFT Province: Governor's Office, PHO	Link with 4.1.
	3.2.2	Applying the "Three Builds" model to the management of HSR implementation to ensure effective implementation of the SHR.	Provincial and district structure on management HSR implementation is established		MOH: DPIC, HSR Unit, TFT Province: Governor's Office, PHO, DHO	
	3.2.3	Develop clear description of responsibilities and functions for oversight and supervision of the implementation of the HSR	Managers of health facilities know and accept their roles and responsibilities	A formal directive from MOH on defined roles and responsibilities is issued	MOH: DHP, DPIC , DTR, cabinet Provincial governors	
	3.2.3	Use of modern technology to support and expedite communication				
	3.2.3.1	*Establish the One Window Service in*				

		MOH for better communication				
	3.2.3.2	*Apply E-management, transferring paper-based documents to e-documents for circulation and tracking*				
3.3	**Define clear reporting and feedback flow mechanism for effective oversight and supervision of the HSR implementation**				MOH/DHP; HSR secretariat PHO, Provincial Governor's Offices	Link with HIS, ME system
	3.3.1	Set-up an M&E system to oversight and supervise the implementation of HSR	A M&E framework with indicator definition, and data collection guidelines is developed and approved	MOH Decree on the M&E system	MOH: Cabinet, DPIC, HSR unit Province: Governor's Office	Link with M&E indicator matrix
	3.3.2	Report on progress in the implementation based on the action plan by district to provincial authorities (monthly)	Monthly reports are distributed to the Minister, provincial and district governors		HSR unit/MOH	
	3.3.2.1	*District submit monthly progress report to provincial authority on routine monitoring and supervision*	*Monthly reports from district submitted to provincial authority*		*Provincial and district HSR managers* *HSR Unit*	
	3.3.2.2	*Organise quarterly meeting between central level departments, development partners and provincial SHR managers*	*Quarterly meeting chaired by the Minister or OiC of the HSR*		*HSR Unit, DPIC, Cabinet*	
	3.3.3	Review the implementation and outcomes in detail on sample intervention sites in order to report and recommend to the officer-in-charge through quarterly meeting between MOH and provincial authorities	Review report is endorsed and disseminated		HSR unit/MOH; national and provincial MNCH experts; and development partner experts	
	3.3.3	Adapt the adjusted plans (including resources issues) in response to the M&E recommendations as necessary at the relevant levels	Results-based planning, link plan with finance DP spending should support HRS priorities, insufficient management/planning.	Government plan for donor coordination with DPs should be improved such as align DP plan with MOH plan	HSR officer-in-charge; HSR unit/MOH Provincial governors PHO	
3.4	**Develop a cross-cutting mechanism for Performance Based Funding (PBF)**					
	3.4.1	Develop a Performance Based Funding in	A draft PBF mechanism jointly	Policy on PBF and PM Decree	MOH: Cabinet, DHP, DOF,	

		collaboration with related Departments in the MOH, MOF, MOHA and NA	developed among related Depts in MOH is submitted for approval of the PM	approves the policy with clear roles of functions of different line ministries	DHC MOF, MOHA,NA Provincial Governor's office	
	3.4.2	Develop clear standards and guidelines to evaluate the performance of the staff in conjunction with regulation on financial allocation, human resource management	Standards and Guidelines to evaluate performance will be approved		MOH: Cabinet, DHP, DOF, DHC MOF, MOHA,NA Provincial Governor's office	
3.5	**Strengthening regulatory enforcement in all aspect**					
	3.5.1	Strengthen the legal division of MOH to support the implementation of the policy matrix	By 6/2014, there will be at least 1 additional staff working full-time on legislation		MOH: Cabinet, DHP, DOF	
	3.5.2	Concerned departments in MOH working with the legal division and line ministries to implement the policy matrix			MOH: legal division, Cabinet, HSR Unit, TFT NA, PMO, other line ministries	
	3.5.3	Expedite the approval process of legislative documents to ensure timely implementation of SHR			MOH: legal division, Cabinet, HSR Unit, TFT Line ministries, PMO	

HSRF PRIORITY AREA 4. Service delivery	**Target**	**Legislative requirement**	**Responsible party**	**HSDF Reference**
Expected Result: ➢ *Basic integrated service package with focus on MCH that meet the national standards is provided at HC and district levels nationwide* ➢ *30% of total health centres and district hospitals have sufficient capacity and adopt a set of quality assurance measure* ➢ *Healthy Village model is expanded to 50% of villages in the country*				
4.1.	**Rationalise allocation of service arrangement through localised planning that is harmonised from central to district levels to ensure availability of services to the population**		Donor funding remains at the same level or even increase; Gov't increases its health budget	DPIC/MOH
4.1.1	Revise a basic package of PHC service, at minimum focus on the standard package of MNCH services as defined in the national MNCH strategy 2009-2020	2014, the basic package of service is determined and approved by MOH		DHC, DPIC, MCHC

	4.1.2	Develop an overall national and provincial PHC plan with focus on MCH improvement plan which identifies priority regions based on existing data and situation analysis	By 2014, the overall plan including service delivery guidelines and funding strategies is approved for implementation		MOH: DHC, DPIC, DOF, MCHC, DHHP Province: Governor's office; PHO, DHO	Link with 3.2
	4.1.2.1	*Conduct a situation analysis to assess the health network at all level (collect baseline data on staff, facilities conditions in term of infrastructure, drugs and equipment)*	*2014, report on the situation analysis is available and shared with stakeholders*		*MOH: DHC, DHP, DHHP, FDD* *Province: Governor office, PHO, DHO, hospitals*	*Link with 1.1.2.1; 4.3.1*
	4.1.2.2	*Determine the network and standards of health services based on the results of the assessment*	*Health care facility plan and standards is developed*		*MOH: DHC, Cabinet, DPIC, HSR unit*	
	4.1.2.3	*Develop guidelines/or conduct a training workshop for provincial and district planning*	*2014, the central plan is distributed including sources of locally relevant data, clear guidance on localised planning and on implementation*		*MOH: DHC, DPIC, HSR unit, TFT* *Province: governor's office, PHO, DHO*	*Link with 3.2*
	4.1.2.4	*Select provinces that need extra efforts to improve the MNCH services to conduct provincial MNCH improvement plan, with technical support from DPIC, HSR team*	*2014, the planning process is completed and lessons learnt to be drawn for the planning of the other provinces.*	*Criteria for selecting province developed and approved by MOH*	MOH: Cabinet, DPIC, DHC, DHHP Province: Governor's office; health office	
	4.1.2.5	*Introduce micro-planning for integrated services for MCNH where applicable (determined by local conditions)*			*MOH: DHC, MCHC, DPIC* *Province and district: governor's office, health office, hospitals*	
	4.1.3	Review and revise the existing treatment guidelines and clinical standard procedures that are relevant to the implementation of the PHC service with focus on the implementation of MNCH strategy	By 2014, revised service delivery guidelines focus on MNCH services at all levels are approved for the implementation.		MOH: DHC, DHHP Province: health office, hospitals	
	4.1.4	MOH and provincial authorities coordinate with development partners implementing in the	The roles and responsibilities of all		DPIC, DHC/MOH; DOH; Provincial Governor's	

		provinces to join the planning process at provincial and district levels and adhere to the joint plans.	implementing partners are clearly stated in the district and provincial plans		Office DPs implement MNCH activities.	
	4.1.5	Develop a Hospital Regimen with clear functions and responsibilities of each type of health facilities at each level	By 2014, hospital regimen is approved by the Minister of Health		MOH: DHC, DHHP; Cabinet	
	4.1.5.1	*Use health facilities information to determine which district hospital to perform caesarean section and EmONC*	2014, a list of district and hospitals to perform Caesarean and EmONC is finalised and approved by MOH		MOH: DHC, DHP, DTR, DHHP Province: Governor's office, health office	Link with HR and HF
	4.1.5.2	*Discuss and agree on the relationship between health facilities of each level, especially in planning for referral system*	*An official MOU on the agreed terms and conditions is signed by all partners in the provinces*		*PHO, DHO, provincial and district hospitals*	*Link 4.7*

4.2	**Mobilise resources for the HSR implementation to ensure financial and human resources for MNCH services are available especially at primary care level.**		2014		MOH: DPIC, DoF, DHP, DFD, CPMS, UHS, NIPH, HSR unit Provinces: Governor's office, DoF, DHO	Link with 2.2
4.3	**Strengthen Primary care to improve access to health services**			MOH Decree on the Hospital Regime, and health network standards		
	4.3.1	Ensure health centres and district hospitals have capacity that meets the national standards to provide the services defined in the basic service package based on the plan.	Q.4 2014 all HC and district hospitals have capacity to provide standard MNCH and basic services based on the defined plan.		MOH: DHC, FDD, DOF, DPIC, DHP, Cabinet, HSROiC Provinces: Governor's office, health office MOF, MOHA	Link with 2.3 on financial resources; 1.2 for HRH
	4.3.1.1	*Develop national standards for health facilities to ensure adequate capacity to provide the basic package of service, prioritise on MNCH, start with health centres and district hospitals*	*6/ 2014, national standards for health facilities are completed and approved*		*MOH: DHC, DHHP, DHP, OiC* *Province: Governor's office, health office.*	*Link with 4.1.2*

	4.3.1.2	*Incorporate the improvement plan for health centres and district hospitals to the provincial health service plan for funding and technical supports.*	*2014*		*MOH: DHC, DPIC, DHHP, DOF, OiC Province: health office, governor's office*	*Link with HF; link with 1.1.2; 4.1.2*
	4.3.1.3	*Set up a monitoring system to ensure health facilities maintain their facilities (infrastructure, equipment) based on the national standards*			*MOH: DHC, cabinet, DHHP Province: PHO*	
	4.3.2	Adapt the health services patterns based on local (district) situation to ensure MNCH services accessible to all, especially on family planning, ANC, nutrition and health education.	2014 types of service package and operational guidelines is developed and endorsed nationwide		DHP,DHC/MOH; MCH centre; PHO, DHO	Link HR, and Governance
	4.3.2.1	*Identify areas require outreach/mobile services by provinces and districts*	*2014, list of villages that require outreach/mobile services is completed*		*MOH: DHC, DPIC, DHHP, MCHC, OiC Province: Governor's Office, health office, hospitals*	
	4.3.2.2	*Provinces and districts decide and plan the type of integrated outreach/mobile services and the health facilities that can provide the outreach services (by district hospitals or health centres) and how the outreach team can be supported*	*2014 the outreach services are incorporated in the provincial and district health service plan*		*MOH: HDC, DPIC, DHHP, MCHC, DoF, OiC Province: Governor's office, health office, hospitals*	*Link with 4.1.1*
	4.3.3	Revise the implementation of primary care level standard treatment guidelines for priority conditions to ensure quality clinical care services with focus on MCH, including clear referral criteria and linkage with hospital services	By 2014 Standard Treatment Guidelines, especially those included in MDGs, are available and their active implementation is regularly monitored through key selected performance indicators, including outreach services	Standards and Directives to support guideline implementation e.g. health facility standards for safe deliveries at different levels of care	National drug and therapeutic committee with subcommittees to cover priority areas targeted for guidelines i.e. maternal and child health, communicable and non-communicable diseases	
	4.3.4	Strengthen the rational use of drug through functioning hospital drug and therapeutic committees (DTC) that oversee and monitor key aspects of medicines management from	By 2015 functional hospital drug and therapeutic committees are in place in all major tertiary level	Directive form MOH and/or contractual obligation by health insurance agency to enable the roles and functions		

		quantification, procurement to monitoring of utilisation, promotion of rational use and medicine safety	hospitals Hospital drug and therapeutic committees are regularly receive support to maintain/develop capacity to ensure appropriate performance	of hospital drug and therapeutic committees to ensure efficient and effective medicines management practices that contribute to delivery of quality care		
	4.3.4.1	*Revise the organisation and TORs of the drug and therapeutic committees at national and hospital levels*				
	4.3.5	Allocate clear responsibility to local authorities, especially at village level to ensure that people access to primary health care services			*MOH: cabinet, HSR unit, DHHP* *Province: governor's office; PHO, DHO*	*Link with 3.2.2*
	4.3.6	Expand the model health village model	By 2015, 50% of villages nationwide certified as healthy village models		MOH: DHHP; DHC; FDD	
	4.3.6.1	*Involve community in the HSR process*				
	4.3.6.2	*Conduct IEC/ health education activities on the intended service improvement (via mass media, media kits for VHW) in simple, understandable language.*	*2014, key messages and media kits are completed*		*MOH: Centre for communication and health education* *PHO, DHO, HC and villages*	
	4.3.6.3	*Keep the community informed of progress of the HSR process though press release and mass media*			*MOH: Centre for communication and health education*	
	4.3.7	Strengthen health services at village level through deployment of VHW			MOH: DHHP, DTR, DHP, cabinet	
	4.3.7.1	*Assess the needs of VHW base on the local conditions and health service delivery status*			*MOH: **DHC**, DHP, DPIC, DTR*	*Link with 1.1.2.1; 1.2.2; 1.2.3*
	4.3.7.2	*Define function and job description for VHW*			*MOH: DHC, **DHP**, DPIC, DTR*	*Link 1.1.3*

