PROVINCIAL HPG MEETING MINUTES

North Star Hotel (Sa Pa, Lao Cai), 02 August 2016

GENERAL INFORMATION

Date and time	8:30 Tuesday 02 August 2016 (01 day, morning for plenary meeting; afternoon for site visit)
Venue	North Star Hotel, Ngu Chi Son, Sa Pa, Lao Cai
Chairpersons	▪ Dr. Trần Thị Giáng Hương, ICD Director General, Ministry of Health ▪ Mr. Đặng Xuân Thanh, Vice Chairman of Lao Cai People's Committee ▪ Dr. Lokky Wai, Representative, World Health Organization Vietnam
Participants	~ 200 official participants
Theme	**Designing local health systems for health equity and universal health coverage: Contextualizing the family medicine approach**
Main content	1. Local health system for health equity and universal health coverage: Can the family medicine approach contribute? 2. Family medicine in Viet Nam: proposal, pilot implementation and plan of development in 2016-2020 3. Sharing perspectives/interventions of provinces/ agencies under MOH/ DPs/ INGOs on developing family medicine integrated with local health system
Agenda & Presentations	*See Annexes*

ABBREVIATIONS (ALPHABET ORDER)

CSOs	Civil-Society Organizations
DOH	Department of Health
DPF	Department of Planning and Finance
DPs	Development Partners
FM	Family medicine
FMCs	Family medicine clinics
HPG	Health Partnership Group
HRH	Human Resources for Health
ICD	International Cooperation Department
INGOs	International Non-Governmental Organizations
MDGs	Millennium Development Goals
MOH	Ministry of Health
NCDs	Non-communicable diseases
NTPs	National Targeted Programs
SEDP	Social and Economic Development Plan
SDGs	Sustainable Development Goals
TBs	Tuberculosis
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHPD	Vietnam Health Partnership Document
WHO	World Health Organization

CONTENT

1. OPENING REMARKS

1.1. Dr. Tran Thi Giang Huong, Director General, ICD, MOH

According to Dr. Giang Huong, in the context of increasing NCDs and aging population in Vietnam, it is necessary to pay high attention to an effective, comprehensive, sheeted?? and people-oriented primary healthcare system in order to address the problems. To build and well develop the primary healthcare system, there might be different approaches, in which Family Medicine (FM) model is one of the typical examples that have been successfully applied in some countries. In the current context of Vietnam, FM model aims at providing comprehensive and continuous primary healhcare with high quality, helping to prevent and screen diseases as well as boosting family-community bond in enhanching/promoting people's health. With such a mandate, FM will help reduce hospital overcrowding and strengthen grassroots health system – 2 out of 9 priorities of the health sector priorities in the period 2016-2020. Dr. Huong shared that the FM model was piloted in 8 cities/provinces across the country and gained a number of results. However, there are still difficulties in terms of infrastructure and facilities, human resources and finance to develop and operate FM model in order to support the grassroots health system effectively and sustainability at local level. Therefore, Dr. Giang Huong hoped that participants would have objective and practical discussions on FM model in the linkage with grassroots healthcare system and on the possibility of developing FM in provinces.

1.2. Mr. Dang Xuan Thanh, Vice Chairman, Lao Cai People's Committee

According to Mr. Thanh, during the past time, although Lao Cai has got significant socio-economic development, it still remains a disadvantaged province. The development of the healthcare network is not synchronous, lacking qualified human resources. Complicated disease pattern still persist, featuring both characteristics of moutainous area and characteristics of a developing economic region. The number of of projects funded by international donors are declining, while the additional resources from national and provincial budget are not sufficient to accomplish and sustain health goals such as MDGs or other prioritized tasks. Health insurance coverage at remote areas is limited, and NCD committed cases/incidence are on increase. Therefore, Mr. Thanh hoped that the provincial HPG meeting 2016 in Lao Cai could facilitate the linkage and promote discussion of mutual-interest issues in developing grassroots health, especially healthcare for households at communities, maternal and child care at remote, and disadvantaged areas where mostly residented by ethnic minority people.

