Tibet Health Personnel Capacity Building Program

Volume 2
Program Design Document - Annexes

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ANNEX A: AIDE MEMOIRE

Tibet Health Personnel Capacity Building Program
Aide Memoire

1. Design Background

The Australian Government has provided assistance to the Tibet Autonomous Region (TAR) since 1991. Over the last six years AusAID's flagship in the TAR has been the A$19.3 million Tibet Health Sector Support Program (THSSP) which was completed in June 2010.

In response to the TAR Government's request that Australia remain engaged in the Tibetan health sector, AusAID conducted a scoping mission in November 2009. A wide range of stakeholders were met at regional and prefectural level in the TAR. Consultations continued in Beijing with the Tibet Regional Bureau of Health Deputy Director General, national ministries and other donors.

There is mutual understanding that the key challenge for the health sector is to manage funds from the central government efficiently and improve effectiveness of human resources. It has to do this with a small number of staff whose managerial and technical skills are generally lower than in the rest of China. A new program could help the TAR resolve this problem by focussing on human resource development (HRD), particularly at management levels

A concept paper was developed that recommended a new program should focus on HRD, particularly at management levels and on the professional development for health workers. It would support Tibet Regional Bureau of Health (TRBH) to conduct its core business to achieve better health outcomes, particularly at county and township level and below. It would also support the TRBH to implement national and TAR health HR plans, supporting integration into the whole health system and working closely with TRBH senior management to achieve this end.

The new program has taken into account the key health status of the population in the TAR, the TAR health priorities and the current reform agenda. Broadly the program will focus on HR and other related management practices at strategic and operational levels, and on priority technical and clinical practices of the existing workforce in pilot sites.

The recommended size of the Australian investment is 10 million. The program is designed for a five year period. Key partners are the TRBH and the Department of Commerce (DOFCOM).

2. Description of proposed activity

Program description

The diagram on page 2 presents the program goal, Component objectives and expected outcomes (indicators). Key Outputs for each Component are described. Achievement will be measured up to the Component level for this program. While the Goal will be measured by the program, it is not expected that achievements (if seen) can be attributed to the program. The indicators at this level (maternal mortality rate [MMR] and infant mortality rate [IMR]) are considered evidence of a health system that is effectively managed.

Activities under the Outputs of Component 1 will result in Bureau managers at regional level better able to understand, develop and implement human resource (HR) policy, and to undertake HR planning in the health system. The approach to build these skills will be highly structured and interactive, and will be based on best practice adult learning methods to encourage critical thinking and problem solving, including off-the-job training, implementing projects in the workplace, and study tours to other parts of China. Follow-up support (expert mentoring, support for individual or teams of managers to undertake projects related to HR) and a mentored learning set will ensure that new skills and knowledge are applied in the work place. An annual regional TAR HR Forum will be established to provide opportunities for managers at different level to discuss current issues, identify and share solutions to problems, assess progress with the 12th Five Year HR Plan, and learn from national experts.

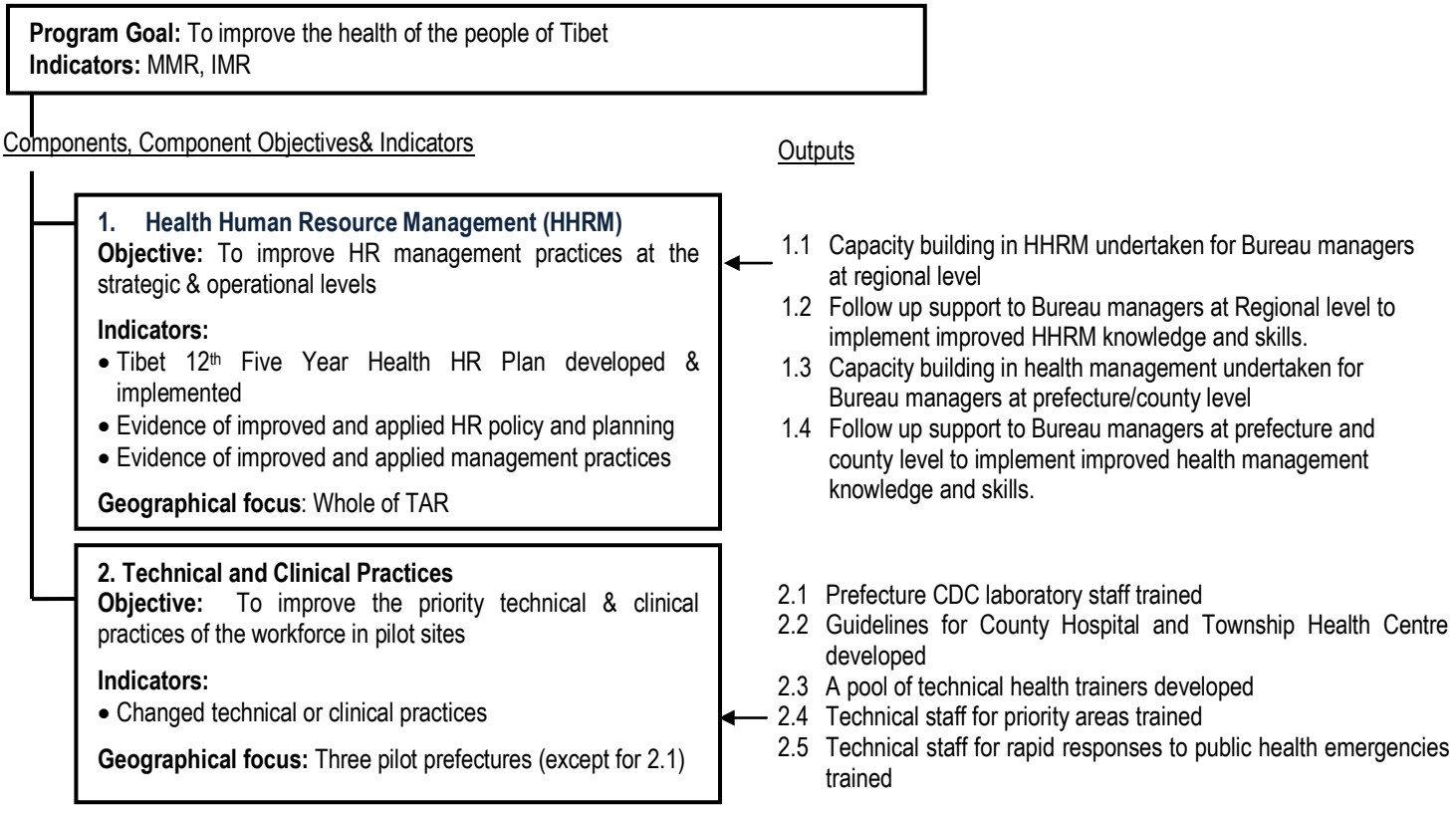
Selected prefecture and county level health managers will have training and capacity development that focuses on operational aspects of HR management, and other subjects linked to effective HR management, such as financial management. Training will use a range of modalities, and follow-up support will be integral to the learning program. Selected groups of these managers would also be involved in the HR Forum to sensitise them to policy developments occurring at the regional or national level. Training needs analysis (TNA) will inform program content of all training.