	4.3.7.3	*Train new VHW and upgrade VHV to meet the skills needs for VHW*	*By Dec 2014, all remote and poor villages have at least 01 fully trained VHW*		*MOH: DHC, DHP, DPIC,* ***DTR***	
	4.3.7.4	*Revise the service delivery guidelines for village health workers (VHW) and traditional birth attendants (TBAs)*	*2014, the revised guidelines is approved*		*MOH:* ***DHC****, DTR,* ***DHHP****, MCHC, OiC*	
	4.3.7.5	*Develop and set up a support system to assure quality of the work of VHW and TBAs*			*MOH: DHC, DTR,* ***DHHP***	
4.4	**Strengthen the referral system and accessibility**		➢ A localised referral system is established in each district and province, approved by provincial authorities ➢ A referral mechanism between central and provincial level is established		MOH: DHC; DHHP; Cabinet, MNCH Province: Governor's office; health office, hospitals, district hospitals, district office	
	4.4.1	Health centres, district and provincial hospitals discuss and agree on the needs and ways of connecting with the receiving service to ensure that the referral will be accepted and treated appropriately.	Q1 2014, provinces have started the arrangement regarding referral system, especially in district without an ambulance		MOH: DHC - guidance Province: PHO, DHO, HC	Link with 4.1.5
	4.4.2	Organise arrangements for access to appropriate, reliable, safe and affordable transport for patient transfer priority for MHC care with specification of scenario with and without available ambulance	Agreement between village, HC and district hospitals on mean of transport, responsibility, payment methods, documentation and role of different partners.		MOH: DHC - oversight Province: PHO, DHO, HC; District and village health committees	
	4.4.2.1	*At the village level, organize arrangements in which*			*Province: PHO, PH, DHO,*	

		the village leader and the village health workers take responsibility for gathering community commitment for providing transport for people in need			*DH* *HC* *Village leaders; VHW*	
	4.4.3	Develop a referral guideline and manual including referral criteria and initial treatment for MNCH services	A referral guideline and manual is approved and implemented		MOH:DHC, MCHC, DTR	
	4.4.4	Develop a referral supervision plan, relates both to providing feedback on the issues relating to the patients referred and to maintaining a supportive relationship	A plan for transport for transfer is drawn up and agreed upon by HC and district, provincial hospitals, especially where ambulance is not available		MOH: DHC; TFT, HSR unit Province: Governor's office; PHO, DHO, hospitals	
	4.4.4	Ensure appropriate Information sharing about treatments and outcomes is a two way necessity to assure continuum of treatment and care for the referred patients			MOH: DHC – Guidance Province: PHO, DHO, HC, hospitals	
4.5	**Improve hospital management for better quality and efficiency of services**					
	4.5.1	Establish quality management in the service delivery system		The National health service system and standards is approved by MOH	MOH: DHC, TFT	
	4.5.1.1	*Introduce quality assurance tool to determine the interventions required to improve quality of services based on the national standards*			*MOH: DHC, TFT*	*Link with 4.1.1; 4.1.2*
	4.5.1.2	*Motivate health workers and promote the use of local information for hospital management through introduction of 5S and national standards*			*MOH: DHC – guidance* *Province: PHO, hospitals; DHO*	
	4.5.1.3	*Train and expand the implementation of the 10 minimum requirements (10 MRs) to province, district hospitals and health centres, emphasising on work ethic*	*Q4 2015, X of hospitals have applied the 10 MRs for the MNCH services*		*MOH: DHC, DTR* *Province: health office, hospitals*	
	4.5.1.3	*Revise the clinical treatment guidelines for hospitals,*	*Q2 2014, treatment protocol*		*MOH: DHC, TFT*	

		with focus on MNCH services	*on MNCH is introduced to all health facilities*			
	4.5.2	MOH supports provincial authorities to set-up a supportive supervision mechanism for MNCH services with focus on the support from districts to health centres and village health workers that is suitable for the characteristics and conditions of the provinces	The supportive supervision mechanism with clear responsibilities and roles for each of the stakeholders is supported and endorsed by the district, provincial authorities Where appropriate, a supportive supervision committee is established	A formal directive from MOH, and/or provincial authorities to empower the roles and functions of the supervisors.	MOH: DHC, DHHP, DHP, OiC Province: governor's office, health office.	Link with HRH
	4.5.2.1	*Develop tools for MNCH/EmONC supportive supervision*	*Q4 2013 a set of tools and checklist is completed and approved for supervision purpose.*			
	4.5.2.2	*Conduct supportive supervision on regular basis*				*Link with 3.2*
	4.5.2.3	*Introduce patient record keeping as a standard procedure start with MNCH including EmONC at all health facilities*				*Link with HIS*
	4.5.2.4	*Develop a mechanism to appraise performance of health workers at health centres, district hospitals level*	*Annual report on staff performance is published*		*MOH: DHC, DHP, DTR, Cabinet, DOF* *Provinces: Governor's office, health office*	*Link with priorities 1 & 3 on performance based payment/ incentives*
	4.5.3	Develop effective measures for infection control in hospital setting	Health facilities meet the required standards for infection control Clinical staff adhere to the guideline on infection control		MOH: DHC, DoF, MPSC, FDD Province: health office, hospitals	
	4.5.3.1	*Develop SOP applying ASEAN standards for infection control in hospital setting focus on MNCH*	*SOP is developed and followed by all health facilities*		*MOH: DHC, MPSC* *Province: governor's office,*	

		services			*health office, hospitals*	
	4.5.3.2	*Conduct training to managers and staff on SOP for infection control.*	*Hospital managers are trained and responsible for the infection control of the health facilities*			
	4.5.4	Accreditation for quality service hospitals, for MNCH services	X health facilities accredited for its quality of MNCH services annually	An accreditation regulation is developed and approved	MOH: HDC, Cabinet	
4.6	**Ensure uninterrupted supply of medicines and medical products**			National policy on infrastructure and medical technology and medical technology is approved		
	4.6.1	Revise national medicine policies to support the delivery of quality and safe health services.	2014,: National Medicine Policy revised in 2013 (NMP) and short term implementation plan inclusive of budget developed for 2014-2015 By end 2014: A five year NMP implementation plan with budget developed and aligned with National Health Policy Strategy and Plan for 2016-2020 By end of 2015: A five year NMP implementation plan with budget developed and aligned with National Health Policy Strategy and Plan for 2016-2020		MOH: FDD, legislation division, HSR unit	
	4.6.2	Develop a national drugs regulatory system including inspection of private pharmacy with clear descriptions, roles and responsibility for different components of the food and drug			MOH: FDD, BFDI, DHP, DPIC, DF, HRS unit	

		inspection bureau				
	4.6.3	Revise and update the essential drugs list to cover the basic health package	2014, essential drug list is revised, then every 3 years			Link to 4.1.1.1
	4.6.4	Improve logistics via a clear plan and promoting supply chain integration for supply of essential medicines and medical supplies for MNCH service provision.			MOH: FDD, MPSC, MPIC, DoF, HSR unit	
	4.6.4.1	*Accelerate the transition of logistic management of centrally procured medicines and medical products*	*2014, medical product and supply centre (MPSC) and nutrition centre in collaboration with MCHC (including EPI programme and DPs) to set-up an uninterrupted operation for logistic information management and distribution of vaccines, family planning commodities, iron, Vit.A, deworming drugs and other centrally procured medicines and medical products to regional warehouses*		*MOH: FDD, MPSC, MCMC DPs*	
	4.6.5	Train pharmacy managers at public health facilities at all levels on Inventory Management System and Good Storage Practices based on the MPSC training manual	Q3, 2014 all managers are trained		MOH: MPSC, FDD, DTR, HSR Unit	Link with HRH

	4.6.6	Review and set-up a rational price setting based on collected evidences			T.A	Linked with 4.6.4
	4.6.7	Pool funds for critical life-saving essential medicines		A MOH decree on pooling funds for a list of life-saving essential medicines that will be fully subsidized	MOH: DHC,DF, DPIC, HSR unit; FDD, MPSC	Link with HF

HSRF PRIORITY AREA 5. Strengthen Health Information Systems to track MDGs, establish civil vital registry system, develop M&E framework			Targets/ Milestones	Legislative requirements	Responsible party	HSDF Reference
Expected Results: • *Overall M&E framework and indicators identified with proper data arrangement* • *Baseline for HSR developed* • *A compulsory birth registration introduced* • *X% of public health facilities able to provide statistical reports timely and accurately*						
5.1	**To improve routine health reporting system**					
	5.1.1	Harmonize and standardize indicators and collection process for better tracking the health system development and reform	having a minimum set of indicators which corresponds to MDG target as well as MOH development indicators	Official document from MOH regarding minimum set of indicators is need	All MOH line department and centres	central HMIS meeting at thalad 2010
	5.1.1.1	Develop the financial and drug management reporting forms and reporting system to provide accurate information and evidence for effective and timely management decisions.	Current HMIS data collection form revised to include information on financial and drug	Official notice from MOH to all health facilities to report using this new data collection form	DHC, hospital and DPIC (statistic unit)	Link with 3.5 on effective management of drug and medical supply system
	5.1.2	Improve information collection and data process: guidelines, manuals for data collection and measure	current HMIS implementation guideline revised and approved by MOH steering committee	Minister decree for countrywide unify data collection form and reporting system		MOH HMIS guideline 2004
	5.1.2.1	Train the personnel in charge reporting (including those reporting on of financial and drugs managements) on the revised reporting forms and its use.	Number of Health personnel received training on new HMIS		DPIC statistic unit	Priority Area 5 – HIS , routine reporting
	5.1.3	Strengthen legislation for better information collection from different facilities, including private sectors	Official notice from MOH on compulsory data collection and report to MOH	Minister decree	DPIC draft minister decree	

	5.1.4	Improve community (village level) information collections, recording	Current HMIS village data collection revised and approved by MOH steering committee	Minister decree for countrywide unify data collection form and reporting system	DPIC statistic unit	MOH HMIS guideline 2004
	5.1.5	Information auditing and data quality improvement	Number of staff has been trained on data processing, data screening		DPIC statistic unit	
	5.1.6	Improve data processing and analytical capacity in all levels including technical on IT and experts panel	Number of health staff trained		DPIC statistic unit	
	5.1.7	Improve information utilization and dissemination at all level including the place of collection	Number of health facilities using information for palling and decision making		DPIC statistic unit	
	5.1.8	Closely monitor MDG progress and performance of health system for the 7th HSDP review	Annually production of National Health statistic report	MOH part of HMIS national guideline	DPIC statistic unit	
	5.1.9	Develop central computerized information platform for disseminating and sharing information	HMIS system using web base system for data collection, reporting, processing, analysing and dissemination		DPIC statistic unit	
5.2	**Develop civil registration and vital statistics (CRVS)**					
	5.2.1	Leadership development through multi-sectoral approach	initiate coordination meeting to discuss on development of civil registration	Ministry decree on assignment of multisectoral organization	Cabinet, DPIC and DPs	
	5.2.2	Develop legislation for applying birth and death registrations (possible including unified ID of all residence)	existing legislation document approved by high level government organization	Ministry decree or notice to inform public of applying this legislation	Cabinet, DPIC and DPs	Experiences form other countries
	5.2.3	Develop national unified birth certification, registration system and reporting process	Existing birth certificate approved by high level organization	Legislation, guideline and instruction for country wide application	Cabinet, DPIC and DPs	Experiences form other countries

	5.2.4	Develop national unified death certification (including causes of death information), registration system and reporting process	existing death certificate approved by high level organization	Legislation, guideline and instruction for country wide application	Cabinet, DPIC and DPs	Experiences form other countries
	5.2.5	Pilot birth registration in selected provinces	Birth registration applied to selected provinces	Legislation, guideline and instruction	Cabinet, DPIC and DPs	Experiences form other countries
	5.2.6	Pilot death registration for maternal mortality in selected provinces	Death registration applied to selected provinces	Legislation, guideline and instruction	Cabinet, DPIC and DPs	Experiences form other countries
	5.2.7	Pilot cause of death registration for death in selected hospitals	cause of death registration piloted in selected hospitals	Legislation, guideline and instruction	Cabinet, DPIC and DPs	
	5.2.8	Encourage hospitals to apply ICD in patient morbidity records	ICD applied in IPD record in selected hospital	ICD10 guideline and MOH legislation	Cabinet, DPIC and DPs	
	5.2.9	Provide national vital statistics through unified birth registration	Vital statistic data and information can be produced from unified birth registration	Legislation to include vital statistic data	Cabinet, DPIC and DPs	
	5.2.10	Provide national death and cause of death statistics through surveillance sites approach?	death and cause of death statistics Can be produce from surveillance system	Legislation to include vital statistic data	Cabinet, DPIC and DPs	
	5.2.11	Enlarge birth registration, death registration and cause of death information collection to the whole country	Data and information on birth, death and cause of death being collected through	Legislation to include vital statistic data	Cabinet, DPIC and DPs	
5.3	**Better apply Information Communication Technologies in health information system**					
	5.3.1	Develop computer based information collection and report system	Computer based system has been applied to collect and report HMIS data at all level	MOH decree or notice to inform province and district on application of web based data collection	DPIC and DPs	

	5.3.2	Improve computerized hospital information system development	Computerized hospital information system developed and applied to all hospital	MOH decree or notice to inform health facilities on the use of computer to collect patient information	DPIC and DPs	
	5.3.3	Use mobile phones for collection information at remote areas on health	Mobile phone or tablet has been used for data collection at remote areas		DPIC and DPs	
	5.3.4	Strengthen computerized hospital information system and electronic medical record application in the country	Current computerized hospital information system and electronic medicals has been applied in the country			
5.4	**Strengthening information standard and interoperability between different information systems**					
	5.4.1	Develop technical capacity of application of ICD at national level	Number of staff has been trained on ICD		Statistics unit	WHO guideline
	5.4.2	Through working with broader users such as hospital manager, doctors, and researcher of ICD, identify possible applications			MOH: Statistic Unit, DPIC, DHC	
	5.4.3	Apply ICD in selected health facilities for patient and mortality records	Number of health facilities are using ICD report to MOH		MOH: DHC, Statistic Unit PHO, Pro. Hospital	
	5.4.4	Provide training on ICD application based on identified applications	Training on using ICD conducted for all level		MOH: DHC, Statistic Unit PHO, Pro. Hospital	
	5.4.5	Enlarge the ICD application in all hospitals both for patient and mortality records	Number of health facilities report using ICD		MOH: DHC, Statistic Unit PHO, Pro. Hospital	
	5.4.6	Study existing international health information standards to identify the national needs of Lao			MOH: Statistic Unit	
	5.4.7	Develop and apply related international information standards in Lao	National HMIS report consistent with international information	MOH decree	MOH: Statistic Unit	