1.3. Dr. Lokky Wai, Representative, World Health Organization in Vietnam

Dr. Lokky Wai considered Vietnam's health system being at the crossroad, where there is significant improvement in the health of the population but health inequity and disparities in health outcomes still remain with the poor and the vulnerable populations. In the meantime, Vietnam is facing double-disease burden where NCDs are now the most

significant cause for morbidity and early deaths, while CDs remain and become more difficult to control, prevent and treat. It is not to include emerging diseases which are threatening the resilience of our health system. In order to tackle those issues, Dr. Lokky Wai emphasized the importance of strengthening our local health system, which can be translated into the decentralization to local government and the community. According to Dr. Wai, the most important determinant of good health can be found in the community, for example, resources within the community are more readily available than the resources coming from the national government level; investments for health can be easily mobilized at local level; and diseases can be treated in the community, and early detection and prevention starts with the community.

On behalf of WHO Vietnam, Dr. Lokky Wai encouraged MOH for its strong focus on strengthening the grassroots health system which is the right direction to go. And he looked forward to facilitating the discussion on family medicine, which should not be a substitute but value added to the existing health system.

1.4. Ms. Astrid Bant, Representative, UNFPA Vietnam

Ms. Bant mentioned the initiative that UNFPA has been supporting MOH to implement activities along the Circular on the establishment of the network of ethnic minority midwives as an example of cost-effectiveness of investing into local human resource. Under the Circular, each midwife should receive the allowance of 300-500,000 VND/month which is very small, but the outcomes are extremely important and highly cost-effective, since those trained midwives have been serving ethnic pregnant minority women right in the communities, and help prevent the complications of prenancy and deliver safely over 30 provinces. UNFPA representative encouraged provincial authorities to continue supporting these ethnic minority midwives by allowing funding from local resources. Ms. Bant also called for attention and encouraged all sides to join UN to support the implementation of the projects that are worth piloting or need to be scaled-up.

2. PRESENTATIONS

2.1. Local health system for health equity and universal health coverage: Can the family medicine approach contribute? (Dr. Socorro Escalante, Health System Development Team Coordinator, WHO)

Dr. Socorro reinforced two important points when providing the general overview on the health system of Vietnam, which describes health as (1) not just the absence of disease but it is the state of mental, physical and social well-being; and (2) there are social determinants of health that impact the conditions of individuals. Dr. Socorro highlighted the uneven progress of health development in Vietnam where access to health services remain low among ethnic minority groups, aging populations and people living in hard-to-reach areas. These inequities are being complicated by changing patterns of diseases, and it is growing over the past few years. The comparison provided by Dr. Socorro on

one commune health station in Cao Bang and one hospital in Dong Nai showed the disparities in investments across different parts of the country and of the health system, which leads to the disparities in health outcomes. Dr. Socorro also recalled the statistic of maternal and infant mortality rate, in which it is 4 times and 3 times higher in ethnic minority than in general population. This posed the question of what are the critical actions that the Vietnamese government, particularly MOH in collaboration with decentralized local authorities need to put attention to. According to Dr. Socorro, we need a well-designed health system, a service delivery structure that meets the needs of the people at local communities, a healthy environment and a strong local government. These would help Vietnam address health inequity and the challenges it has to face in the new time.

Dr. Socorro similed the health service delivery structure of Vietnam as the tree, where MOH is the trunk – the foundation of all policies and regulations; the branches are provincial and district hospitals and commune health stations – which should be able to reach the most difficult areas; and the green leaves are communities. In order to ensure that the leaves are healthy, it is needed to develop a strong service delivery network and to find the way for the provincial and district hospitals and commune health stations to be integrated and support each other. The network of services is not just about the local health stations providing curative services but also about environmental factors that impact the health of the population. In the assessement on the impact of the environment on population health conducted by WHO in 2004, it was discovered that 94% of diarrhea could be attributed to environmental factors such as lack of clean water and poor sanitation. In Soc Trang, 50% of households at hard-to-reach areas do not have latrines, and in Vietnam in general, 150-200 out of 100,000 people died because of factors caused by the environment, which is almost as high as maternal mortality rate 15 years ago. This is to show how a healthy environment is impacting the health of the population, and all issues need to be taken into consideration. Lastly, Dr. Socorro emphasized that local government and communities need to initiate actions and innovations at local level, to have local approaches and mobilize local resources. The community need to be well-informed, be able to adapt to health interventions, and contribute to health outcomes. She once again highlighted the need to focus on hard-to-reach areas and vulnerable populations, and confirmed that WHO and DPs have always been trying to advocate local government for supporting national government in ensuring that no one is left behind in health.