Activities under the Outputs of Component 2 will contribute to a clear focus on building technical and clinical skills of those currently in the workforce. Support to building capacity in prefecture Centres for Disease Control (CDC) laboratories recognises the importance of accurate and timely testing in support of rapid and correct diagnosis and treatment as critical to the provision of effective care to patients. Training and on-the-job support and mentoring will be supported by a Chinese Short Term Adviser (CSTA) affiliated with a relevant Chinese institution. Some basic essential laboratory equipment may be procured to support effective delivery of training and sustainable impact. This activity will commence very early in the program, initiated by a TNA to identify areas of most need.

There is no overall set of guidelines that identify the functions and related staffing skills for county hospitals and township health centres in Tibet. These will be developed within the program, and could be used by managers to identify critical staffing or skills gaps in their hospitals or health centres. The program will support a group of managers (Guidelines Technical Group) to develop the guidelines.

To increase the capacity to deliver training to technical and clinical staff, the program will support the development of a pool of trainers skilled in and able to apply adult teaching and learning method to technical training of staff. The pool will comprise existing trainers and beneficiaries of a new train-of-trainers (TOT) program. This approach will increase the number of trainers available to the system. A data base of these trainers will be developed with program assistance, to facilitate identification of trainers for technical/clinical areas of need. This will provide an effective method of matching training requirements to trainers. Closely linked to this will be an activity that increases staffing skills and capacity in priority technical and clinical areas. The capacity building will be aligned with other current and planned training provision and will focus on technical skills areas of unmet need. Trainers will be drawn from the newly established pool of trainers.

A flexible funding mechanism will be established that can be accessed quickly to respond to public health emergencies that have not been identified in the initial stage of the program. An important element of this will be to build workforce capacity in these areas as they are identified.



Management arrangements

The governance of the program will rest with the **Program Coordination Committee (PCC)**, comprising representatives of the Government of Australia (AusAID), the Government of the People's Republic of China (MOFCOM) and the Government of the Tibet Autonomous Region (DOFCOM, TRBH). It is the main formal committee for GOPRC and GOA discussion and decision-making. The role of this committee will be to provide strategic direction to the program. It will meet annually. Secretariat support will be provided by the MC. The MC will attend meetings but not be a member of the PCC.

A **Program Management Team (PMT)** will be established at start-up.

The PMT function will be to develop annual plans, implement the program, coordinate activities, report on progress, and inform the PCC of progress. Roles of all key stakeholders will be clearly articulated.

The Chinese team will comprise DG or DDG as the Chinese Team Leader, to be nominated by the TRBH. In addition two full time staff, nominated by the TRBH, will have responsibility for supporting and coordinating the Components. The PMT will work with representatives from Divisions in the Regional Bureau of Health – Human Resource, Disease Control, Medical Administration (includes Science, Technology and Education), Rural Health, Finance, MCH and Community Health. Other Divisions may be added when additional technical priority areas have been confirmed.

The MC team will comprise the ATL and two Chinese Long Term Advisers (CLTA).

Teams will meet regularly to assess progress, identify barriers, and ensure activities are consistent with GOTAR priorities

Implementation partners and stakeholders

The key implementation partner is TRBH. DOFCOM is the coordinating agency for this program at the Regional level.

Amongst the key stakeholders are the Regional Human Resource Bureau in relation to the development of the Regional 12th Five-Year HR Plan, and the Regional Education Bureau in relation to engagement with training institutes. Training institutes will be identified as the program rolls out.

Other important stakeholders will include targeted prefecture, county and township groups and individuals who will be direct beneficiaries of program activities.

Monitoring and review mechanisms

The program will be monitored at the Output (process) and Component objective (outcome) levels. Achievement of the Goal will not be measured by the program. An M&E matrix will be elaborated on by the PMT to assist summary reporting at the activity and output level. Informative baseline data was not available at the time of design, necessary for measuring outcomes at the Component level. Baseline surveys and case studies will be methodologies used to identify how practice has changed as a result of Component activities. Other methodologies may be identified as the program rolls out.

Monitoring and review will occur through provision of reports as well as other mechanisms such as meetings, TAG visits and reviews.

Six monthly reports: The MC will be responsible for providing six monthly reports to AusAID and MOFCOM. These will succinctly summarise progress, major issues, risks and strategies, and progress in implementing program components and principles.

Annual Plans: Annual plans will be provided to the PCC by the PMT.

Annual PCC meetings: The PCC will meet annually to review progress and provide strategic direction to the program.

Technical Advisory Group (TAG): A TAG will provide advice to AusAID and MOFCOM, and will visit the program as required. Consulting widely, it will assess program technical and monitoring reports, and review progress against the logical framework and the M&E framework, including progress of capacity building.

Independent Progress Report (IPR): This is referring to a Mid Term Review (MTR) which will occur within the first four years of the program. The key objectives of the MTR will be to assess program progress, review the appropriateness of the program design in view of any relevant changing circumstances, and assess the lessons learned and local absorptive capacity.

Activity Completion Report (ACR): The ACR is produced by the MC and provides a balanced assessment of activity performance against design objectives at the completion of the project and when AusAID funding ceases.