5.5	**Harmonize health related survey and surveillance for better population based information**					
	5.5.1	Develop an inventory of essential health related surveys and surveillances to support the health system of Lao PDR			MOH: DHC, DPIC, related centres	
	5.5.2	Identify gaps in the existing survey and surveillance system			MOH: DHC, DPIC, related centres	
	5.5.3	Work with concerned partners (national and international) to decide the frequency and how they survey and surveillance system should be interlinked and supported.			MOH: DHC, DPIC, related centres	
	5.5.4	Advocate for budget allocation and joint-funding for health surveillance and surveys.			MOH: DHC, DPIC, related centres	

PHASE 2: 2016 - 2020

Objective: Improving access to basic health services and financial protection

HSRF PRIORITY AREA 1. Human Resources for Health			Targets/ Milestones	Legislative requirements	Responsible party	HSRF Reference
1.1	**Adjust the production to the needs of the country**					
	1.1.1	Plan of training sites (theoretical and practical) adequately equipped				
	1.1.2	Provide short-course or executive training on management and leadership development				
	1.1.3	Strengthen Master of Public Health and other post-graduate training programmes				
1.2	**Improve quality of health professional training to meet the needs of the country**					
	1.2.1	Training of supervision to health staff at health centres and district hospital to support lower levels of service providers through in-service training				
	1.2.2	Improve capacity of trainers/teachers				
	1.2.3	Review all current training programmes, curriculums used by health training institutions based on the national standards and norms for health workers of different health services				
	1.2.4	Improve working condition at health facilities, including infrastructure, equipment and supply				
1.3	**Improve performance and productivity of health workers at different levels of health facilities**					
	1.3.1	Develop supportive supervision mechanism to ensure adequate support				
	1.3.2	Institutionalise a health personnel performance monitoring system				

	1.3.4	Ensure that incentives are in place to reward the performance of health workers	FOR 2020 – 2025			
	1.3.5	Institutionalise Continuing Professional Development (CPD) nationwide	Begin expansion in phase in 2016			
1.4	**Improve the capacity of the Medical Council**					
	1.4.1	Develop and strengthen professional council to be able to regulate health professionals				
1.5	**Strengthening HRH governance capacity**					
	1.5.1	Enhance the capacity and position the MOH to engage all relevant stakeholders in the development and implementation of the HRH strategies	On going			
	1.5.2	Develop a health management training (bachelor and/or post-graduate) for health managers especially for district and provincial levels.				
HSRF PRIORITY AREA 2. Health Financing			**Targets/ Milestones**	**Legislative requirements**	**Responsible party**	**HSRF Reference**
2.1	**Improve financial management system for budget allocation and expenditure tracking**		Budget Law and charter of accounts revised	MOF endorses the needs	MOH: DOF NA, MOF, State Audit Authority	
	2.1.1	Collaborate with MOF to revise budget law and charter of accounts				
	2.1.2	Align and harmonize all funding sources (including provincial, district and donor funding) to the Health Sector Reform Strategy and Planning Matrix; and to the government five year development plans and annual plans	Majority of donors move towards sector and budget support funding program base	MOH Decree	MOH (including all departments), MOF, MPI, MOFA and provincial and district authorities	HFS, HF1
	2.4.3	Implement the stepwise phasing out of Drug Revolving Fund with more government funding to provide essential medicines	Implementation of phasing out to be completed by 2020	Health Financing Strategy approved	DF, DPIC, DC, FDD, TA	HFS, HF2
2.2	**Expand population coverage and consolidate**					

	different social health protection schemes into bigger pools					
	2.2.1	Enforce compulsory contribution, enrolment for SASS and SSO and merging of SHP schemes				
	2.1.2	Regulate and develop guidelines on private investment in health				
	2.1.3	Subsidise premium for informal sector, the poor and other disadvantage groups				
	2.1.4	Allocate more funds to rural areas to strengthen integrated service delivery network				
2.2	**Enlarge benefit packages of SHP schemes**					
	2.2.1	Introduce co-payment, safety net programmes				
2.3	**Transition from multiple pools to a single pools for SHP with different provider payment mechanisms**					
	2.3.1	Coordinate different provider payment mechanisms and align incentives				
	2.3.2	Revise the real cost of services, together with the revenue for SHP schemes to support the operation of health facilities				

HSRF PRIORITY AREA 3. Governance, Organisation and Management		**Targets/ Milestones**	**Legislative requirements**	**Responsible party**	**HSDF Reference**
3.1	**Continue to improve policy and regulation to support the health sector reform progress**				

	3.1.1	Regularly revise and update existing policies and regulations				
	3.1.2	Incorporate the HSR framework of phase II into the five year Health Sector Development Plan 2016-2020				
3.2	**Ensure adequate resources including financial resources are made available to improve regulatory enforcement**					
	3.2.1	Collect evidence to prove the needs for more national funding for health				
	3.2.2	Use the improved financial tracking and management system to recommend for better regulatory enforcement				
3.3	**Continue the coordination at national and provincial levels through the cross-sectoral structure**					
	3.3.1	Apply the concept of 3-builds to strengthen the localised health service delivery and management mechanism for HSR.				
3.4	**Strengthen regulatory enforcement in all aspects of health services, including regulation for medicines, and medical supplies**					
	3.4.1	Conduct regular inspection on Good Manufacturing Practices (GMP) to all pharmaceutical factories operating in Lao PDR.				
	3.4.1.1	*Strengthen hospital pharmacy management (good dispensary practice; good storage practice; pharmaco-vigilance system)*				
	3.4.2	Develop policies ensuring that all remote villages have at least one village health workers; all health centres will have reasonable catchment				
	3.4.3	Develop appropriate policies and				

		regulations to manage the increased autonomy of hospitals, especially at central level				
	3.4.4	Establish an incentive system that rewards staff with strong performance record based on the performance monitoring system				Link with 1.3.2
3.5	**Strengthen E-government**					

HSRF PRIORITY AREA 4. Improve infrastructure and quality of service deliveries. Invest in referral hospitals and specialised care.			**Targets/ Milestones**	**Legislative requirements**	**Responsible party**	**HSDF Reference**
4.1	**Expand availability of quality health services especially from health centres, district hospitals, provincial and regional hospitals**					
	4.1.1	Improve the network of delivery				
	4.1.2	Improve clinical treatment guidelines for hospitals, including district hospitals				
	4.1.3	Develop quality assurance measures to be applied in the country				
	4.1.4	Upgrade health service package including major NCDs interventions to be implemented nationwide				
	4.1.5	Improve quality of service covered by insurance schemes				
4.2	**Improve basic infrastructure, supply equipment and provide tools appropriate to health service facilities set up by the MOH**					
	4.2.1	Upgrade health facilities according to the national standards requirement for each type of facilities				
	4.2.3	Continue to improve the supply chains of medicines and medical supplies to other areas of health services				

	4.2.4	Develop a planning mechanism for a functional BFDI (annual plan including clear targets and budget, monitoring and supervision)				
	4.2.5	Strengthen governance of the RDF by applying the National Good Governance Medicine (GGM) Framework			MOH: FDD, MPSC, SHR unit DoF	I
4.3	**Improve referral system among different service providers**					
	4.3.1	Continue to strengthen the working relationship between health care providers at different levels for effective patient care				
	4.3.2	Continue to improve transportation system for referral that is most appropriate and convenient for the patients and the communities.				
	4.3.3	Develop guidelines and training on informed guidance including the autonomy of district level to arrange suitable mode of transport	Guideline is approved by MOH and distributed to health facilities in the referral system		DHC/MOH; central level hospitals, UHS? NIPH?	
	4.3.4	Extend the service to two-way transfer with downwards referral as appropriate for patients in need of longer-term care with technical support from higher level				
	4.3.5	Develop an internal system for quality assurance and auditing				
	4.3.5	Expand the coverage of district with ambulance				
	4.4.6	Develop an ambulance fleet with clear SOP for effective use of vehicles under an emergency service network, start at central and provincial levels				

HSRF PRIORITY AREA 5. Update, improve health information system and build capacity, monitoring and evaluate reform	Targets/ Milestones	Legislative requirements	Responsible party	HSDF Reference

5.1	**Apply adequate IT technique to the reporting of service use and expenditure, morbidity and mortality.**					
5.2	**Expand CRVS to the coverage of all births and deaths in the country**					
5.3	**Develop quality assessment of routine data**					
	5.3.1	Regular audit routine report as				
	5.3.2	Use of IT technology to avoid human errors				
	5.3.3	Promote the analysis and utilisation of the health statistics reports				
5.4	**Setting up routine national health surveys**					
	5.4.1	Make an inventory of national health surveys and needs				
	5.4.2	Plan national health surveys in advance in order to promote use and supports from stakeholders				

PHASE 3: 2021 – 2025

HSRF PRIORITY AREA 1. Human Resources for Health			Targets/ Milestones	Legislative requirements	Responsible party	HSDF Reference
1.1	**Further develop health workforce ensuring availability of skilled health workers to the whole population of Lao PDR**					
	1.1.1	Upgrading low-level health workers to mid-level and higher				
	1.1.2	Continue update training programmes				
1.2	**Improve quality, performance and productivity of health staff at all facility levels**					
	1.2.1	Introduce performance – based payment mechanisms				
	1.2.2	Institutionalise supportive supervision to all level of health facilities				
1.3	**Continuous professional development**					
	1.3.1	Strengthen health facility based training capacity.				
	1.3.2	Apply competencies in training curricular across all faculties				
	1.3.3	Expand post-graduate training programme				

HSRF PRIORITY AREA 2. Health Financing		Targets/ Milestones	Legislative requirements	Responsible party	HSDF Reference
2.1	**Increase government domestic funding to similar level with other ASEAN countries**				
2.2	**Expand population coverage by SHP schemes**				

	2.2.1	Increase total funding for health care from different sources				
	2.2.2	Continue to improve quality and accessibility of expanded health services benefit package				
2.3	**Consolidate social health protection schemes into a single pooled fund**					
	2.3.1	Pool funds from mixed provider payment mechanisms				
	2.3.2	Expand the single-window approach to health insurance at facilities				
2.4	**Develop clear regulation for payment of service providers**					

HSRF PRIORITY AREA 3. Governance, Organisation and Management			**Targets/ Milestones**	**Legislative requirements**	**Responsible party**	**HSDF Reference**
3.1	**Continue to improve policy and regulation to support the health sector reform progress**					
	3.1.1	Regularly revise and update existing policies and regulations				
	3.1.2	Incorporate the HSR framework of phase II into the five year Health Sector Development Plan 2016-2020				
3.2	**Ensure adequate resources including financial resources are made available to improve regulatory enforcement**					
3.3	**Continue the coordination at national and provincial levels through the cross-sectoral structure**					

HSRF PRIORITY AREA 4. Health Service Delivery	**Targets/ Milestones**	**Legislative requirements**	**Responsible party**	**HSDF Reference**

4.1	**Adjust the structure of the service provider system to meet the needs of and demands for health care of the Lao population**					
4.2	**Standardise service delivery management at each health facility level through a computerised system**					
	4.2.1	Continue the development of capacity for organising and management of service delivery at health facilities levels				
	4.2.2	Increase accountability of health facilities and health staff				

HSRF PRIORITY AREA 5. Health Information System			**Targets/ Milestones**	**Legislative requirements**	**Responsible party**	**HSDF Reference**
5.1	**Continue to improve CRVS registration**					
5.2	**Continue to improve routine health reporting system**					
	5.2.1	Improve facility-based reporting system				
	5.2.2	Improve the health related surveys				
5.3	**Improve capacity of data analysis and use**					

Annex 3 – COSTING AND FUNDING REQUIREMENTS

➢ Methodology

○ General principles

The methodology used for Health Sector Reform costing was to extract the **priority activities with direct impact on the achievement of health MDGs and associated health systems costs** from the Ministry Of Health existing consolidated exercises.

○ Sources of data used for the HSR costing

Several key costing exercises have been performed within the health sector in the past years. As already mentioned, the HSR costing for the first phase is directly based on the MOH 5-year National Socio-Economic Development Plan 2011-15 for the Health Sector and MOH Consolidation of Existing Costing Exercises in the Health Sector, Lao PDR. Ministry of Health Costing Team assisted by WHO - Report December 2011.