2.2. Family medicine in Viet Nam: proposal, pilot implementation and plan of development in 2016-2020 (Dr. Tran Quy Tuong, Deputy Director, Medical Services Administration, MOH)

In Vietnam, family doctors are general practitioners, who take care of the population's health basing on the principle of comprehension and continuity. It means that, they provide comprehensive care to patients of all ages with all sorts of conditions, from prevention, consultation, disease screening to treatment, during patients' whole lives. They are the physicians who are most close to people, households and communities.

Dr. Tuong emphasized the benefits that family medicine (FM) can bring to the population, to family doctors themselves and to the society and the health system, in which the most significant function of family medicine is comprehensive, continuous,

friendly, low-cost, human-oriented primary health care and contributing to reducing hospital overcrowding.
Dr. Tuong introduced the project on "Developing the model of family medicine clinics in Viet Nam for period 2013 – 2020", which is divided into 2 phases: (1) piloting at 8 cities/provinces from 2013-2015, and (2) scaling-up all-over the country from 2016-2020. The results of the piloting phase confirmed the possibility of scaling up the model, with the target of ensuring 80% of central cities/provinces to implement the FM model by 2020.
He affirmed that FM model will be integrated with local health system, and there is no separated system for it. MOH adopted two models of FM: a) Commune health stations operating according to FM principles, and b) Private FM clinics or FM clinics belonging to district general hospitals. FM model (a) is evaluated to be suitable for Vietnam situation. When operating according to FM principles, besides basic tasks of a commune health station, those stations will be in charge of taking care of individuals, households and communities, providing health consultation, screening and early detection.
According to Dr. Tuong, the development of legal documents on FM is one of the important solutions for developing the model in Vietnam, including regulations on financial mechanism, health insurance payment method, patient profile templates, consultation fee or transportation fee for family doctors when providing medical services at people's homes. Besides the funding for FM project implementation from donors and loans of development banks, Dr. Tuong suggested that provinces allocate budget for implementing the project. He wished to receive comments in the meeting so that the project on FM development in Vietnam to be successfully implemented in the coming time.

See annexes for full presentations.

3. DISCUSSION

- **Mr. Lalit Patra, Water and Hygienic Sanitation Team Leader, UNICEF**

Mr. Lalit raised two points on the importance of clean environment and the 1000-day care of maternal and child health. He affirmed that sanitation can be the most preventive aspect of properly health in addition to immunization. In Vietnam, there has been analysis that children under 5 who reside in villages where people using latrines are 3.7 cm taller than children in open defecation areas, which means that environmental factors can have big impacts on health. Hospital overcrowding can be reduced by half if preventive measures are put in place. Regarding the 1000-day concept, starting from day of pregnancy until the child is 2.5 years age, Mr. Lalit affirmed that if all kind of cares are paid attention to including immunizations, mother's care, internatal, postnatal and so on, the child will come out very robust and mortality rate reduces.
Mr. Lalit also highlighted the importance of having latrines and access to safe drinking water as those are also medicine that helps prevent a lot of diseases. It is therefore needed to develop a mechanism or a full diagram that place those elements in the overall health development of the community. He mentioned the issue of nutritional deficiency in daily diet that caused stunting rate in the country (26% of children under 5 years old are

stunted). By this, he emphasized the importance of preventive part in health service delivery, and suggested training family medicine doctors on this issue.

- **Dr. Le Van Hoi, Deputy Director, National Lung Hospital**

Dr. Le Van Hoi raised the question: Under the current changes of the health system with aging population, climate change, changing disease patterns and NCDs, where FM services would be placed; what components of Vietnam health system that FM is attached to, especially with regards to grassroots health system; how they would provide their services under the support of local public health system; and to whom and what resources they would be supported by? How FM is linked with our developing private health system? Dr. Hoi expected that the meeting would have a lot of opinions from experts so that those questions could be answered

- **Mr. Dang Xuan Thanh, Vice Chairman, Lao Cai People's Committee**

Mr. Thanh thanked Dr. Tuong for providing basic knowledge on FM, which serves as the foundation for detailed discussion on the issue. Mr. Thanh shared that the FM model is still a vague concept for Lao Cai, since the HRH in Lao Cai is limited, with the total number of health staff being of 3000 people including 672 doctors who do not work at local health facilities but at public hospitals, and mostly local health services depend on village health workers. Mr. Thanh posed the question that in the next 5-7 years, whether the retired doctors could join family doctors network, and he hoped to listen to experiences of other provinces on the issue.