Independent Completion Report (ICR): This will constitute the end-of-project evaluation.

3. Observations and Key Recommendations

Various approaches have been identified to ensure flexibility and adaptability so that the program responds to emerging priority needs and addresses a range of issues, some of which cannot be defined at design stage. These include the rolling annual planning process, and the establishment of a simple small grants scheme that is able to respond quickly to emerging public health issues.

The program will complement existing activities being implemented with government funding, and ensure that there is no duplication of activities. It clearly supports the TAR focus on developing health human resources.

To contribute to the longer term sustainability of activities and outputs, the program will support the establishment of models that can be replicated by the TRBH beyond the program timeframe.

The THSSP reported many lessons that had been learned during its implementation. This program has considered those as the design has been developed.

A key principle underpinning the program is that the design should ensure ownership by TAR stakeholders. The structure of both components will support this: training needs analyses (TNA) conducted early on in the program will identify capacity building priorities, and individuals will be supported to identify the areas in which they want to make change. This is a flexible learning program that will respond to changing needs.

Ownership is also more likely to be achieved by having had the committed involvement of TRBH and DOFCOM in the whole design process. A broad range of people have been met during the process, contributing to the ongoing development of the draft PDD while in Tibet.

Thorough approaches to capacity building have been identified, ensuring a range of modalities to be applied throughout the program, including follow-up and work based projects to ensure success and implementation of what has been learned.

Strong management and coordination within and across Bureaus will be essential to an appropriately targeted program. All stakeholders will have a responsibility to ensure this occurs.

The program recognises the importance of aligning with regional policies and plans.

Key risks and their mitigation

Coordination between key stakeholders and implementers: A strong and cohesive PMT led by TRBH will be essential to ensure that the necessary coordination of activities occurs. Continuity of both Chinese and Australian team members will contribute to minimising this risk.

Availability of key groups for training: the program will be providing many capacity building opportunities for a potentially large number of people. It will be important that annual planning identifies when training is to occur and beneficiaries can be supported by management to incorporate these activities into their schedules.

Availability of trainers at required times: annual planning and communication with trainers will expect to reduce this risk.

Lack of engagement and/or support from key regional stakeholders: The annual planning process, the annual Regional HR Forum, follow-up support and relationship building by members of the PMT will all attempt to reduce this risk.

Delay in full development and implementation of the HR Five Year Plan and other relevant policies: to reduce the impact of delay of one key activity in the development of the plan on rollout of associated program activities a

number of factors are identified: maintaining engagement with key people, monitoring progress to check that development of the Plan is on track, and negotiating involvement in the planning/implementation process itself.

Scope to influence change: There may be systems barriers that impede implementation in the workplace of what is learned. This needs to be monitored as part of the M&E of the program, and the PMT use its regular coordination mechanism to negotiate addressing those barriers.

Unanticipated health outbreaks diverting staff from involvement in program: the occurrence of outbreaks is out of the control of the program; the flexibility that is inherent in the program will permit rescheduling activities should that be needed.

Lack of full engagement of some pilot sites: Motivation as a site selection criterion will minimise this risk.

4. Next steps

The following are the steps to be undertaken up to mobilisation:

- Draft PDD – by mid September
- Peer review
- Final PDD
- Approval by AusAID and the partner Government (MOU signed off by AusAID and MOFCOM)
- Request For Tender (RFT) preparation
- Tendering process
- Contracting and mobilisation.

It is hoped the program will be able to mobilise by early to mid 2011.

5. Acknowledgements

The Design Team would like to thank the AusAID country office for the excellent logistical support that has been provided, for original sourcing of key documents for to inform the design, and for daily support to the design exercise. We do not underestimate the demands of this task.

We would also like to thank all those with whom we have consulted. They have given us the opportunity to experience their enthusiasm for a new program, have provided input into design, and have demonstrated their commitment to a new program once it is mobilised. In particular we are grateful the DOFCOM and TRBH for the time they have spent with us, and the many opportunities to test ideas as the design has taken shape. We are also extremely grateful for the excellent logistical support provided to the Team while in Tibet.

Annexes

1) The Design Team

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2) People/agencies consulted

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TIBET AUTONOMOUS REGION

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Ms Zhou Qing	County Vice Governor in charge of Health

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Mr Pubuciren	Director

ANNEX B: SECTOR/PROBLEM ANALYSES

The HHR context at national level

The health human resources (HHR) context at national level in China has, in recent years, been characterized by staffing growth due to an expansion of training numbers, but this growth has been accompanied by the acknowledgement that geographic distribution of staff within the system was not at optimum level, and that some staff required a higher level of skills to be at their most effective[1]. Lack of co-ordination between the education sector, which trains health workers, and the health sector, which employs them, has also been identified[2]- one reported result being a current oversupply of doctors relative to employers needs. For example, a recent broad based OECD[3] review of China noted that "The number of doctors has increased rapidly but their qualification levels are often modest and their geographical distribution does not match local needs" and that "It will also be important that hospitals are managed more efficiently, with less hierarchical structures".

There has also been a recognition of the need to improve the capacity of management and administration within the system, by increasing the numbers of managers, and by providing additional training to those currently working in the system- many of whom are health professionals and technical staff who have not received formal training in management/ administration.

This section looks first at national developments on HHR that have relevance to the program, and then provides a more detailed report on HHR challenges in the TAR, based on recent reports and documentation.

National Health Human Resource Development Plan for the 11th Five Year Period

The HHR policy focus at national level is framed by the five year plans. The 11th Five Year Plan, which covers the period until the end of 2010, identified a range of policy priorities related to improving the quality, distribution and education of the health workforce, and improving the skills and competence of health managers. Key points were:

(1) Strengthen the cultivation of health human resources and improve their quality completely, with an emphasis on continuing education.
(2) Adjust the structure of health human resources and prioritize the construction of health human resources in the countryside, communities and western regions, in part through the "Project of 10,000 Doctors to Support Rural Health Program".
(3) Strengthen the construction of high-level health human resources. Build up a higher-level talents base including more than 1000 experts.
(4) Increase the training of health managers and their professionalization.
(5) Improve further the evaluation system of health human resources. Accelerate the innovation of health work system.