These two secondary sources summarize various costing exercises and sub-sector plans. Based on this review, the following costing exercises have been used to determine the cost of the different components and cost categories of the consolidated costing for the health sector, as shown in table 1:

Table 1: Summary of costing exercises used by source and by year

Component		Cost category	Source	Year
Health Related MDGs	MDG 1	Nutrition (not included in MNCH)	MOH/WHO - Unicef	2012
	MDG 4	Child Health	MNCH costing MOH/WHO	2010
		Immunization recurrent	MOH EPI Costing - GAVI	2011
		Immunization priority investments	MOH EPI Costing - GAVI & MOH/MCHC plan 2013-14	2013
		Free services for Children under 5	MOH/WHO SHP projections 2011-2020	2012
	MDG 5	Maternal Health	MNCH costing MOH/WHO	2010
		Reproductive Health	MNCH costing MOH/WHO	2010
		Training Skilled Birth Attendants	Unit costs & target figures MOH/DP	2012
		MNCH priority investments	MOH/MCHC plan 2013-14	2013
		Free Maternity services	MOH/WHO SHP projections 2011-2020	2012
	MDG 6	Malaria	MOH Malaria Strategy - WHO	2011
		HIV/AIDS	MOH HIV/AIDS Strategy	2010
		Tuberculosis	MOH TB strategy	2011
	MDG 7	Water	MOH Strategy on Rural Water Supply, Sanitation & Hygiene	2010
		Sanitation	MOH Strategy on Rural Water Supply, Sanitation & Hygiene	2010

Component		Cost category	Source	Year
Health systems	Health systems	**Human resource development**		
		Salaries & allowances	GOL budget Ch10-11 approved	2012
		Salaries & allowances new staff	MOH DOP Plan and projections 2013-15	2013
		Placement of new graduates in rural settings	MOH DOP Plan and projections 2013-15	2013
		Health workforce development	MOH DOP 5 year-plan 2011-15	2010
		Health Financing	MOH/EU-WHO MOH National HFS 2011-15	
		Health Protection towards Universal Coverage	MOH/WHO SHP projections 2011-2020	2012
		Subsidies to informal sector HI (CBHI)	MOH/WHO SHP projections 2011-2020	2012
		Subsidies to health safety net for poor (HEF)	MOH/WHO SHP projections 2011-2020	2012
		Health Financing system		2010
		Organization, management & working style		
		Administration-Management-Coordination	MOH/WHO Consolidated costing health sector	2012
		Health Services		
		Model Healthy Villages	Unit costs & target figures MOH/DP	2012
		Operations & Maintenance focus on PHC	MOH/WHO Consolidated costing health sector	2011
		Basic routine investments	MDG costing	2010
		Improving Food and drug quality	MOH FDD Plan	2011
		Information, Monitoring and Evaluation		
		HIS systems	MOH/WHO Health MOH National HISS Plan 2009-15	2011
		Monitoring & evaluation	MOH Health Sector development Plan 2011-15	2011

- **Organization of the HSR Costing Study**

  - **Purpose**

Calculate the total public health costs for the first phase of the HSR Strategy. Extract from the MOH consolidated costing exercises the priority routine activities with direct impact on the achievement of health MDGs, as part of the phase 1 of the Health Sector Reform strategy.

The following methodology and key principles were used during the HSR costing process:

4. Use the MOH/WHO consolidated costing as basis and 5-Year NSEDP as a reference
5. Include minimum overall operation costs
6. Include public subsidies required to social health protection schemes as per National Health Insurance Decree.
7. Include all costs domestically funded
8. Exclude operations, administration and maintenance of health facilities

For the HSR-related interventions:

9. Include only basic capital investment (domestically funded and MNCH specific)
10. Exclude overall capacity building, monitoring & evaluation

For the non-directly HSR-related interventions:

11. Include Non-MDG interventions
12. Include overall capacity building
13. Include necessary remaining planned capital investments
14. Include monitoring and research

  - **Detailed methodology**

The table 2 synthesizes the methodology used in the adjustment of the costing of the components of the MOH/WHO consolidated costing exercise in 2011.

Table 2: Prioritization and adjustments made in costing exercises compared to MOH consolidated costing

	Cost category	Priorization compared to the MOH/WHO Consolidated costing
MDG 1	**Nutrition (not included in MNCH)**	Increased direct costs
MDG 4	**Child Health**	Remove activities in nutrition and free U5
	Immunization recurrent	Remove operational costs incl. in MNCH
	Immunization priority investments	
	Free services for Children under 5	Updated assumptions excluding Start-up and invest. Costs
MDG 5	**Maternal Health**	Remove Free Maternity and activities in nutrition
	Reproductive Health	No change
	Training Skilled Birth Attendants	New: Replace figures from HRH plan for SBA/CMW
	MNCH priority investments	
	Free Maternity services	Updated assumptions 2012 excluding Start-up and invest. Costs
MDG 6	**Malaria**	Remove overheads, others, M&E
	HIV/AIDS	Adjusted with funds availale to 2015
	Tuberculosis	Remove overheads, other,s M&E, PSM
MDG 7	**Water**	Exclude M&E
	Sanitation	Exclude M&E
Health systems	**Human resource development**	
	Salaries & allowances	Updated official MOH/MOF approved planswith new index
	Salaries & allowances new staff	Add required staff from MOH DOP with corresponding salaries & allowances
	Placement of new graduates in rural settings	Add required staff from MOH DOP with corresponding salaries & allowances
	Health workforce development	
	Health Financing	
	Health Protection towards Universal Coverage	New: Updated assumptions 2012 excluding Start-up and invest. Costs
	Subsidies to informal sector HI (CBHI)	Updated assumptions 2012 excluding Start-up and invest. Costs
	Subsidies to health safety net for poor (HEF)	Updated assumptions 2012 excluding Start-up and invest. Costs
	Health Financing system	Keep only activities not included in SHP and HR
	Organization, management & working style	
	Administration-Management-Coordination	15% of overall operation, administration and maintenance
	Health Services	
	Model Healthy Villages	New: Remove the limited amount included in Facilities O&M
	Operations & Maintenance focus on PHC	New estimates: 2$ to 5$/cap including HIS and IEC
	Basic routine investments	Construction/Rehabilitation and equipments included in MDG costing only
	Improving Food and drug quality	Remove training
	Information, Monitoring and Evaluation	
	HIS systems	Remove training and M&E
	Monitoring & evaluation	

MDG1: Nutrition

- Four key direct interventions not included in MNCH costing in 2010 were costed here based on the MDG costing, MNCH costing and UNICEF estimates. These are:
  - Community-based nutrition (breastfeeding, complementary feeding, hand-washing)
  - Vitamin A and deworming
  - Multiple micronutrient powder
  - Salt iodization

  Therapeutic zinc for diarrhea and Iron Folic Acid for pregnant women were already included in the MNCH costing.

MDG 4: Child Health

- Activities already counted in nutrition as well as free services for children under 5 were removed from the Child Health Costing exercise within the MNCH costing performed in 2009/2010 for the period 2011-15
- Add priority MNCH investments based on MCHC plan 2013-15

MDG 4: Immunization

- Operational costs were removed from the EPI National Strategy - Summary Costs MYP included in the MNCH costing performed in 2009/2010 for the period 2011-15
- Add priority MNCH investments based on MCHC plan 2013-15

MDG 4: Free services for Children under 5

- New costing projections were performed in 2012 for social health protection and Free MNCH based on updated current coverage, costs targeted scenarios (see appendix 3). Start-up and investment costs were removed.
- Change of target to 50% in 2014 and 70% in 2015

MDG 5: Maternal Health

- Activities already counted in nutrition as well as free services for free MNCH were removed from the Maternal Health Costing exercise within the MNCH costing performed in 2009/2010 for the period 2011-15
- Add priority MNCH investments based on MCHC plan 2013-15

MDG 5: Reproductive Health

- No change compared to the MNCH Costing included in the MOH Consolidated costing exercise 2011.

MDG 5: Training Skilled Birth Attendants

- Specific costing estimates performed based on MOH/ Department of Planning figures provided in November 2012 (unit costs and targeted number of SBA and Community Midwives trained). These estimates replace the cost figures included in the MOH/Human Resource for Health Plan 2011-2015 included in the MOH consolidation of costing exercises performed in 2011

MDG 5: Free Maternity services

- New costing projections were performed in 2012 for social health protection and Free MNCH based on updated current coverage, costs targeted scenarios (see appendix 3). Start-up and investment costs were removed.
- Change of target to 70% in 2014 and 90% in 2015

MDG 6: Malaria

- Training, technical assistance, monitoring & evaluation, overheads and others were removed from the costing figures of the "Malaria strategy 2011-2015" included in the MOH consolidation of costing exercises performed in 2011

MDG 6: HIV/AIDS

- The costing of the "HIV/AIDS Strategy: 5 year 2010/11 to 2014/15" included in the MOH consolidation of costing exercises performed in 2011 was adjusted to the amount of budget available through the Global Fund and other donors up to 2015. Available funding is indeed considered as sufficient to fund the essential package by MOH/DP and WHO technical assistance.

MDG 6: Tuberculosis

- Training, technical assistance, monitoring & evaluation, overheads, procurement and supply management costs and others were removed from the costing figures of the "Tuberculosis Programme 2011-2015" included in the MOH consolidation of costing exercises performed in 2011

MDG 7: Water & Sanitation

- Capacity building, technical assistance, monitoring & evaluation and research were removed from the "National Strategy for Rural Water Supply, Sanitation and Hygiene in Lao PDR (May 2011 v4) 5

year 2010/11 to 2014/15" included in the MOH consolidation of costing exercises performed in 2011

MDG 7: Model Healthy Villages

- Specific costing estimates performed based on MOH/ Department of Planning figures provided in November 2012 (unit costs and targeted number of MHV). These estimates replace the limited cost figures included in the Health systems strengthening component Facilities Operations & Maintenance included in the MOH consolidation of costing exercises performed in 2011

Health systems: Health Protection towards Universal Coverage

- New costing projections were performed in 2012 for social health protection and Free MNCH based on updated current coverage, costs targeted scenarios (see annex 3). Start-up and investment costs were removed.

Administration-Management-Coordination

- Updated costing based on average unit cost per capita for overall operations and maintenance of facilities
- Use 15% for general administration

Operations, Maintenance, HIS, IEC focus PHC

- Updated costing based on average unit cost per capita for overall operations and maintenance of facilities
- 85% for operations, maintenance of health facilities

Health Systems: Salaries & allowances

- Updated figures based on MOH/MOF official planned figures for FY 2010/11, 2011/12 and 2012/13.
- Apply new index to salaries for 2012/13 (4,800), 2013/14 (6,700) and 2014/15 (6,700)
- Add salaries and allowances of new staff to be recruited based on MOH DHP plan for 2013/4 and 2014/15

Placement of new graduates in rural settings

- Allowances of new staff to be placed in rural areas based on new decree as calculated by MOH DHP plan for 2013/4 and 2014/15

Health Systems: Basic routine investments (GOL funded)

- Use the MDG costing for health for construction/rehabilitation, equipment and referral equipment.

Improving Food and drug quality

- MOH FDD Plan excluding training and investments

HIS systems

- Remove training, monitoring and evaluation from the MOH Plan

o Quantification of targets

Baseline targets for each intervention are come from official health information system and available surveys. Targets used for subsequent years are the MDG government targets and MOH sub-sector targets have been used for each intervention.

Aggregate targets have been calculated for compilation of costed interventions.

The table below summarizes the major targets used for each sub-sector/key intervention. A complete list of targets is in annex 2.

Table 3-7: Main targets for each sub-sector and key interventions

Nutrition	Y2011	Y2012	Y2013	Y2014	Y2015
Community-based nutrition	5%	8%	10%	25%	45%
Vitamin A and deworming	59%	69%	79%	85%	90%
Multiple micronutrient powder	1%	11%	20%	35%	50%
Salt iodization	79%	82%	85%	90%	90%

Component	Some key Coverage Indicators	Coverage						
		2009	2010	2011	2012	2013	2014	2015
Maternal Health	Births in facilities	17%	20%	22%	24%	26%	28%	30%
	Family Planning	38%	40%	45%	48%	51%	53%	55%
	Antenatal Care 1st Visit	29%	35%	40%	45%	50%	55%	60%
	Caesarean Section	14%	20%	25%	30%	35%	40%	50%
Child Health	ALRI/ Pneumonia	38%	45%	50%	60%	65%	70%	75%
	Severe Malnutrition	3%	5%	10%	20%	30%	40%	45%
	Diarrhoea	51%	55%	60%	65%	70%	75%	80%
Reprod. Health	Aggregate coverage all methods	38%	40%	42%	44%	46%	48%	50%
Immunization	TT - Pregnant women	85%	90%	95%	95%	95%	95%	95%
	DTP-Hep B-Hib(1)	44%	90%	92%	92%	92%	92%	92%

	Target	Y2011	Y2012	Y2013	Y2014	Y2015
Training Skilled Birth Attendants	7,500	34%	52%	72%	86%	100%

	Target	Y2011	Y2012	Y2013	Y2014	Y2015
Water	5,088,078	79%	80%	82%	84%	85%
Sanitation	5,088,078	53%	55%	57%	59%	60%
Model Healthy Villages	5,000	50%	55%	60%	65%	70%

Social Health Protection % coverage	Y2011	Y2012	Y2013	Y2014	Y2015
Civil servants (SASS)	69%	97%	100%	100%	100%
Private employees (SSO)	12%	15%	32%	40%	50%
Informal sector (CBHI)	5%	5%	20%	40%	50%
Health safety net for poor (HEF)	11%	28%	60%	75%	100%
Free Maternity services	5%	10%	30%	70%	90%
Free services for children under 5	0%	2%	10%	50%	70%
Total insured	**20%**	**26%**	**44%**	**63%**	**76%**

New staffing: 2013/14: additional 5,016 staff, 2014/15: additional 3,010 staff

- **Assumptions**

The costing and funding requirement for the first phase of the HSR (2013-2015) used the main following assumptions:

- **Costing:**

Table 8: Utilization of SHP & Free MNCH

Utilization / Cap / Year	Y2011	Y2012	Y2013	Y2014	Y2015
SASS	**2.5**	**2.8**	**3.0**	**3.3**	**3.5**
SSO	**1.8**	**2.0**	**2.2**	**2.4**	**2.5**
CBHI/ Informal	**2.5**	**2.8**	**3.0**	**3.3**	**3.5**
HEF	**0.5**	**0.6**	**0.6**	**0.7**	**0.7**
Free Maternity	**0.2**	**0.3**	**0.3**	**0.4**	**0.4**
Free U5	**0.5**	**0.7**	**0.8**	**1.0**	**1.1**

Table 9: Average costs SHP & Free MNCH

Average direct cost in US$/ Cap/ Year excluding double counting	Y2011	Y2012	Y2013	Y2014	Y2015
SASS	4.3	4.6	4.7	4.6	4.2
SSO	5.0	5.3	5.6	5.4	4.8
CBHI/ Informal	4.0	4.3	4.6	4.6	4.3
HEF	8.0	8.5	8.9	8.7	7.7
Free Maternity	43.0	46.6	50.4	54.6	59.2
Free U5	6.7	7.2	7.8	8.4	9.1

Table 10: Needs for overall operations and maintenance of facilities increasing from US$2 per capita in 2011 to US$5 per capita in 2015

Operations & Maintenance	Y2011	Y2012	Y2013	Y2014	Y2015
Total US$ / Cap	2.0	2.5	4.0	4.5	5.0

- **Funding requirements:**

- GOL budget FY 2013/14 based on initial MOH budget submitted to MOF in May 2013. Keep same % of GGE for FY2014/15.
- Donors funding for the health sector kept constant at the level of US$ Mill. 52.4 disbursements (US$ Mill.40 through government and $12.4 directly managed) for the year FY2011/12 as reported by the MPI database of donors plans and actual disbursements.