- **Assoc. Prof. Trinh Thi Ly, Deputy Director, Hai Phong DOH, Head of Family Medicine Division of Hai Phong Medical & Pharmaceutical University**

Dr. Ly affirmed that, FM physicians are doctors for primary health care with the mandate of exploring and evaluating risk factors, and consulting for screening and immunization. Family doctors must be internists who provide out-patient health care instead of taking care of patients at hospital. According Dr. Ly, we are investing ineffectively when a lot of high-tech equipment are provided for primary health care, while overcrowding is still happening at higher-level hospitals. The difference between FM model and other models, and its humanity lies in the fact that FM focuses on the patient as a human and related factors such as family medical history and living environment other than focusing on the disease itself.

Up to now, Hai Phong has established 9 FMCs, in which 5 clinics have operated since 2006, and the clinics have well complied with FM principle.

According to Dr. Ly, FM can bring a lot benefits for the people such as convenience in linking with medical services, low cost, comprehensive health care. However, the FM health staff has not got adequate compensations. Therefore, Ms. Ly gave some suggestions in order to ensure their benefits, including (1) developing policies for family doctors; (2) training for more family doctors to meet the demand of the health sector; and (3) allowing health insurance payment at commune level.

- **Mr. Phan Thanh Hai, Deputy Director, Thai Binh DOH**

Dr. Hai mentioned the issue on human resources for FM, in which besides the difficulty in HR training following FM principle, i.e. they must be general doctors with additional the knowledge on FM, there is difficulty in mobilizing those human resources to work at health stations. Dr. Hai raised the question that whether the number of more than 900 general doctors come to work at local health stations after training, or they would work at provincial and district hospitals. If so, is it considered a waste in funding for the training of those doctors?

Regarding operation mechanism, Dr. Hai emphasized the need for evaluating whether the FMCs work according to the principles. As he stated, the number of trained doctors are not sufficient to supply to all levels, as well as the FM model is still unrealistic to the people's demands. In order for the model to work effectively in the coming time, Mr. Hai recommended that there are directions and solutions for organizing, training and implementing the model.

- **Mr. Duong Hong Thai, Deputy Director, Thai Nguyen Central General Hospital, Member of Family Medicine division, Thai Nguyen Medical & Pharmaceutical University**

Dr. Duong Hong Thai mentioned the situation of training family doctors in previous time when this human resource was not used correctly and trained family doctors worked as other general doctors. However, since MOH decided to develop the FM model, the orders for family doctor training for Thai Nguyen Medical and Pharmaceutical University had increased. In 2016, there have been two specialized classes on FM at this university.

Dr. Thai shared two main differences between doctors at commune health stations and family doctors, which revealed that doctors at commune health stations are covered by subsidy financial mechanism and have general or specialized profession, while family doctors are trained comprehensively and operate independently and can be paid through health insurance coverage. Thus, family doctors need to always train themselves and improve their profession and service quality in order to increase their credits and attract patients. FM mechanism will help improve the capacity of the doctors, thus health investment will not need to focus on salary payment or infrastructure upgrade but on the network of disease control and prevention, which helps to make substantial changes.

Dr. Thai also mentioned the challenges that the process of scaling up FM model nationwide has to face, which is about geography. FM would work well at crowded and civilized populations. However, in remote areas with low number of patients and limited awareness of the community, the income of family doctors will not be secured. Therefore, Dr. Thai suggested that FM is developed firstly at crowded areas. The existing commune health station system should be retained at disadvantaged areas.