Suggestion on Further Strengthening Health System Reform (China endorse No. 6, 2009)

The policy direction of the 11th Five Year Plan was reinforced by the CPC Central Committee and the State Council's Suggestion on Further Strengthening Health System Reform (China endorse No. 6, 2009), which made similar suggestions on improving the quality and distribution of the workforce and improvements in leadership and management.

Research Review of HHR challenges

A review of HHR challenges in the China health system in recent years (Report on Health Human Resources Research in China 2006, by HR department of MOH and Statistical & Information Center of MOH) highlighted several key issues, against a backdrop of overall staffing growth:

1. The majority of health professionals had an education background of secondary technical school or junior college so the general level of education was not high.

[1] Anand S, Fan Y , Zhang J, Zhang L, Ke Y, Dong Z, Chen L (2008) China's human resources for health: quantity, quality, and Distribution. The Lancet October 20, 2008 DOI:10.1016/S0140-6736(08)61363-X

[2] Likun, Legge , Liu Yi (2009) Workforce Development in: China Health Policy, (Vivian Lin, Guo Yan, David Legge) , ISBN: 978-7-81116-699-6

[3] OECD (2010) Economic Survey of China 2010: Improving the health care system

2. Staff with advanced levels of health skills were in relatively short supply.
3. A relatively low percentage of staff had received post-graduate education and continuing medical education (e.g. 28 percent of doctors-in-charge and above receiving continue medical education).
4. There was some mismatch between supply and demand for health workers. The number of graduates was increasing and there was now an oversupply of secondary technical school graduates. From 2005 to 2010, the need for complementing health technicians in health organizations would be up to 150,000 per year but output of graduates from medical schools per year would reach more than 500,000 to 600,000.
5. There was significant regional variation in distribution of health workers, with highest levels in the east of the country and lowest in the west. Resources to train and employ staff are limited in the west, workload is higher and training opportunities lower; this regional imbalance has been exacerbated by "brain drain" of staff from west to east.
6. Urban areas have higher levels of staffing provision. Two thirds (67%) percent of health human resource is located in urban areas- which account for 47 percent of population. There is both a numerical and a "quality" imbalance- with higher trained staff in urban areas.
7. General practitioners are in short supply. The number of registered doctors and assistant doctors majoring in general practice was approximately 30,000, covering only 1.9 percent of certified doctors and assistant doctors.
8. The ratio of doctors to nurses is "inverted", with a low rate of nurses per doctor compared to many other countries. This relates in part to a long-term shortage of nurses[4]
9. Health human resource is overly concentrated in secondary care/ hospitals; public health staff is in short supply.
10. There are insufficient trained managers in the health system. Most health managers are health technicians who are often short of management experience and training - 43% of managers majored in medical health including clinical medicine, Chinese medicine, public health, pharmacy, nursing care, laboratory science, etc), 24% majored in management, and 32% in engineering and communication. Of all administrative management staff, the percentage with medical health major is up to 85 percent, while that with management major is less than 4 percent.
11. There was been some decreased efficiency in the utilization of our health human resource in the first part of the last decade. For example, in hospitals, daily outpatients per doctor decreased from 5.5 in 1990 to 4.9 in 2004, average stay days per doctor declined from 2.1 to 1.5, and utilization of beds dropping from 80.7 percent to 68.4 percent. increase of beds

The report made several key suggestions to address these HR challenges, including:

- "Appropriately control the total amount of health workforce", by optimizing staff numbers and allocation, with a focus on health workforce in rural areas and western regions of the country;
- Enlarge the share of the workforce that have a college degree or above, and improve the entire quality of health workforce.
- Adjust doctors' specialty composition; secure the quality and stability of recruits for nurses and healthcare workers.
- Strengthen the public health workforce
- "Vigorously develop" continuing medical education.
- Improve in-service training of the workforce, including actively develop the professionalization for health administration staff
- Enhance the planning and management of health human resources.

Gender distribution on the health workforce

The gender distribution in the workforce is uneven. Two thirds (64.3%) of the total workforce is female, but only 43% of doctors are female (see Table 1).

[4] See also Likun, Legge , Liu Yi (2009) Workforce Development in: China Health Policy, (Vivian Lin, Guo Yan, David Legge) , ISBN: 978-7-81116-699-6

Table 1: China: % of health professionals by gender 2005

	health professional						other technical	manager
	total	doctor	nurse	pharmacist	laboratory	others		
total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
male	35.7	57.1	1.7	39.6	37.5	46.3	44.7	49.1
female	64.3	42.9	98.3	60.4	62.5	53.7	55.3	50.9

Source: Chinese Health Statistical Yearbook 2009

The National Health Services Survey conducted by the Ministry of Health across 31 Provinces/autonomous regions in China in 2008 identified several critical challenges, including the need to strengthen the capacity of health institutions at grass roots level, and the quality of health services provided. The survey found that many grass roots health workers had no qualifications, and that poor skills were one of the factors contributing to low satisfaction rate towards health services[5].

The HHR context at TAR level

Any assessment of HHR priorities and action in TAR must begin with a recognition of the challenges created by the geographic and demographic context. TAR covers 1.23 million square kilometres of south-western China. The average altitude is above 4000 metres, the climate is arid. Winters are extremely cold and dry. Vacation breaks are reportedly as long as three months. TAR's seasonal work patterns are a critical factor in staffing availability within the health sector and will have implications for planning of program activities.

With a population of 2.84 million (2007) TAR is the most sparsely populated area in China. There are two municipalities in TAR (Lhasa and Shigatse), six prefectures, 74 counties and 725 administrative townships.

TAR is the poorest of China's provinces and autonomous regions. The annual per-capita disposable income in 2007 of urban residents was 11,131 yuan. The annual per-capita net income of farmers was 2,788 yuan. Approximately 90% of recurrent funding is from Central Government. Roads are generally poor and travel slow.

TAR's health indicators are reportedly the poorest in China, with wide variation between urban and rural areas. TAR's infant mortality rate in 2008 was 27.1 per 1000 live births; maternal mortality rate was 233.96 per 100,000[6]. Life expectancy in 2000 in TAR is lower than in the rest of China (62.5 and 66.1 for TAR males and females, respectively, compared to 69.6 and 73.3 for males and females, respectively, nationally).[7]

There is currently investment in building of new health facilities and refurbishment of older health facilities, but there are not always sufficient water supply and sanitation services, or essential PHC and hospital equipment in the rebuilding and refurbishment program.