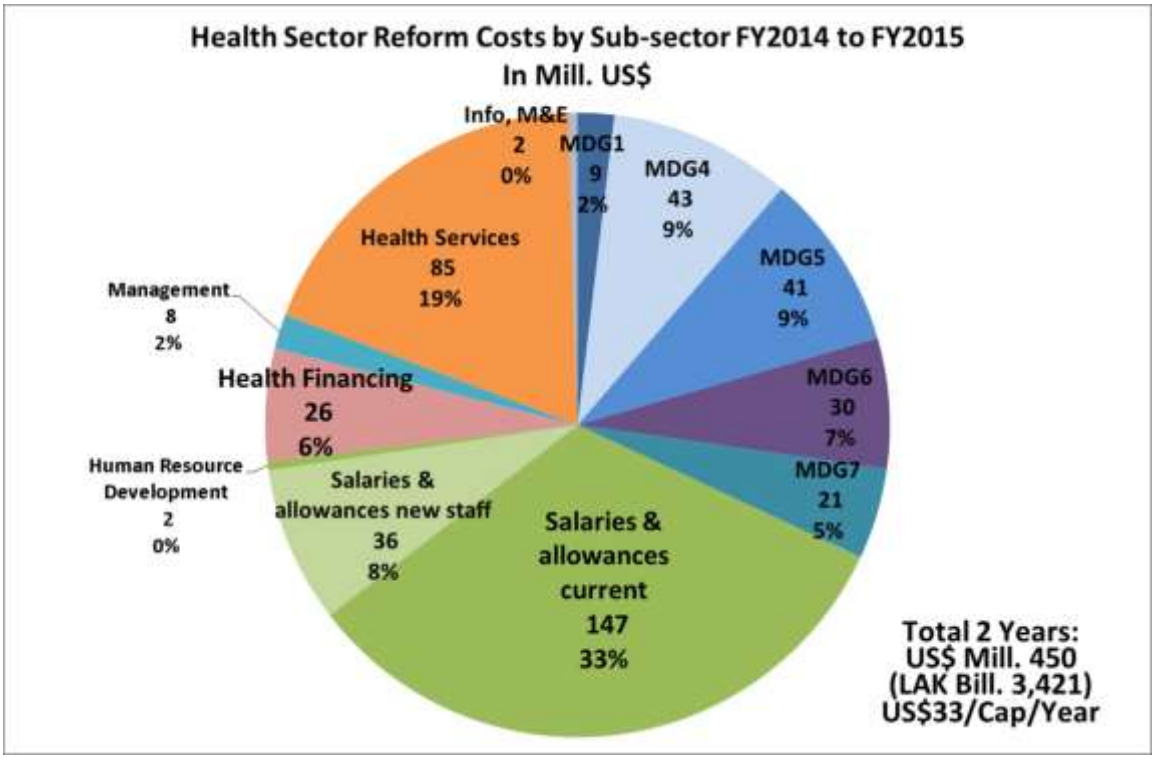
Costing tools used

The present consolidated costing exercise for the health sector reform relies on (a) the same Excel file consolidating the results of several tools listed below and using many different costing tools and (b) summary Excel file synthesizing the essential package of activities for the HSR strategy and comparing with macro-economic figures and other countries.

Limitations

The consolidated costing comes with a set of limitations mainly due to (a) the heterogeneity of the costing exercises to consolidate, (b) the mix between real costing exercises and sub-sector plan prone to overestimation and (c) the limited time devoted to the consolidation exercise and related validation requirements.

➢ Costing of priority interventions directly related to the 1st Phase of the HSR Strategy



➢ The cost of priority interventions directly related to HSR is at US Mill. 450 (LAK Bill. 3,421) equals to US$33/capita/year. It represents 6.9% of the GGE Plan and 1.7% of the GDP. It increases from US$ Mill. 216 in 2014 (LAK Bill. 1,642) to US$ Mill. 234 in 2015 (LAK Bill. 1,778).

➢ Summary table of Priority Interventions directly related to the HSR strategy for the 1st phase FY2014-15

					In Million US$					GOL Funding	DP funding	GAP
GOV'T	**Health Sector Reform: Costing & Funding Plan**	**Indicator**		**Targets 2015**	**Y2014**	**Y2015**	**Phase 1: 2013/14-2014/15**	**US$/ Cap/ Y**	**%**	**Y2014 & 15**	**Y2014 & 15**	**Y2014 & 15**
MDG health related	MDG1: Nutrition	U5 underweight; U5 stunted	%	22% - 34%	3.4	5.1	8.5	0.6	2%	5.6	3.0	(0.0)
	MDG 4: Child Health	U1 - U5 Mortality Rate	Per 1,000	45 - 70	20.3	22.2	42.5	3.1	9%	33.6	8.6	0.4
	MDG 5: Maternal Health	Maternal Mortality Rate	Per 100,000	260	18.8	22.5	41.3	3.0	9%	25.6	15.5	0.1
	MDG 6: Malaria-HIV/AIDS-Tuberculosis	HIV prevalence, Malaria & TB mortality	%, Per 100,000	<1% 0.2 240	15.1	15.2	30.3	2.2	7%	2.7	27.8	(0.2)
	MDG 7: Water, Sanitation and Hygiene	Access to clean water, latrines	%	80% 60%	10.3	10.9	21.2	1.5	5%	9.8	11.2	0.2
Non-MDG	NCD & Others				-	-	-	-	0%	-	-	-
Health Systems	Human Resource Development	Min. # Doctors-midwives at each hospit	#	-	85.8	99.7	185.5	13.5	41%	185.5	-	0.1
	Health Financing	National Health Insurance coverage	%	50%	11.9	14.3	26.1	1.9	6%	22.4	3.2	0.5
	Organization, management & working style	Population	-	-	3.7	4.3	8.0	0.6	2%	-	8.1	(0.1)
	Health Services	Hospitals with surgery, VHV per village	%, #	-	45.9	38.8	84.7	6.2	19%	68.3	15.2	1.2
	Information, Monitoring and Evaluation	Population	-	-	1.0	1.0	2.0	0.1	0%	0.7	1.3	(0.1)
TOTAL	TOTAL HSR COSTS				216.3	233.8	450.2	32.8	100%	354.2	93.9	2.1
	Recurrent	Population			194.0	222.0	416.0	30.3	92%	326.8	88.3	1.9
	Investments	Population			22.3	11.8	34.2	2.5	8%	27.4	5.6	0.1
FUNDING	Government	Population			166.5	187.6	354.2	25.8	79%	354.2	-	-
	Development Partners	Population			47.0	47.0	93.9	6.8	21%	-	93.9	-
	TOTAL HSR FUNDING PLAN				213.5	234.6	448.1	32.6	100%	354.2	93.9	-
	GAP	Population			2.8	(0.8)	2.1	0.2	0%	-	-	2.1
HSR Costs in % of	GGE				6.9%	6.9%	6.9%					
	GDP				1.7%	1.7%	1.7%					
Gap in % of	GGE				0.1%	0.0%	0.0%					
	GDP				0.0%	0.0%	0.0%					
Comparison	Needs to reach MDGs for avg 49 Low-Income							$58				

					In Million US$					GOL Funding	DP funding	GAP
	Non-HSR	**Indicator**		**Targets 2015**	**Y2014**	**Y2015**	**Phase 1: 2013/14-2014/15**	**US$/ Cap/ Y**	**%**	**Y2014 & 15**	**Y2014 & 15**	**Y2014 & 15**
Non-MDG	**NCD & Others**				**8.0**	**8.5**	**16.5**	**1.2**	**10%**	**14.7**	**5.1**	**(3.3)**
Health Systems	**Organization, management & working style**	-	-	-	**5.5**	**5.5**	**11.0**	**0.8**	**7%**	**11.6**	**-**	**(0.6)**
	Health Services	Hospitals with surgery, VHV per village	%,#	-	**47.5**	**70.5**	**117.9**	**8.6**	**71%**	**110.9**	**-**	**7.1**
	Information, Monitoring and Evaluation	-	-	-	**1.5**	**1.5**	**3.0**	**0.2**	**2%**	**3.5**	**-**	**(0.5)**
TOTAL	**TOTAL NON-HSR COSTS**	-	-	-	**71.9**	**94.9**	**166.8**	**12.1**	**100%**	**153.1**	**10.9**	**2.8**
	Recurrent	Population	-	-	33.7	41.9	75.6	5.5	45%	152.4	1.7	2.7
	Investments	Population	-	-	38.1	53.0	91.2	6.6	55%	0.7	9.2	0.1
FUNDING	**Government**	Population	-	-	73.3	79.9	153.1	11.2	34%	153.1	-	-
	Development Partners	Population	-	-	5.4	5.4	10.9	0.8	2%	-	10.9	-
	TOTAL NON-HSR FUNDING PLAN	-	-	-	**78.7**	**85.3**	**164.0**	**11.9**	**36%**	**153.1**	**10.9**	**-**
	GAP	Population	-	-	**(6.9)**	**9.6**	**2.8**	**0.2**	**1%**	**-**	**-**	**2.8**

					In Million US$					GOL Funding	DP funding	GAP
	Total HSR and Non-HSR Costing & Funding Plan	**Indicator**		**Targets 2015**	**Y2014**	**Y2015**	**Phase 1: 2013/14-2014/15**	**US$/ Cap/ Y**	**%**	**Y2014 & 15**	**Y2014 & 15**	**Y2014 & 15**
TOTAL	**TOTAL HSR COSTS**	-	-	-	**216.3**	**233.8**	**450.2**	**32.8**	**73%**	**354.2**	**93.9**	**2.1**
	TOTAL NON-HSR COSTS	-	-	-	**71.9**	**94.9**	**166.8**	**12.1**	**27%**	**153.1**	**10.9**	**2.8**
	Recurrent	Population	-	-	227.7	263.9	491.6	35.8	80%	**479.2**	**88.9**	**4.6**
	Investments	Population	-	-	60.5	64.9	125.3	9.1	20%	**28.1**	**15.9**	**0.2**
	TOTAL PUBLIC HEALTH COSTS	-	-	-	**288.2**	**328.8**	**616.9**	**44.9**	**100%**	**507.3**	**104.8**	**4.8**
FUNDING	**TOTAL HSR FUNDING PLAN**	-	-	-	**213.5**	**234.6**	**448.1**	**32.6**	**73%**	**354.2**	**93.9**	**-**
	TOTAL NON-HSR FUNDING PLAN	-	-	-	**78.7**	**85.3**	**164.0**	**11.9**	**27%**	**153.1**	**10.9**	**-**
	TOTAL PUBLIC HEALTH FUNDING PLAN	-	-	-	**292.2**	**319.9**	**612.1**	**44.6**	**100%**	**507.3**	**104.8**	**-**
	Government	-	-	-	**239.8**	**267.5**	**507.3**	**37.0**	**83%**	507.3	-	-
	Development Partners	-	-	-	**52.4**	**52.4**	**104.8**	**7.6**	**17%**	-	104.8	-
	GAP	**-**	**-**	**-**	**(4.0)**	**8.9**	**4.8**	**0.4**	**1%**	**-**	**-**	**4.8**
Total Costs in % of	**GGE**				**9.2%**	**9.6%**	**9.4%**					
	GDP				**2.3%**	**2.3%**	**2.3%**					
Gap in % of	**GGE**				**-0.1%**	**0.3%**	**0.1%**					
	GDP				**0.0%**	**0.1%**	**0.0%**					
Comparison	**Needs to reach MDGs for avg 49 Low-Income**							**$58**				

➢ Summary table of Priority Costs for the 1st phase of HSR FY2014-15 by unit costs