- **Dr. Tran Quy Tuong, Deputy Director, Medical Services Administration, MOH to response to the questions**

Regarding Mr. Thanh's opinion about the participation of village health workers and retired doctors, Dr. Tuong stated that it is completely possible, but village health workers would have to coordinate with family doctors in a team to carry out the tasks of FMCs. Retired doctors need to follow the regulation of FM practicing certificate. Before 2020, one needs to take a 3-month course and 18 months practicing at a FMC, but after 2020, it

must be a 9-month course specializing in FM and 18 months practicing at a FMC to get practicing certificate.
Regarding Ms. Ly's opinion, Dr. Tuong confirmed that MOH would support localities in terms of facilities and infrastructure to develop FM model.
Regarding Dr. Hai's opinion, Dr. Tuong agreed that currently the resource of 900 family doctors trained since 1998 has not been well managed. However, it takes time and will be improved gradually. HPET project by World Bank will continue to support the training of human resource for FM.
Regarding Dr. Thai's opinion, Dr. Tuong shared that the FM model can still be launched in remote areas through commune health stations, and health staff can come to the people's houses for direct health care and consultation.
Dr. Tuong emphasized the importance of communications in disseminate knowledge on this model in the society, and persuading people to come to FMCs for medical services.

- **Mr. Bui Hong Son, Medical Officer, GaneshAID**

Regarding the economic dimension of FMC model, Mr. Son questioned about the total number of medical visits of each clinic per year, from which the estimation of how many visits each clinic needs a year for maintaining their operation can be made.

- **Dr. Socorro Escalante, Health System Development Team Coordinator, WHO Vietnam**

Firstly, Dr. Socorro emphasized the need to make sure that Family Medicine Clinics (FMCs) do not duplicate with what the commune health stations and district/provincial hospitals are going to deliver, and to carefully plan the volume of FMCs in order to avoid driving high demand of health services of local level. Secondly, she raised the need of considering the impact of reforming any part of the health system. For example, if FMCs are established across the country, it would not be possible to remain the same financial mechanism since a lot of money might be spent by health insurance for services that may not be needed.
Dr. Soc took examples of how FMCs are operated in countries like the UK, in which a pool of budget is allocated for each Family Medical Practice (FMP) with their assigned number of households and with the list of services contracted by the government such as immunization, counseling, screening for cervical cancer, urinalysis, etc. The performance of the FMPs will be assessed against the budget spent for the services being delivered. In the meantime, Vietnam is investing a lot of equipment for FMCs and people have to pay fee for basic services. For example, a commune health station-based FMC might have two ultrasound machines, an X-ray machine, and an endoscopy machine which should only be placed in specialized hospitals. Therefore, carefully assessing the model is strongly advised by Dr. Socorro, including assessing the number of visits of patients or number of volumes of services that those commune health station-based FMCs provided.
Dr. Socorro expressed WHO's willingness in supporting the assessment of the current pilot implementation which would help the government solidify and concretize the concept of family medicine (FM), and identify what would be the services that Vietnam needs to input into FM. Lastly, Dr. Socorro raised the question on whether the FM concept be able to address the inequalities and disparities that have been existing in hard-to-reach areas and ethnic minorities.

- **Mr. Tham Chi Dzung, Payment Method Division, DPF, MOH**

Mr. Dzung pointed out 5 prerequisites for developing appropriate payment method for FM model:

(1) Identifying the type of FMCs at different levels and different regions before defining payment method. Specifically, they are a) FMCs based at commune health stations for mountainous and remote areas; b) Private FMCs for big cities; and c) FMCs based at district hospitals.

(2) Identifying disease patterns of each region, age group and health insurance card group. Up to now, there has been no report on disease patterns at commune and district levels.

(3) Identifying the type of services and relevant list of medicines of FM model

(4) Defining service cost. There is a number of diagnosis and treatment guidelines, however there should be specialized procedures to regulate a consistent expense rate for a kind of disease at different FMCs, which would ensure equity for patients at all levels.

(5) There should be monitoring and evaluation process of service provision and payment. There are two payment modes, which are a) Service fee and b) Capitation. For commune level, it is not possible to apply capitation since social health insurance cannot be paid at commune health stations but at district hospitals or health centers. Therefore, it is needed to do it at district level. For FMCs based at district hospitals, service fee mode should be applied.

To sum up, with FM model, different payment methods should be applied to fit with different conditions.

4. CONCLUSION

4.1. By Dr. Tran Quy Tuong, Deputy Director, Medical Services Administration, MOH

Dr. Tuong recognized the constructive opinions of participants on the development of FM model, and expected that they continue contributing if there are any problems during implementation process so that MOH can finalize the model.