Table 2 (below) highlights that the current health staff: population ratio in Tibet is below the national average, most notably for nurses. There is also a marked variation in the ratio between urban and rural areas.

Table 2: China: Number of health professionals per 1,000 population by main region, and in Tibet, in 2009

Region	**Health professional group**								
	Health professional			**doctors**			**nurses**		
	total	**city**	**rural**	**total**	**city**	**rural**	**total**	**city**	**rural**
Total	4.15	6.03	2.46	1.75	2.47	1.10	1.39	2.22	0.65
East	4.93	6.37	2.61	2.04	2.59	1.15	1.72	2.35	0.70
Middle	3.79	5.53	2.49	1.59	2.27	1.08	1.24	2.04	0.65
West	3.59	5.98	2.33	1.56	2.47	1.08	1.14	2.18	0.60
Tibet	**3.49**	**9.20**	**2.77**	**1.57**	**4.27**	**1.23**	**0.69**	**3.15**	**0.38**

Source: Chinese Health Statistical Yearbook 2009

[5] Ministry of Health, Analysis Report of the National Health Services Survey in China, 2008.
[6] China Health Statistical Yearbook 2009
[7] China Health Statistical Yearbook 2009

The issue of relatively low staffing ratios in TAR is well recognized, and recent analysis and policy assessment at TAR and prefecture level, discussed below, has set out a range of responses to improve quantity and quality of health workforce in Tibet.

Other key HHR challenges are that health worker basic and continuing education is limited[8], teaching and training is often didactic, and problem solving skills and critical thinking capacity are not usually included. Teaching materials and facilities are limited. The technical roles at each level of the health service are defined but would benefit from greater specificity as would standards, so that training, equipment, and referral strategies can be better targeted.

Compared to the national averages, the Tibet health workforce also has a relatively low qualification structure. Table 3 presents a comparison of qualification levels of the workforce in Tibet[9], compared to the whole of China[10]. One quarter of the Tibet workforce have no qualifications, compared to one in ten at national average, and only one quarter have a college diploma or degree, compared to almost half in the national average.

Table 3: Comparison of Tibet and whole of China health workforce qualification levels (%)

	Qualification level				Total
	Bachelor degree or above	**College diploma**	**Technical/secondary school diploma**	**No qualifications**	
China	17.1	29.2	43.3	10.3	100
Tibet	8.2	15.45	53.3	23.05	100

Township-level health facilities are often poorly attended and have few resources available to improve service delivery. There are relatively low numbers of women doctors and midwives. Nurses are usually women and are reportedly offered fewer opportunities for training and advancement than other health workers. There are many women health workers in a variety of roles and levels but there are insufficient numbers of women doctors in a culture where women prefer their health care from women, particularly during pregnancy and childbirth. The new program will support equal opportunity for men and women in training and development.

The key recent and current policy responses to these challenges in HHR are summarized in the 11th Five Year Plan for health human resource development.

The TAR Health Human Resource Development Plan for the 11th Five Year Period (Tibet Government Endorse No.69, 2006).

This Plan was developed to carry out the TAR Communist Party Commission and TAR Government's Suggestion about Carrying out " CCCP and the State Council's Decision on Strengthening Human Resource Work"(Tibet Party Endorse No.3 2005), Decision on Strengthening Rural Public Health Work"(Tibet Party Endorse No.7, 2003), TAR's Human Resource Development Outline 2004- 2010 (Tibet Party Endorse No.6 2005) and MoH's Health Human Resource Development Outline for China, 2001-2015 (Health Human Resource Endorse No.35, 2002).

The Plan identified critical Issues with health human resource development in TAR:

1) Insufficient numbers of health workers and uneven distribution between urban and rural areas.
2) Health workers speciality, qualification and technical ranks were not distributed optimally. As noted above in Table 1, there was a shortage of nurses, with numbers of nurses for per thousand population at only 60% of national average level. There was also an imbalance between proportion of doctors and nurses, with low ratio of numbers to doctors. Staffing gaps were also noted in the areas of health management, preventive medicine, MCH, oral health, medical technology and health inspection. The current health workforce had a relatively low qualification structure with 75% having only technical secondary school diploma or lower.

[8] See e.g. also Likun, Legge , Liu Yi (2009) Workforce Development in: China Health Policy, (Vivian Lin, Guo Yan, David Legge) , ISBN: 978-7-81116-699-6

[9] The TAR Health Human Resource Development Plan for the 11th Five Year Period (Tibet Government Endorse No.69, 2006)

[10] *China Health Statistical Yearbook 2010*

3) Health workers at grassroots had poor welfare treatment and this had affected stability of the force. Among all health workers at township clinics in TAR, 42% were contracted rather than permanent which means they had lower wages. Low income, rough working and living conditions, inadequate transportation and poor weather made it hard to convince professionals to be assigned to posts and hard for current workers to stay at their work in rural/ remote areas.

4) The capacity to develop high level health professionals was low. The current graduates from university in TAR could meet the need for junior and middle level health professionals, but due to weak capacity with medical education and research and the lack of high level personnel, there was difficulty in developing high level health human resources.

5) There was not a strong mechanism to bring health professionals in to the region. Tibet was less developed economically therefore policies and terms were not attractive enough for health professionals to come to work in the region. At same time it was also the challenge to retain existing professionals. This has resulted in severe shortage of high level, highly skilled and high quality professionals.

Specific objectives set out in the 11TH Five Year Plan were:

- Total numbers of health workers to be increased.
- Skilling up: through recruiting of personnel and conducting education program for upgrading qualifications, the amount of health workers who own bachelors or higher degree and college diploma is aimed to reach 24% and 42% respectively.
- Build capacity of leaders from each discipline. Each year 20-25 health professionals should be selected to study for master's degree and 3-5 people selected to study for doctor's degree.
- Conduct education to upgrade qualifications. Encourage health professionals to participate in different levels of education program to upgrade their qualifications.
- Conduct continuous medical education program in different formats and in different specialized areas
- Implement training program for township doctors.
- Attract and import professionals in to TAR through developing relevant welfare policies.
- Encourage and select medical professionals at work to study and obtain master's or doctor's degree; implement continuous medical education program.
- All levels of health administration departments should improve their training plan and regulations targeting rural health workers.
- The Plan also proposed for closer working between different departments- in particular human resources, education, finance and health.