				Public health costs				Y2014-15							
Component	MDG	Cost category	Year	Y2014	Y2015	Unit	Tracer	Target Population	Coverage	Unit cost/ case	Utilization	Unit cost	Mill. US$	US$/Cap	%
Health Related MDGs	MDG 1	**Nutrition (not included in MNCH)**	2012	3.4	5.1	U5	4 interventions	857,054	43%			11.5	**8.5**	**0.62**	**2%**
	MDG 4	**Child Health**	2010	8.6	9.3	U5	*ARI treatment*	857,054	68%			15.5	**18.0**	**1.31**	**4%**
		Immunization recurrent	2011	6.6	5.7	U1	DTP-HEP B-HiB	181,658	88%			38.4	**12.2**	**0.89**	**3%**
		Immunization priority investments	2011	1.1	0.3	U2	DTP-HEP B-HiB	181,659	88%			4.3	**1.4**	**0.10**	**0%**
		Free services for Children under 5	2012	4.0	7.0	U5	U5 covered	571,369	27%	10	1.05	10.9	**11.0**	**0.80**	**2%**
	MDG 5	**Maternal Health**	2010	9.8	10.6	PW	*Delivery by SBA*	192,030	48%			111.6	**20.4**	**1.48**	**5%**
		Reproductive Health	2010	1.9	2.0	WRA	*FP coverage*	1,710,213	49%			2.3	**3.8**	**0.28**	**1%**
		Training Skilled Birth Attendants	2012	1.2	1.2	SBA/CMW	# new SBA/CMW traine	7,500	93%			1,100	**2.3**	**0.17**	**1%**
		MNCH priority investments	2013	2.5	3.5	PW	Delivery by SBA	192,030	48%			36	**6.0**	**0.44**	**1%**
		Free Maternity services	2012	3.5	5.3	PW	PW covered	192,030	78%	68	0.42	28.2	**8.8**	**0.64**	**2%**
	MDG 6	**Malaria**	2011	4.4	4.8	At Risk Pop	Sustain program	2,580,029	100%			1.8	**9.2**	**0.67**	**2%**
		HIV/AIDS	2010	8.0	7.0	At Risk Pop	Sustain program	3,419,244	100%			2.2	**15.0**	**1.09**	**3%**
		Tuberculosis	2011	2.6	3.4	Prevalence	Sustain program	37,066	100%			81.8	**6.1**	**0.44**	**1%**
	MDG 7	**Water**	2010	6.0	6.3	Rural Pop	Expand & sustain wate	5,088,078	85%			1.4	**12.4**	**0.90**	**3%**
		Sanitation	2010	4.3	4.5	Rural Pop	Expand & sustain toile	5,088,078	60%			1.5	**8.8**	**0.64**	**2%**
Non-MDG	Non-MDGs	Neglected Tropical Diseases	2011			Population	US$/Cap/year	6,360,098	100%			-	-	-	**0%**
		EID & Emergency	2011			Population	US$/Cap/year	6,360,098	100%			-	-	-	**0%**
		Non-Communicable Diseases	2011			Population	US$/Cap/year	6,360,098	100%			-	-	-	**0%**
		Others				Population	US$/Cap/year	6,360,098	100%			-	-	-	**0%**
Health systems		**Human resource development**		**85.8**	**99.7**	Staff	US$/Cap/year	*15,542*				*5,968.5*	***185.5***	***13.51***	***41%***
		Salaries & allowances	2012	84.8	98.6	Staff	US$/Cap/year	*15,542*				*5,899.3*	***183.4***	***13.36***	***41%***
		Placement of new graduates in rural settings	2013	1.0	1.1	Staff	US$/Cap/year	*15,542*				*69.3*	***2.2***	***0.16***	***0%***
		Health workforce development	2010			Staff	US$/Cap/year	*15,542*				-	-	-	***0%***
		Health Financing		**11.9**	**14.3**	Population	US$/Cap/year	*15,542*				*840.8*	***26.1***	***1.90***	***6%***
		Health Protection towards Universal Coverage	2012	11.9	14.3	Members	# of members	6,175,000				2.1	**26.1**	**1.90**	**6%**
		Subsidies to Civil Servants HI (SASS)	2012	-	-	Members	# of members	*345,000*	*100%*	*2.9*	*3.29*	-	-	-	***0%***
		Subsidies to Private employees HI (SSO)	2012	-	-	Members	# of members	*1,350,000*	*45%*	*0.1*	*2.40*	-	-	-	***0%***
		Subsidies to informal sector HI (CBHI)	2012	6.2	7.6	Members	# of members	*3,415,000*	*45%*	*1.4*	*3.35*	*4.5*	***13.9***	***1.01***	***3%***
		Subsidies to health safety net for poor (HEF)	2012	5.6	6.6	Members	# of members	*1,065,000*	*88%*	*10.0*	*0.66*	*6.6*	***12.3***	***0.89***	***3%***
		Health Financing system	2010			Population	US$/Cap/year	*6,864,037*					-	-	***0%***
		Organization, management & working style		**3.7**	**4.3**	Population	US$/Cap/year	*6,864,037*					***8.0***	***0.58***	***2%***
		Administration-Management-Coordination	2012	3.7	4.3	Population	US$/Cap/year	*6,864,037*					***8.0***	***0.58***	***2%***
		Health Services		**45.9**	**38.8**	Population	US$/Cap/year	*6,864,037*					***84.7***	***6.17***	***19%***
		Model Healthy Villages	2012	1.0	1.0	Village	# of new MHV	*5,000*	*68%*			*4,000.0*	***2.0***	***0.15***	***0%***
		Operations & Maintenance focus on PHC	2011	25.0	28.5	Population	US$/Cap/year	6,864,037	0%			3.9	***53.5***	**3.90**	**12%**
		Basic routine investments	2010	18.8	8.0	Population	US$/Cap/year	*6,864,037*				*2.0*	***26.8***	***1.95***	***6%***
		Improving Food and drug quality	2011	1.2	1.2	Population	US$/Cap/year	*6,864,037*				*0.2*	***2.4***	***0.17***	***1%***
		Information, Monitoring and Evaluation		**1.0**	**1.0**	Population	US$/Cap/year	*6,864,037*				*0.1*	***2.0***	***0.14***	***0%***
		HIS systems	2011	0.7	0.7	Population	US$/Cap/year	*6,864,037*				*0.1*	***1.4***	***0.10***	***0%***
		Monitoring & evaluation	2012	0.3	0.3	Population	US$/Cap/year	*6,864,037*				*0.0*	***0.6***	***0.04***	***0%***
		TOTAL PRIORITY RECURRENT COSTS in Mill. US$		**216**	**234**								**450**	**32.8**	**100%**

➢ List of HSR-related interventions costed for the 1st phase of HSR FY2014-15

Priority Area	Key programme areas	Interventions costed	Y2011	Y2012	Y2013	Y2014	Y2015	Y2011-15	Y2014-15	% 2014-15
MDG1	Nutrition (not included in MNCH)	**Total Nutrition**	**1.02**	**1.55**	**2.07**	**3.44**	**5.09**	**13.17**	**8.53**	**1.9%**
		Community-based nutrition (breastfeeding, complementary	0.29	0.44	0.59	1.46	2.63	5.41	4.10	0.9%
		Vitamin A and deworming	0.67	0.78	0.89	0.96	1.02	4.32	1.98	0.4%
		Multiple micronutrient powder	0.03	0.29	0.56	0.98	1.40	3.27	2.39	0.5%
		Therapeutic zinc for diarrhea	-	-	-	-	-	-	-	0.0%
		Iron Folic Acid for pregnant women	-	-	-	-	-	-	-	0.0%
		Salt iodization	0.03	0.03	0.03	0.04	0.04	0.17	0.07	0.0%
MDG4	Child Health	**Total Child health**	**6.59**	**7.58**	**8.13**	**8.64**	**9.32**	**40.27**	**17.97**	**4.0%**
		Breastfeeding Counseling	-	-	-	-	-	-	-	0.0%
		Complementary Feeding	-	-	-	-	-	-	-	0.0%
		Vitamin A	-	-	-	-	-	-	-	0.0%
		LLITNs	1.20	1.30	1.39	1.48	1.65	7.03	3.13	0.7%
		Neonatal Infections	0.00	0.00	0.00	0.00	0.01	0.02	0.01	0.0%
		ALRI/ Pneumonia	2.25	2.69	2.91	3.11	3.31	14.27	6.42	1.4%
		Diarrhoea	1.23	1.34	1.44	1.54	1.64	7.19	3.18	0.7%
		Severe Malnutrition	0.08	0.16	0.24	0.33	0.37	1.18	0.69	0.2%
		Measles Treatment	0.00	0.00	0.00	0.00	0.00	0.01	0.00	0.0%
		Deworming	-	-	-	-	-	-	-	0.0%
		Dengue Fever	0.02	0.01	0.01	0.01	0.03	0.07	0.04	0.0%
		Malaria	0.03	0.03	0.03	0.04	0.04	0.17	0.08	0.0%
		Other service delivery costs (outreach)	1.34	1.57	1.59	1.60	1.70	7.81	3.31	0.7%
		Supervision	0.18	0.21	0.23	0.23	0.25	1.10	0.49	0.1%
		IEC/social mobilization	0.06	0.07	0.07	0.07	0.08	0.36	0.15	0.0%
		Disease surveillance	0.07	0.07	0.07	0.08	0.08	0.37	0.16	0.0%
		Programme management	0.13	0.13	0.14	0.15	0.16	0.70	0.30	0.1%
	Immunization	**Total Immunization**	**6.43**	**3.70**	**5.94**	**7.63**	**5.97**	**29.68**	**13.60**	**3.0%**
		Routine vaccines	1.94	1.97	4.11	4.07	4.13	16.22	8.20	1.8%
		Routine injection supplies	0.11	0.12	0.17	0.17	0.18	0.76	0.35	0.1%
		Campaign vaccines	1.72	-	-	0.19	-	1.90	0.19	0.0%
		Campaign injection supplies	0.28	-	-	-	-	0.28	-	0.0%
		Campaign operational costs	0.90	-	-	0.81	-	1.72	0.81	0.2%
		EPI personnel costs	0.72	0.75	0.79	0.83	0.87	3.97	1.70	0.4%
		Transportation cost for outreach	0.18	0.19	0.20	0.21	0.22	0.99	0.43	0.1%
		IEC/social mobilization	0.09	0.09	0.09	0.09	0.09	0.45	0.18	0.0%
		Disease surveillance	0.08	0.08	0.08	0.08	0.08	0.40	0.16	0.0%
		Programme management	0.10	0.10	0.10	0.10	0.10	0.50	0.20	0.0%
		Equipment & infratructure	0.30	0.40	0.41	1.08	0.30	2.49	1.38	0.3%
	Free services for Children under 5	**Total Free services for U5**	-	**0.13**	**0.68**	**4.02**	**6.96**	**11.77**	**10.97**	**2.4%**
		Public subsidies for children U5	-	0.08	0.54	3.61	6.16	10.08	9.78	2.2%
		Start-up & investment costs	-	0.04	0.08	0.19	0.35	0.50	0.54	0.1%
		Administration costs	-	0.01	0.05	0.22	0.44	1.01	0.66	0.1%
MDG5	Maternal Health	**Total Maternal Health**	**6.21**	**7.18**	**9.15**	**12.31**	**14.05**	**48.90**	**26.36**	**5.9%**
		MPS.01 - ANC 1	1.23	1.42	2.25	2.49	2.70	10.09	5.19	1.2%
		MPS.02 - ANC 2								
		MPS.03 - ANC 3								
		MPS.04 - ANC 4								
		MPS.11 - Normal labour & delivery	0.63	0.69	1.05	1.11	1.16	4.65	2.28	0.5%
		MPS.05 - Anaemia in Pregnancy	0.60	0.70	0.92	1.00	1.10	4.33	2.10	0.5%
		MPS.06 - STIs and RTIs in Pregnancy								
		MPS.07 - Mild Hypertension								
		MPS.08 - Malaria in Pregnancy								
		MPS.09 - HIV in Pregnancy								
		MPS.10 - Antenatal Infection								
		MPS.12 - Obstructed Labour								
		MPS.13 - Antepartum Haemorrhage								
		MPS.14 - Postpartum Haemorrhage								
		MPS.16 - Prelabour Rupture Of Membranes								
		MPS.17 - Eclampsia								
		MPS.18 - Fetal Distress								
		MPS.19 - Caesarean Section								
		MPS.22 - Post Partum Infection								
		MPS.20 - Postpartum Care	0.26	0.32	0.45	0.51	0.56	2.10	1.07	0.2%
		MPS.21 - Postpartum Family Planning								
		MPS.23 - Routine Newborn Care 1° Hour	0.60	0.70	0.85	0.90	0.94	3.99	1.84	0.4%
		MPS.24 - Routine Newborn Care 1-24 Hours								
		MPS.25 - Routine Newborn Care 3-7 Days								
		MPS.26 - Low Birth Weight	0.65	0.76	0.96	1.09	1.22	4.68	2.31	0.5%
		MPS.27 - Birth Asphyxia								
		MPS.28 - Newborn Infection								
		MPS.29 - Newborn Malformation								
		MPS.30 - Newborn Birth Injury								
		MPS.31 - Breathing Difficulties								
		Other service delivery costs (outreach)	1.69	1.98	2.01	2.02	2.15	9.86	4.18	0.9%
		Supervision	0.23	0.26	0.28	0.30	0.32	1.39	0.61	0.1%
		IEC/social mobilization	0.08	0.09	0.09	0.09	0.10	0.45	0.19	0.0%
		Disease surveillance	0.08	0.09	0.09	0.10	0.10	0.46	0.20	0.0%
		Programme management	0.16	0.17	0.18	0.19	0.20	0.89	0.38	0.1%
		Infrastructure and Other Equipment	-	-	-	2.50	3.50	6.00	6.00	1.3%
	Reproductive Health	**Total Reproductive Health**	**1.54**	**1.69**	**1.78**	**1.86**	**1.98**	**8.85**	**3.85**	**0.9%**
		Iron and folate supplementation	1.00	1.07	1.15	1.22	1.30	5.75	2.53	0.6%
		Women contraception								
		Male contraception								
		Vasectomy and tubal ligation								
		Other service delivery costs (outreach)	0.40	0.47	0.48	0.48	0.51	2.34	0.99	0.2%
		Supervision	0.05	0.06	0.07	0.07	0.08	0.33	0.15	0.0%
		IEC/social mobilization	0.02	0.02	0.02	0.02	0.02	0.11	0.05	0.0%
		Disease surveillance	0.02	0.02	0.02	0.02	0.02	0.11	0.05	0.0%
		Programme management	0.04	0.04	0.04	0.04	0.05	0.21	0.09	0.0%
	Training Skilled Birth Attendants	**Training Skilled Birth Attendants**	**1.16**	**1.49**	**1.65**	**1.16**	**1.16**	**6.60**	**2.31**	**0.5%**
	Free Maternity services	**Total Free Maternity**	**0.15**	**0.30**	**1.24**	**3.51**	**5.26**	**10.46**	**8.77**	**1.9%**
		Public subsidies for Free Maternity	0.08	0.22	0.95	2.95	4.61	8.80	7.56	1.7%
		Start-up & investment costs	0.07	0.06	0.19	0.35	0.22	0.89	0.57	0.1%
		Administration costs	0.01	0.02	0.10	0.21	0.44	0.77	0.65	0.1%