He stated three points: a) Regarding the results of implementation in the previous phase, MOH produced the assessment phase I. The number of 240 FMCs at 8 provinces/cities are mostly based at commune health stations, and only under 10 clinics are private ones; b) The number of medical visits after establishing FMCs increased by 10-15%; and c) The operation fund of commune health stations hardly changed since it is still in the first phases of applying the model. For private FMCs, most of them are integrated with general FMCs so their major income source is from general medical services.

Dr. Tuong hoped that FMCs would strongly develop in the coming time with the attention of related sides.

4.2. By Mr. Dang Xuan Thanh, Vice Chairman, Lao Cai People's Committee

Vietnam is a transforming country, therefore the disease pattern is changing accordingly. Gladly, the solutions are focusing on human and take human as the center. Mr. Thanh stated that, the meeting is not technically helpful but also meaningful. He expressed the

hope that the model is further accelerated and becoming the typical model for provinces to follow.

4.3. By Dr. Lokky Wai, Representative, WHO Vietnam

Dr. Lokky Wai appreciated the opportunity of having a better understanding of the FM model of MOH through Dr. Tuong's presentation. However, he considered the plan of introducing FM model to 80% of provinces in the country quite ambitious. Dr. Wai also expressed his concern about the HR factor to introduce the FM approach in the next 4 years, which requires the readiness of medical colleges and universities to prepare the human resource. Therefore, he highlighted the importance of having a long-term plan and more proper way of introducing the model in order to ensure that FM would add value to the existing health system.

4.4. By Dr. Tran Thi Giang Huong, Director General, ICD, MOH

Dr. Huong affirmed that the meeting is the illustration for the success of HPG, the forum for Vietnamese policy makers to share with DPs and provinces about future plans, strategies and orientation of the health sector. She also expected that other provincial authorities would support HPG as Lao Cai province does for the current HPG meeting.

In explanation for the selected topic of the HPG meeting, which is about FM, Dr. Huong stated that, since grassroots healthcare had always been one of the major priorities of the health sector, an advantaged model like FM with the potential of contributing to the effort of the health sector in strengthening grassroots healthcare system should be utilized. Dr. Huong agreed with other opinions, especially Ms. Ly's opinion on considering the investment of costly infrastructure and equipment for facilities that only serves 5% of the population, while communities in remote areas are in high need of grassroots doctors. If FM principle is applied, which focus on human, the model certainly would help address hospital overcrowding and improve health services quality at local level.

About WHO's concern on the risk that FMCs might become small hospitals at lower level, Dr. Huong emphasized the need to remember that FM has the mandate of providing basic comprehensive and continuous health care for the people. She highly appreciated the opinions of participants, and confirmed that those ideas would be reported to the Minister, who has strong determination of developing FM model. She hoped to receive the ongoing support of DPs and provinces who directly implement MOH policies.

The morning session ended at 12:30 same day./.

5. AFTERNOON SESSION: SITE VISIT

5.1. Group 1: Tả Phìn Commune Health Station. Head of station: Hoang Thi Huong

The human resource of Ta Phin health station consists of 06 health staff including 02 physicians, 01 midwife, 01 pharmacist, 01 nurse and 01 population staff; and 06 village health workers. During the first 6 months of 2016, Ta Phin health station has carried out health-care activities for its people focusing on preventive medicine for TB, malaria, HIV/AIDS, diabetes, etc and communications for health. Reproductive health and

stunting prevention for children are launched intensively such as providing vitamin A for children from 6 months to 5 years old, providing iron tablets for pregnant women, communications on nutrition and so on. Ta Phin health station received more than 1500 visits for medical services in the first 6 months of 2016. However, the challenges such as high rate of poor households (43.1%) and limited network of village health workers have affected primary health care work at the commune.

5.2. Group 2: Sa Pả Commune Health Station. Head of station: Lang Duc Ngoc

Sa Pả commune health station has just moved to a new location with upgraded infrastructure and facilities. The human resource of Sa Pả health station consists of 07 health staff including 02 general doctors, 01 physician, 01 midwife, 01 pharmacist, 01 nurse and 01 population staff; and 06 village health workers. As Ta Phin health station, Sa Pả station pays high attention to reproductive health and stunting prevention for children. However, 3 infant deaths were recorded in the first 6 months of 2016 due to preterm birth. The rate of households having access to clean water and having clean latrines is about 70%. The number of patients covered by health insurance is over 1200 people. The difficulties facing Sa Pả health station include backward traditions of the community, difficult transportation among villages, high rate of 3rd-child birth, limited capacity of health staff, and language barriers between health workers and villagers, since a majority of the community is H'mong people.