The TAR Health Human Resource Development Plan for the 11th Five Year Period noted that "In particular, lacking of health human resource has become a key factor in hindering development of health course". In particular it was highlighted that the health workforce in pastoral areas was insufficient and of poor quality[11]. Prevalence of infectious diseases was higher in TAR than the national level, and the MCH care system in pastoral areas was not well established. A 12th Five Year Plan on HHR is currently under development. Given the likely timing on its full development and implementation, there should be scope for the new program to have involvement in its development, and to provide some assistance in implementation.

[11] The TAR Health Human Resource Development Plan for the 11th Five Year Period (Tibet Government Endorse No.69, 2006)

Lessons from the THSSP

The TAR's health system has been characterized as "traditional vertical bureaucracies, demarcations within and between departments, and between levels of the system, and hierarchical processes. Budgets are low, and there is generally weak human resource development, infrastructure, and equipment. TAR's difficult terrain, poor health indicators, low community knowledge of healthy behaviours, and scattered population, makes effective management of health services difficult.[12]"

Management areas for strengthening may include strategic thinking, critical problem analysis, change management, leadership, health services integration, personal development, team work, motivation, strategic orientation, and information management and utilisation (e.g. for policy, planning, financial management, human resource management, workforce planning, quality assurance, monitoring and evaluation, key performance indicators, community responsiveness, communication etc.).

As part of the THSSP Program, a study on health resource allocation and utilization in TAR was conducted by Tibet University Medical School and Shandong University Health Management and Policy Study Center (published in June 2010). The study gave specific attention to HHR issues. Main findings included:

(1) In the last 15 years, the numbers of health care agencies, sick beds, health care workers and input to infrastructure had kept increasing in TAR, especially in recent years, but due to increase of population, the ratio of population to number of beds, health technicians, doctors and nurses had not changed much.

(2) In 2008, the numbers of health technicians and nurses per thousand people in Tibet were lower than national average and far behind that of Xinjiang, Inner Mongolia and Qinghai. The number of doctors per thousand people equalled national average, but was lower than that of Qinghai, Xinjiang, and Inner Mongolia. In terms of health sector human resource allocation, there is big gap between Tibet and national average or neighbouring provinces (see also Table 2 above).

(3) The education background and professional qualification for health care workers are poor; the proportion of health care workers with professional qualification is low. There was a shortage of lab technicians in health care agencies.

(4) Compared with national averages, the proportion of TAR health care workers with university level qualifications and junior college degrees is much lower.

(5) Health sector human resource utilization is not efficient, and the proportion of health care workers receiving further education is low. A staff survey revealed that only 7.2% health technicians considered they had "a lot" of training opportunities, and almost 50% thought they only had "few" training opportunities.

(6) There is big gap between incomes for permanent and temporary staff, village doctors are poorly paid. Average income of permanent health technicians is RMB4114 which is 3.4 times more than contract/temporary staff's average monthly income of RMB1208.

The report made a series of suggestion to policy makers:

(1) Human resource management systems

- Increase human resource management power to health care agencies and health institutions to enable rational allocation of health care workers across all levels of health care agencies;
- Revise "assigning of medical graduates directly to health care agencies on township and village levels" policy;
- Promote rational talents flow system to enable rational flow of human resource within health sector; revise "all new employees should pass relevant tests" policy to allow more candidates apply for positions in health sector. Draft specific policy for professionals urgently needed by health care agencies.
- Increase amount of positions for "public welfare" while considering actual demands of health care agencies on all levels. Provide reasonable remuneration and professional titles to people employed for "public welfare".

(2) Improve general competence of health care workers by focusing on capacity building

[12] PDD THSSP

- On policy level, take basic level health care workers as main force of health service, village doctors should be included into development program;
- Draft specific human resource development program for health care agencies. Set up explicit development goals for amount, agency, competence and allocation of health care workers. Implement a series of measures to build capacities of health care workers.
- Improve content, method and management of training. Based on requests of garget population, training input should be strengthened to help resolve issues and improve effectiveness.
- Establish a system within health sector which enables high level health care agencies to provide supports to basic level health care agencies. To improve capacities of basic level health care workers, human resource from high level health care agencies should be fully utilized; they can be assigned to work temporarily in basic level agencies, provide on-site guidance and centralized training to basic level agencies.
- Improve incentive mechanism for health care workers, improve their working environment and condition, and increase stability of health care workers' jobs.

(3) Specific suggestions on how to build health care workers' capacities

- Improve education for health care workers; increase the amount of health care workers who are formally educated.
- Basic qualification standard for health care workers should be strictly applied.
- Increase further education opportunities for health care workers, improve training effectiveness.
- Improve village doctors' remuneration by revising relevant policies.

(4) Change the way government provides input, improve utilization of equipment

- Change the way medical equipment was allocated to meet demands and avoid idleness. Equipment should not be allocated to satisfy some agencies' goal of getting "advanced, big and comprehensive" equipment.
- Increase trainings for basic level health care workers gradually; improve utilization of equipment to avoid idleness.

The TAR wide study reported above was complemented by a report on health resource allocation and utilization in Shigatse Prefecture, also conducted by Tibet University Medical School and Shandong University Health Management and Policy Study Center (published in March 2010)[13]. The study gave specific attention to HHR issues. Main findings included:

1） Staffing limitations. Health sector human resource in Shigatse Prefecture was "insufficient"; the education background and professional qualification for health care workers in Shigatse Prefecture were reportedly generally poor, with township hospital workers having the best education background. The proportion of health care workers with no professional qualification was high in county level and township hospitals; the ratio between doctor and nurse was seriously imbalanced.

Workers in township hospitals in Shigatse Prefecture had the best education background, with more than 35% having junior college and university educations, while in prefecture and county level hospitals, the figures were only less than 25% and 27.5% respectively.