Priority Area	Key programme areas	Interventions costed	Y2011	Y2012	Y2013	Y2014	Y2015	Y2011-15	Y2014-15	% 2014-15
MDG6	Malaria	**Total Malaria**	**4.69**	**2.43**	**3.98**	**4.38**	**4.82**	**20.30**	**9.20**	**2.0%**
		Health Products and Health Equipment	2.48	0.55	1.94	2.13	2.35	9.45	4.48	1.0%
		Medicines and Pharmaceutical Products	0.08	0.07	0.06	0.07	0.07	0.35	0.14	0.0%
		Procurement and Supply Management	0.32	0.27	0.30	0.33	0.37	1.59	0.70	0.2%
		Infrastructure and Other Equipment	0.05	0.06	0.04	0.04	0.05	0.24	0.09	0.0%
		Communication Materials	0.08	0.08	0.08	0.09	0.10	0.42	0.18	0.0%
		Planning and Administration	0.10	0.08	0.08	0.08	0.09	0.43	0.18	0.0%
		Overheads	0.28	0.27	0.27	0.30	0.33	1.46	0.63	0.1%
		Personnel costs	0.62	0.53	0.69	0.76	0.83	3.44	1.59	0.4%
		Technical assistance	0.68	0.51	0.52	0.57	0.63	2.91	1.20	0.3%
	HIV/AIDS	**Total HIV/AIDS**	**6.62**	**8.04**	**8.04**	**8.04**	**6.96**	**37.70**	**15.00**	**3.3%**
		Activities (Need to be detailed)	5.94	7.22	7.22	7.22	6.25	33.86	13.47	3.0%
		Management & recurrent Costs	0.55	0.67	0.67	0.67	0.58	3.12	1.24	0.3%
		Technical Assistance	0.13	0.15	0.15	0.15	0.13	0.72	0.28	0.1%
	Tuberculosis	**Total TB**	**3.06**	**2.42**	**2.96**	**2.64**	**3.42**	**14.49**	**6.06**	**1.3%**
		Communication Materials	0.17	0.09	0.15	0.08	0.08	**0.56**	0.15	0.0%
		Health Products and Health Equipment	0.37	0.44	0.85	0.55	0.57	**2.79**	1.12	0.2%
		Human Resources (specific to TB)	0.69	0.76	0.78	0.80	0.84	**3.86**	1.64	0.4%
		Infrastructure and Other Equipment	0.90	0.19	0.23	0.21	0.21	**1.73**	0.41	0.1%
		Living Support to Clients/Target Population	0.21	0.24	0.26	0.27	0.29	**1.26**	0.56	0.1%
		Overheads	0.08	0.11	0.16	0.18	0.87	**1.40**	1.05	0.2%
		Pharmaceutical Products (Medicines)	0.19	0.23	0.20	0.23	0.25	**1.10**	0.48	0.1%
		Planning and Administration	0.24	0.27	0.26	0.24	0.25	**1.26**	0.49	0.1%
		Technical & Management Assistance	0.21	0.08	0.07	0.08	0.07	**0.52**	0.15	0.0%
MDG7	Water	**Total Water**	**5.22**	**5.48**	**5.75**	**6.04**	**6.34**	**28.82**	**12.38**	**2.8%**
		WS investments	4.09	4.29	4.51	4.73	4.97	22.59	9.70	2.2%
		Management, activities	0.72	0.75	0.79	0.83	0.87	3.95	1.70	0.4%
		Technical assistance	0.41	0.43	0.46	0.48	0.50	2.28	0.98	0.2%
	Sanitation	**Total Sanitation**	**3.71**	**3.90**	**4.09**	**4.30**	**4.51**	**20.52**	**8.81**	**2.0%**
		RSH investments	2.91	3.06	3.21	3.37	3.54	16.09	6.91	1.5%
		Management, activities	0.51	0.53	0.56	0.59	0.62	2.81	1.21	0.3%
		Technical assistance	0.29	0.31	0.32	0.34	0.36	1.62	0.70	0.2%
Non-MDG	Total	**Total Non-MDGs related**	-	-	-	-	-	-	-	**0.0%**
Human Resource Developmen	Salaries & allowances	**Salaries & allowances**	**22.95**	**24.63**	**62.08**	**84.80**	**98.57**	**293.04**	**183.37**	**40.7%**
	Placement of new graduates in rural settings	**Placement of new graduates in rural settings**	-	-	-	**1.03**	**1.13**	**2.15**	**2.15**	**0.5%**
	Health workforce development	**Total health workfore development**	-	-	-	-	-	-	-	**0.0%**
Health Financing	*Establishing Sustainable financing: SHP*	***Total Social Health Protection***	***1.11***	***3.01***	***8.00***	***11.87***	***14.26***	***38.26***	***26.13***	***5.8%***
	Contributions to Civil Servants HI (SASS)	**Contributions to Civil Servants HI (SASS)**	-	-	-	-	-	-	-	**0.0%**
	Contributions to Private employees HI (SSO)	**Contributions to Private employees HI (SSO)**	-	-	-	-	-	-	-	**0.0%**
	Subsidies to informal sector HI (CBHI)	**Total Subbsidies to informal sector HI (BHI)**	**0.18**	**0.57**	**3.27**	**6.23**	**7.64**	**17.88**	**13.87**	**3.1%**
		Public subsidies to HI premium	-	-	2.32	5.26	6.49	14.07	11.75	2.6%
		Start-up & investment costs	0.18	0.57	0.67	0.55	0.82	2.79	1.38	0.3%
		Administration costs	-	-	0.28	0.42	0.32	1.02	0.75	0.2%
	Subsidies to health safety net for poor (HEF)	**Total subsidies to health safety net for poor (HEF)**	**0.93**	**2.44**	**4.74**	**5.65**	**6.62**	**20.37**	**12.27**	**2.7%**
		Public subsidies to HI premium	0.68	1.92	3.87	4.74	5.86	17.06	10.59	2.4%
		Start-up & investment costs	0.12	0.19	0.29	0.34	0.29	1.23	0.63	0.1%
		Administration costs	0.14	0.34	0.58	0.57	0.47	2.09	1.04	0.2%
	Health Financing system	**Total health financing system**	-	-	-	-	-	-	-	**0.0%**
Organizatio n, managemen	Strengthening health systems	**Strengthening health systems**	-	-	-	-	-	-	-	**0.0%**
	Administration-Management-Coordination	**Administration-Management-Coordination**	**1.56**	**2.01**	**2.98**	**3.75**	**4.28**	**14.58**	**8.03**	**1.8%**
	Combining use of modern & traditional medicines	**Combining use of modern & traditional medicines**	-	-	-	-	-	-	-	**0.0%**
	Promoting PPP	**Promoting PPP**	-	-	-	-	-	-	-	**0.0%**
Health Services	Model Healthy Villages	**Model Healthy Villages**	**2.00**	**1.00**	**1.00**	**1.00**	**1.00**	**6.00**	**2.00**	**0.4%**
	Quality improvement of hospitals & referral syste	**Quality improvement of hospitals & referral system**	-	-	-	-	-	-	-	**0.0%**
	Modernizing hospitals	**Modernizing hospitals**	-	-	-	-	-	-	-	**0.0%**
	Operations & Maintenance at facilities	**Operations & Maintenance at facilities**	**10.42**	**13.40**	**19.84**	**25.00**	**28.53**	**97.18**	**53.53**	**11.9%**
	Basic investments	**Total Basic investments**	**6.59**	**18.30**	**8.87**	**18.77**	**8.04**	**60.57**	**26.81**	**6.0%**
		Construction & Rehabilitation	3.79	9.59	4.89	9.59	4.13	32.00	13.72	3.0%
		Equipment	1.61	6.61	1.61	6.61	1.12	17.55	7.73	1.7%
		Referral equipment	1.19	2.10	2.37	2.57	2.79	11.02	5.36	1.2%
	Improving Food and drug quality	**Total Food & Drug Quality**	**1.00**	**1.05**	**1.10**	**1.15**	**1.21**	**5.50**	**2.36**	**0.5%**
		Programme improvement of Food & Drug	0.63	0.67	0.70	0.73	0.77	3.50	1.50	0.3%
		IEC regarding Food & Drugs	0.10	0.11	0.11	0.12	0.12	0.56	0.24	0.1%
		Administration and improvement of services F&D	0.26	0.27	0.29	0.30	0.32	1.44	0.62	0.1%
Information, Monitoring and Evaluation	HIS systems	**Total HIS Systems**	**0.02**	**0.20**	**2.85**	**0.70**	**0.70**	**4.46**	**1.39**	**0.3%**
		Equipments	-	-	2.76	0.67	0.67	4.10	1.34	0.3%
		Communication Materials	0.01	0.01	0.01	0.01	0.01	0.06	0.02	0.0%
		Planning and administration	-	0.01	-	-	-	0.01	-	0.0%
		Technical & Management Assistance	0.01	0.18	0.07	0.01	0.01	0.28	0.03	0.0%
	Monitoring & evaluation	**Monitoring & evaluation**	**0.29**	**0.29**	**0.29**	**0.29**	**0.29**	**1.43**	**0.57**	**0.1%**
	Research	**Research**	-	-	-	-	-	-	-	**0.0%**
	TOTAL HSR COSTS		92.33	109.76	162.47	216.31	233.85	814.71	450.15	100.0%

➢ List of interventions costed non-directly HSR-related for the 1st phase of HSR FY2014-15

Priority Area	Key programme areas	Interventions costed	Y2011	Y2012	Y2013	Y2014	Y2015	Y2011-15	Y2014-15	% 2014-15
Non-MDGs	**Total**	**Total Non-MDGs related**	**8.99**	**7.16**	**7.58**	**8.03**	**8.51**	**40.27**	**16.54**	**9.9%**
	Neglected Tropical Diseases	Neglected Tropical Diseases	0.94	1.04	1.14	1.25	1.38	5.75	2.63	1.6%
	EID & Emergency	EID & Emergency	3.22	3.38	3.55	3.72	3.91	17.78	7.64	4.6%
	Non-Communicable Diseases	Non-Communicable Diseases	4.83	2.75	2.89	3.05	3.22	16.74	6.27	3.8%
	Others	Others				-	-	-	-	0.0%
Human Resource Development	Health workforce development	**Total health workfore development**	**7.64**	**8.05**	**7.97**	**7.95**	**7.95**	**39.55**	**15.89**	**9.5%**
		Quality improvement of health personnel training -Educatio	1.00	1.41	1.33	1.31	1.31	6.36	2.62	1.6%
		Pre-service training of all categories of Health personnel	4.64	4.64	4.64	4.64	4.64	23.19	9.27	5.6%
		In service training of all categories of Health personnel	2.00	2.00	2.00	2.00	2.00	10.00	4.00	2.4%
Health Financing	***Establishing Sustainable financing: SHP***	***Total Social Health Protection***	-	-	-	-	-	-	-	***0.0%***
	Contributions to Civil Servants HI (SASS)	**Contributions to Civil Servants HI (SASS)**						-	-	**0.0%**
	Contributions to Private employees HI (SSO)	**Contributions to Private employees HI (SSO)**						-	-	**0.0%**
	Subsidies to informal sector HI (CBHI)	**Total Subbsidies to informal sector HI (BHI)**	-	-	-	-	-	-	-	**0.0%**
	Subsidies to health safety net for poor (HEF)	**Total subsidies to health safety net for poor (HEF)**	-	-	-	-	-	-	-	**0.0%**
	Health Financing system	**Total health financing system**	**1.22**	**1.22**	**1.42**	**1.39**	**1.01**	**6.27**	**2.41**	**1.4%**
		Make districts accountable for the funding they receive thro	0.10	0.10	0.10	0.11	0.11	0.52	0.22	0.1%
		Strengthen the capacity of hospitals at all levels to provide a	1.03	1.05	0.97	0.89	0.85	4.78	1.74	1.0%
		Develop and implement an operational plan to merge all exi	0.04	0.02	0.30	0.34	0.00	0.71	0.35	0.2%
		Limit the negative effects of user fees for the uninsured in g	0.05	0.05	0.05	0.05	0.05	0.25	0.10	0.1%
Organization, management & working	**Strengthening health systems**	**Strengthening health systems**						-	-	**0.0%**
	Administration-Management-Coordination	**Administration-Management-Coordination**						-	-	**0.0%**
	Combining use of modern & traditional medicines	**Total Combining use of modern & traditional medicines**	-	-	-	**7.70**	**3.30**	**11.00**	**11.00**	**6.6%**
		Construction Traditional Medicinal Center	-	-	-	7.70	3.30	11.00	11.00	6.6%
	Promoting PPP	**Promoting PPP**	-	-	-	-	-	-	-	**0.0%**
Health Services	**Model Healthy Villages**	**Model Healthy Villages**						-	-	**0.0%**
	Quality improvement of hospitals & referral syste	**Quality improvement of hospitals & referral system**	**12.54**	**12.91**	**28.09**	**29.74**	**45.82**	**129.10**	**75.56**	**45.3%**
		Construction & Rehabilitation of health facilities	12.54	12.91	28.09	29.74	45.82	129.10	75.56	45.3%
	Modernizing hospitals	**Modernizing hospitals**	**5.37**	**5.53**	**12.04**	**12.74**	**19.64**	**55.33**	**32.38**	**19.4%**
		Construction & Rehabilitation of health facilities	5.37	5.53	12.04	12.74	19.64	55.33	32.38	19.4%
	Operations & Maintenance at facilities	**Operations & Maintenance at facilities**						-	-	**0.0%**
	Basic investments	**Total Basic investments**						-	-	**0.0%**
	Improving Food and drug quality	**Total Food & Drug Quality**	-	-	-	**7.00**	**3.00**	**10.00**	**10.00**	**6.0%**
		Construction food analysis & research center	-	-	-	7.00	3.00	**10.00**	10.00	6.0%
Information, Monitoring	**HIS systems**	**Total HIS Systems**	-	-	-	-	-	-	-	**0.0%**
	Monitoring & evaluation	**Monitoring & evaluation**	-	-	-	-	-	-	-	**0.0%**
	Research	**Research**	**1.51**	**1.51**	**1.51**	**1.51**	**1.51**	**7.53**	**3.01**	**1.8%**
	TOTAL NON HSR COSTS		**24.72**	**23.47**	**58.60**	**76.05**	**90.74**	**299.03**	**166.79**	**100%**