5.3. Sa Pa District General Hospital

Sa Pa District General Hospital is a level-3 hospital with nearly 150 health staff, in which 16 are doctors. With good basic infrastructures and facilities, the hospital has provided a lot of medical services for people in the location with the number of medical visits recorded for 45% during the first 6 months of 2016. Preventive medicine is also paid much attention to through communications activities to the community and nearly 5000 inpatients. One of the biggest challenges facing Sa Pa district hospital is human resource, in which the number of 14/16 doctors (02 doctors are studying) have to cover both medical management and treatment, which causes work overload. Sa Pa district hospital suggested that O Quy Ho polyclinic be abolished due to downgraded infrastructure, and move the human resources and facilities to Thanh Phu cluster with crowded population and far from district center in order to adapt to new situation.

The activity ended at 17:00 PM same day./.

ICD Deputy Director

(signed)

Nguyen Thi Minh Chau

ANNEX 1. PROVINCIAL HPG MEETING 2016 AGENDA

Theme: Designing local health systems for health equity and universal health coverage: Contextualizing the family medicine approach

Date: Tuesday 02/08/2016 (01 day)
Location: North Star Hotel, Ngũ Chỉ Sơn, Sa Pa town, Lào Cai province
Chair: Dr. Trần Thị Giáng Hương, Gerneral Director, Ministry of Health
Co chairs: Mr. Đặng Xuân Thanh, Vice Chairman of Lao Cai People's Committee
Dr. Lokky Wai, Representative, World Health Organization

Time	Content	Person in charge
08:00-08:30	**Registration**	**HPG Secretariat**
08:30-09:00	Welcome and introduction	HPG Secretariat
	Opening remarks of Chair	Dr. Trần Thị Giáng Hương, General Director International Cooperation Department , MOH
	Remarks of Co chairs	Mr. Đặng Xuân Thanh, Vice Chairman of Lao Cai People's Committee Dr. Lokky Wai, Representative, World Health Organization
9:00-10:15	• Local health system for health equity and universal health coverage: Can the family medicine approach contribute? • Family medicine in Viet Nam: proposal, pilot implementation and plan of development in 2016-2020 • Sharing perspectives/intervention about the implementation and the feasibility of developing/integrating family medicine in local health system *Guiding questions for the plenary:* • *How can local health systems be strengthened to achieve health equity and universal health coverage?* • *What is the concept of family medicine? How is this different to the current grassroots health system?*	Dr. Socorro Escalante, Health System Development Team Coordinator, WHO Dr. Trần Quý Tường, Deputy Director, Medical Services Administration, MOH MOH institutes, Provincial Department of Health, DPs/INGOs

	• *How can the family medicine approach contribute to this goal?* • *What are the pros and cons/ difficulties of implementing family medicine in connection/ to strengthen local health care system?* • *How can family medicine be integrated in the current system to fulfil its roles in supporting local health care system?* • *How feasible it is to implement family medicine in provinces? How can local government make it sustainable to support local health system?*	
10:15-10:30	***Tea/coffee break***	
10:30-11:30	• Sharing perspectives/intervention about the implementation and the feasibility of developing/integrating family medicine in local health system *(Continue)* Plenary discussion	MOH institutes, Provincial Departments of Health, DPs/INGOs
11:30-12:00	Conclusion and closure of morning session	Chair and Co chairs
12:00-13:30	***Lunch***	
13:30-17:00	**Site visit in Lao Cai**	
13:30-15:30	**Group 1** Site visit to Tả Phìn Commune Health Station in Sa Pa, Lao Cai (~12km from Sa Pa center)	
	Group 2: Site visit to Sa Pả Commune Health Station, Sa Pa, Lao Cai (~6km from Sa Pa center)	
15:30-17:00	**Group 1 + Group 2** Site visit to Sa Pa district hospital, Lao Cai (two groups move from Tả Phìn and Sa Pả to Sa Pa center) Meet up at hospital hall: findings, report, discussion and sum up of site visit	
	Conclusion and closing remarks	**Chair and Co chairs**