A large proportion of health care workers were not qualified, especially in township hospitals. In all township hospitals in the 6 counties, there was no registered nurse, and only 3.2% of doctors are licensed.

2） Inefficient use of available staff. The number of staff was increasing but is still limited; turnover of health care workers was not high, but utilization of human resource was "not efficient". Health care workers on different levels did not have equal training opportunity and training was often not effective. The number of patients received by every township hospital doctor per day is higher than national average but human resource utilization in Prefecture level and township hospitals is not efficient. Workers in prefecture and township level health facilities have more training opportunities while county level workers have less training opportunities.

13 *Study on Health Resource Allocation and Utilization in Shigatse Prefecture*. Tibet University Medical School, Shandong University Health Management and Policy Study Center. March 2010

3） Varying contracts for staff. The "quota" system for allocating new funded staffing posts that is applied in TAR and throughout China means that there is limited local flexibility to develop additional staffing posts and roles. As an additional way to introduce health care workers, organizations create contracted posts. One in ten (9.5%) of the jobs in the surveyed health care organizations were contracted posts funded from "public welfare" sources. In 2009, all workers recruited from society by township hospitals were assigned to "public welfare jobs".

4） Human Resources Allocation. There was a significant gap between Tibet, national standard and other neighbouring provinces (autonomous regions) in terms of quantity and quality of health resource allocation. The number of health technicians per thousand people in Tibet was lower than national average and far behind that of Xinjiang, Inner Mongolia and Qinghai. The number of nurses per thousand people was not only lower than national average, but also much lower that of Xinjiang, Inner Mongolia and Qinghai, and the numbers of doctors and nurses per thousand people in Shigatse Prefecture were in turn much lower than the Tibet average.

The survey report identified four major factors contributing to inefficient HHR allocation and utilization:

- A lack of human resource management capacity; and rigidity of human resource assignment (the impact of the top down "quota");
- Staff do not have sufficient clinical and operational training opportunities and training is not effective; it is difficult to organize relevant training because of problems getting "cover" for staff on training;
- Motivation and incentive mechanism for health care workers are limited, this is compounded by harsh working and living environment and condition lead to draining of basic level workers;
- Lack of basic level personnel and low capacity of human resources are main factors influencing poor utilization of equipment; equipment is often allocated without taking into account local needs.

The first two points - the limited capacity in management, particularly HR management, and more effective delivery of appropriate clinical/ technical training - will be main areas for the new program. Whilst it will not be within the scope or resources of the new program to address the issue of the "quota", which is a national policy, the new program will focus on developing the ability of local management to make more effective use of current staff, in order to improve access and delivery of care. It will also aim to align itself with the main objectives of the 12th Five Year Plan, as these emerge.

It is also recognised in developing the program that the HHR challenges are not unique to Tibet. Careful analysis of HRH policy developments in other countries can provide insights and assist in identifying possible policy solutions for Tibet. For example, whilst taking account of context differences, there will be some scope to draw relevant lessons from country case studies, commissioned as part of the WHO Task Force work on Scaling up [e.g. countries such as Bangladesh, Ethiopia, Ghana, India and Malawi][14], the global work on health workforce scaling up [15], research and policy guidance on the scope to use financial and non financial incentives to motivate health workers[16], and the more recent WHO led evidence based policy recommendations on retaining health workers in remote areas[17] . One key message from these initiatives is that there has to be support and commitment to sustained improvement in HHR at the most senior level in government, that there needs to be effective HHR management systems in place, and that "scaling up" the health workforce is not primarily about "more" or "different" workers, it is about investing in training, developing and deploying the current workforce as effectively as possible.

The program focus and priorities take account of the limited available evidence base on the impact of HHR improvements on health service effectiveness and outcomes, particularly in developing countries. The incomplete evidence that does exist, summarised in Cochrane reviews, suggests that in-service

[14] WHO (2008a) Task shifting: global recommendations and guidelines. http://www.who.int/healthsystems/TTR-TaskShifting.pdf
[15] WHO (2008b) Task Force on Scaling up Education and Training of Health workers --Scaling Up, Saving Lives
[16] World Health Professions Alliance (2008) Guidelines: Incentives for Health Professionals. http://www.whpa.org/PPE_Incentives_Guidelines.pdf

[17] WHO (2010) Increasing access to health workers in remote and rural areas through improved retention: http://www.who.int/hrh/retention/guidelines/en/index.html

training may be followed by improved health professional practice[18]; that lay health workers in primary/community care can have positive impacts on MCH and management of infectious diseases[19] that educational meetings/workshops may improve professional practice[20], and that tailored interventions including focus group discussions of healthcare professionals can remove barriers to change and can change practice of health professionals[21].

This program focuses explicitly on HHR; in part this is because, as noted in the 11th Five Year Plan, current HHR limitations are constraining improved health service performance and access/access in TAR, and improved HHR will enable improved performance/access. It is recognised that for any health system to have sustained improvements in terms of performance, effectiveness and improved access there is clearly a need to identify all the necessary components that need to be aligned and managed. The WHO framework which identifies six critical components (service delivery, health workforce, information, medicines, financing and governance) illustrates the interconnectedness of the different components that require to be aligned to support improved performance and effectiveness[22].

This program has as its core focus the improvement of the health workforce component, but its coverage also links explicitly with improvements in the management capacity of the health system, and as such the aim is that this will "read across" to the improved management and deployment of other components such as management of the system and more effective use of financial resources in the labour intensive health sector. The focus of the program is on improving the effectiveness of the current workforce, building on the lessons of THSSP. As such the emphasis is on skilling up and more effectively managing a main cost component within the system- the workforce; and supporting improved effectiveness and access by ensuring that the skilled health workers are best deployed and supported locally by effective management systems which provide them with appropriate facilities, resources and drugs etc. It is emphasised in taking this approach that any limitations or constraints in maintaining the other components of the WHO framework (e.g. financing) could compromise the ability of the program to deliver fully on its objectives. This point is highlighted in the risks assessment.