Annex 4 - M&E INDICATORS MATRIX

No	Input	No	Output/Process	No	Outcomes	No	Impact
					National MDG targets met (see MGD table)		
			HRH				
1	Total health expenditure per capita	18	Number and % new graduate that allocated to rural/remote areas (by administrative levels, by facility, skills)	58	% of rural, remote villages with at least one trained (6 months) village health worker (VHW)	81	Life expectancy at birth
2	General Government Health Expenditure as % of General Government Expenditure	19	*% health workforce at rural and remote location express their satisfaction with their motivation package provided???*	59	Health workers per 10,000 population	82	Infant mortality ratio (per 1000 live births)
3	Government health expenditure from domestic sources as % of GGE	20	% health facilities that all have specific job descriptions for all of its posts (aggregated by facility types; provinces)	60	Health facilities per 10,000 population (by type)	83	Under-5 mortality ratio (per 1000 live birth)
4	Quota of health workers granted annually by health facility types and skills, administrative levels	21	% of health facilities without low-level training health workers	61	% of women of reproductive age who receive free MNCH services (by provinces, districts and rural/urban)	84	Maternal Mortality Ratio (per 100 000 live births)
5	Non-wage expenditure as % of national health expenditure or GGE	22	% hospitals that have medical training unit to support clinical training (central, provincial levels)	62	% of population covered by any of the social health protection (SHP) schemes (by schemes, province, districts, poor)	85	Mortality by major cause of deaths by sex and age
6	Number and ratio of doctors, nurses and midwives per 10,000 population (by rural/urban; provinces; doctor/nurse/midwives)	23	% of health professional training graduates from university that passed the final exams (by skill types)	63	Number of health centre and district hospitals that have the proper funding mechanism for performance improvement	86	TB prevalence among adult population

No	Input	No	Output/Process	No	Outcomes	No	Impact
7	Annual number of graduates of doctors, nurses, midwives and pharmacists	24	HRH information system provides enough evidence for the HRH planning and allocation of staff at all administrative levels	64	Governance and health system management effectiveness status???	87	Malaria incidence
8	% of hospitals with obstetrician and gynaecologist		**Health Financing**	65	% of villages certified as 'healthy village model' according to the national standards	88	Mortality caused due to Malaria
9	% of recurrent non-wage budget for health centres and district hospitals	25	Number and % of districts that have sufficient funds to cover the free MNCH services	66	% total population with improved access to sanitation	89	Adolescent birth rate
10	% of deaths that are registered	26	The national health account is conducted on regular bases	67	% of health facilities have adopted the quality assurance measure	90	HIV prevalence among adults (15-49)
11	Progress status of the policy matrix (status of policy and legislative requirements met)	27	Financial Audit conducted regularly and clear of issues	68	Children under 5 years underweight for age (%)	91	Mortality due TB (per 100,000 population
12	Total number of health workforce employed in the public health sector (disaggregated by skills and work allocations)	28	Unified financial reporting forms (Chapter 4 of the HMIS) is revised and used for financial tracking and reporting at facility level	69	Children under 5 years stunted for age (%)	92	Reported Incidence of ARI among under 5
13	Number and % of health centre have at least 01 community or mid-level midwife (by province, rural/urban)	29	A common agreed provider payment mechanism is adopted across health facilities	70	Birth attended by skilled health personnel (%)	93	Reported Incidence of diarrhoea among under 5 years
14	Number and % of trained health workers have been officially deployed to health facilities nationwide (by skills)	30	Number and % of districts and provinces that have harmonised management system for all existing SHP schemes through the National Health Insurance Agency	71	Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	94	Prevalence of anaemia among pregnant women

No	Input	No	Output/Process	No	Outcomes	No	Impact
15	% of health facilities have health workforce according the national standards (by types of facility, skills, sex and administrative levels)		**Governance, Management and Coordination**	72	Measles immunization coverage (%)	95	Prevalence of diabetes mellitus
16	The annual provincial health sector work plan is endorsed and funded by government (central and provincial levels) and development partners	31	A management structure for HSR is established according to the PM Decree by Q3 2013	73	Children under 5 treated with appropriate anti-malarial drugs (%)	96	Out – of – pocket expenditure as % of Total Health Expenditure
17	% of births that are registered	32	An OiC is appointed under the MOH Decree	74	Contraceptive prevalence rate (by type of contraceptive)	97	Incidence of catastrophic health expenditure amongst socio-economic groups
		33	Provincial Governor appointed OiC with roles and responsibilities for the HSR implementation	75	% of unmet needs for family planning		
		34	The HSR team is established in MOH by Dec 2013	76	Number and % of patient referred from lower level health facilities to provincial and central level hospitals) according the national standards		
		35	The M&E system for HSR is established and annual review and report is conducted to support planning at all levels.	77	Number and % of public health facilities able to provide statistical report timely and accurately		
		36	Number of provinces implementing joint planning with other stakeholders working in the provinces	78	ANC coverage (at least 1 time)		

No	Input	No	Output/Process	No	Outcomes	No	Impact
		Service Delivery		79	TT2+ coverage among pregnant women (%) by provinces and districts		
		37	Service Availability and Readiness Assessment scores	80	Caesarean section rate % (by provinces)		
		38	Number and % of health centres and district hospitals that have availability of essential medicines as listed in the national list				
		39	Median price ratio for tracer medicines (public procurement prices for selected medicines in comparison to international reference price)				
		40	Outpatient visit per person per year (by health facility types, administrative levels)				
		41	Outpatient per health staff ratio by facility types, admin. Levels				
		42	In-patient days per health staff ratio (by health facilities)				
		43	Bed occupation rate (day) by facility type and levels				
		44	Number of health centres and district hospitals that have been upgraded to enable to deliver MNCH services in the last 12 months				
		45	Number and % of villages that have received to outreach or mobile services in the last 12 months				

No	Input		No	Output/Process		No	Outcomes		No	Impact
			46	Number and % people seen by village health workers for PHC services						
			47	Number of provinces with a functional provincial hospital drug and therapeutic committee						
			48	Number and % of hospitals that have adopted quality assurance measure in the last 12 months (by type of hospitals)???						
			49	Number and % of health facilities that meet the national standards for infection control in the last 12 months???						
			50	Number and % of villages and districts that have a locally adopted arrangement for referral to higher level of health facilities in the last 12 months						
			51	Number of health facilities reported stock-out of essential drugs, vaccines and family planning methods in the last 12 months (by levels and facility types)						
				Health Information System						
			52	The National Health Statistic Report is established annually with a standard set of national indicators and evidences for recommended policy and actions						
			53	Number of provinces and districts that submitted the routine report on time, according to the guidelines by facility type						

No	Input		No	Output/Process		No	Outcomes		No	Impact
			54	Number of provinces and districts that conducting data quality audit and quality assessment in the last 12 months by						
			55	Number of health facilities produce health information report applied ICT applications by facility types						
			56	Baseline for HSR is developed						
			57	Number and % of health facilities applied ICD (by facility types)						

HEALTH RELATED MDG INDICATORS TRACKING

Health Related MDGs Indicators		1990	1995	2000	2005 [ii]	2009	2010	2012	2013	2014	Target [ii] 2015
Target 1C: Halve, between 1990 & 2015, the proportion of people who suffer from hunger											
1.8	Prevalence of underweight children under 5 years		44(1)	40	37(2)		27(10)				22%
1.8A	Prevalence of stunting in children under 5 years		48(1)	42	40(2)		38(10)NCHS.Std. 44(10)WHO.Std.				34 %
Target 4A: Reduce by two-thirds, between 1990 & 2015, the under-5 mortality rate											
4.1	Under-5 mortality rate		170	107	98		73(10)				70
4.2	Infant mortality rate		104	82	70		68(10)				45
4.3	Proportion of 1 year-old children immunized against measles		68	60	69		55(10)				90%
Target 5A: Reduce by three-quarters, between 1990 & 2015, the maternal mortality ratio											
5.1	Maternal mortality ratio (deaths per 100,000 live births)		650	530	405		357(10)				260
5.2	Proportion of births attended by skilled birth personnel		14(3)	17	23(4)		42(10)				50%
Target 5B: Achieve, by 2015, universal access to reproductive health											
5.3	Contraceptive prevalence rate		20(3)	32	38		50(10)				55(5)
5.4	Adolescent birth rate (number of births per 1,000 adolescents)			96	76		94(10)				No
5.5	Antenatal care coverage (ANC1)			21	28.5		54(10)				60(5)
5.6	Unmet need for family planning			40	27		20(10)				No
Target 6A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS											
6.1	HIV prevalence among general population (%)			0.1	0.18	0.2	0.25	0.28			<1%
	HIV prevalence among high risk groups, 15-24 years (%)			0.03	1.83		1.38	1.2			<5%
	HIV prevalence among MSM, 15-49 years (%)			0.38	1.26		2.12	2.44			<5%

6.2	Percentage of condom use of high risk groups (%)				91.4	78.04	95	92.5			95%
6.3	Proportion of population aged 15-24 with comprehensive knowledge of HIV/AIDS										
	Young women aged 15-24							24[10]			
	Young men aged 15-24							28[10]			
	Women aged 15-49							23[10]			
	Men aged 15-49							30[10]			
Target 6B: Achieve, by 2015, universal access to treatment for HIV/AIDS for all who need it											
6.4	Percentage of adults and children with advanced HIV infection receiving ARV				40.77		50.83	55.36			>90%
Target 6C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases											
6.5	Malaria incidence (per 1000 pop.)	10[6]	12	8.1	3.5	2.8	3.5	2.7			0.6
	Death rate associated with malaria (per 100,000 pop.)	9	14	7.1	3.5	1.4	0.4	0.3			0.2
6.6	Proportion of children under 5 sleeping under insecticide - treated bed nets - any bed net				18 82	41 87	81.2 97.9				90%
6.7	Proportion of under 5 testing positive for malaria who are treated with anti-malaria drugs					98%	95%	93%			
6.8	Incidence of tuberculosis (per 100 000 pop.)	492	403	330	270		213				240
	Prevalence of tuberculosis (per 100,000 pop.)	1500	1200	900	700		540[8]				750
	Mortality rate due to tuberculosis (per 100,000 pop.)	41	29	21	16		11[8]				22.5
	Proportion of tuberculosis cases detected and cured under DOTS: - Detected - Cured	50	20 48	49 77	74 90		72[9] 91				70 85
Target 7C: Halve, by 2015, the population of people without sustainable access to safe drinking water and basic sanitation											
7.8	Proportion of population using an improved drinking water source (%)	28	44	52	57[7]		70[10]				80%
7.9	Proportion of population using an improved sanitation facility (%)	8	29	37	49[7]		59[10]				60%

Acknowledgement

The development process of the Health Sector Reform Strategy and the Reform Framework in this document evolved under the leadership and guidance of H.E. Prof. Dr. Eksavang Vongvichit. Under the leadership and guidance of the Health Sector Reform Committee, the initial drafting process of this Health Sector Reform Document was undertaken by a Technical Focal Point Team with members from all departments and centres within the Ministry of Health. This process was coordinated by the Director General of the Department of Planning and International Cooperation - Dr. Prasongsidh Boupha; Deputy Director - Dr. Founkham Rattanavong and their team in the Department of Planning and International Cooperation. Gratitude is expressed to all members of the Technical Focal Point team in particular to Dr. Chanthakhath Paphassarang and Dr. Khampasong Theppanya (Priority area 1); Dr. Khotsaithoun Phimmasone (Priority 2); Dr. Founkham Rattanavong; Dr. Soulivanh Pholsena; Dr. Bounfeng Phoummalaysith (Priority 3); Dr. Bounnack Xaysanasonkham, Dr. Manisone Oudom; Dr. Chandavone Phoxay; Dr. Lamphone Syhakhang (Priority 4); Dr. Bounserth Keoprasith, Dr. Chansaly Phommavong (Priority 5).

Special thanks also goes to the following for their technical and financial support and contribution throughout the development process of this framework: Dr. Liu Yunguo – WHO Lao representative, Dr. Asmus Hammerich, Dr. Gao Jun, Dr. Valeria De Oliveira Cruz of the health system unit and other technical staff in WHO Lao Office; Dr. Annie Chu, Dr. Gulin Gedik, Dr. Klara Tisocki; and Dr. Xu Ke from WHO Western Pacific Regional Office; Dr. Azusa Iwamoto, Dr. Shin-Ichiro Noda and Ms. Halumi Kobayashi from JICA. The work and contribution of international experts are highly valued, especially the work of Dr. Shenglan Tan for the facilitation of the development process for the health sector reform strategy document; Dr. Christopher Scarf; Dr. Chu Hong Anh; Mr. Jean-Marc Thome – WHO consultants and other consultants supported through WHO and JICA in the process.

Finally, the Ministry of Health would like to express their sincere thanks to all of its staff, the concerned staff in the line ministries (Ministry of Finance; Ministry of Planning and Investment; Ministry of Home Affairs), the National Assembly and other development partners for their support and inputs throughout the development process of this document.

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