[18] Opiyo N, English M. In-service training for health professionals to improve care of the seriously ill newborn or child in low and middle-income countries (Review). Cochrane Database of Systematic Reviews 2010, Issue 4. Art. No.: CD007071. DOI: 10.1002/14651858.CD007071.pub2

[19] Lewin S, Munabi-Babigumira S, Glenton C, Daniels K, Bosch-Capblanch X, van Wyk BE, Odgaard-Jensen J, Johansen M, Aja GN, Zwarenstein M, Scheel IB. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. Cochrane Database of Systematic Reviews 2010, Issue 3. Art. No.: CD004015. DOI: 10.1002/14651858.CD004015.pub3

[20] Forsetlund L, Bjørndal A, Rashidian A, Jamtvedt G, O'Brien MA, Wolf F, Davis D, Odgaard-Jensen J, Oxman AD. Continuing education meetings and workshops: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD003030. DOI: 10.1002/14651858.CD003030.pub2

[21] Baker R, Camosso-Stefinovic J, Gillies C, Shaw EJ, Cheater F, Flottorp S, Robertson N. Tailored interventions to overcome identified barriers to change: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews 2010, Issue 3. Art. No.: CD005470. DOI: 10.1002/14651858.CD005470.pub2

[22] WHO (2010) Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. http://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf

ANNEX C: BRIEF INTRODUCTION OF HEALTH MANAGERS' TRAINING PROGRAM

Background

In 2004, Ministry of Heath (MOH) required to launch a nationwide health management job training project based on summarizing health management job training work. To insure the training work carried out in fluently, MOH set up experts' steering committee, taking responsible for making training outline, establishing the training bases standard, selecting and editing the training textbooks, assessing the training base, etc. The Committee of experts working office set in Health Human Resources Development Centre (HHRDC), which is responsible for daily work.

For the senior manager having heavy and stressful workload, difficult to spare enough time to participate in face to face teaching, most of the job training work is distance education and self-study, supplemented by the necessary face to face teaching together. HHRDC as the organization and implementation institution, do the work actively according to the spirit of relevant policy documents. Especially in distance training, HHRDC contributed to organize well-known academic experts in health management both domestic and foreign to record distance education multimedia courseware varied from person to person, including Hospital Management, Public Health Management, Community Health Service Management, Township Health Service Management, edit Supplemental Materials.

Objectives

The general objective is to establish perfect administrators training system gradually according to the health administrator training work, form all health administrator certificate system, improve the overall quality and management level of the health administrator, create a professional health administrator troop meeting health service development.

The specific objective is to improve the trainees' understanding of the importance and scientific to health management, through the study of new knowledge, new methods and new technology in medical treatment and public health policies and regulations, Management, Economics, Science of health law, master the basic knowledge and skills in scientific management, have the ability of adapting to socialist market economy, administrate according to law, survey research, learning innovations to adapt the needs of health innovation and development.

Target group

The enrolment target of the project are health managers at present and reserved of all forms of health institutions at all levels in the whole country.

Classify the managers into four categories according to the medical institutions function and task:

1) Hospital managers: refers to managers at present and reserved of the county and above general hospital, hospital of traditional Chinese medicine, specialized hospital and so on.
2) Public health managers: refers to managers at present and reserved of all forms of center for disease control at all levels, health inspection institute, maternal and children health institution etc.
3) Community health service managers: refers to managers at present and reserved of community health center and community hospital, hospital heads and heath managers engaged in the community health service management.
4) Township managers: refers to managers at present and reserved of townships health centre.

Course Design

The project includes distance education and face to face teaching. Face to face teaching courses are designed by project undertaking units according to <health managers training> made by experts committee referring to actual work and needs of trainees. Distance education courses are designed by experts committee uniformly. Distance education includes optional course and compulsory course. Trainees can choose courses according to their own needs. Courses are mainly covers:

1) Hospital managers' training courses include 5 modules. The main content involves fundamental of modern hospital management, hospital resources management (including human resource, financial, material, information, etc.), hospital services management (including quality and marketing), relevant laws and regulations and sharing hospital management experience.
2) Public health managers' training courses include 2 modules: One is comprehensive quality of public health managers, which purpose to improve the ability of the trainees in fundamental management, information acquisition, gain and discrimination, self-studying, interpersonal communication and so on. The other module http://dict.youdao.com/search?q=modules&keyfrom=E2Ctranslation is how to solve practical problems, which purpose to improve the ability of trainees in financial management, human resources management, grasping relevant policies and regulations, guiding professional technique, dealing with public health emergencies.
3) Community health service managers' training courses include 5 modules. The main content involves modern management, economic management laws and regulations, community care, disease prevention, community health management and operation.
4) Township health centre managers' training courses include 5 modules. The main content involves macro economy and rural health, practice medicine according to law, township health centre management and building, rural health care, site inspection and so on.

Learning style

Health managers' training is mainly distance education and self-study supplemented by the necessary face to face teaching uniformly. Trainees attend training every five years in no less than 3 months, face-to-face with concentrated time no less than 10 days in principle.

1) Distance education: rely on distance education platform with systematic, basic characteristics. Trainees study through web with a kind of study-cards. The study-cards are divided into four kinds by specialized courses: hospital managers' training study-card, public health managers' training study-card, community health service managers' training study-card, township heath centre managers' training study-card. Trainees could debate, question and answer, coaching, hand in their homework and take subject tests, etc.
2) Face to face tutoring: Face to face tutoring rely on national grade and provincial project undertaking units designated by experts steering committee. National grade units undertake health administrator training of provincial medical and public health institutions, provincial units undertake health administrator training of prefecture-level and below medical and public health institutions. When the trainees apply the project, they could choose the nearest face to face tutoring undertaking unit.

Evaluation and Certificate

Evaluation strategies: Case analysis, writing work experience is used to M&E. Distance education and evaluation is carried out by experts' steering committee uniformly. After class finishing, trainees could choose anytime to take web-test. They could gain distance education score and certificate after passing web-test. Face to face evaluation is organized by HHRDC.

Certificate: When the trainees finished the training course and pass the evaluation, they could acquire score-certificate awarded by experts' steering committee. When the score accumulate to "standard" score, they could apply for "health managers training certificate".

Trainers and resources

HHRDC has established a trainer's pool. For example,

Table 1 trainers and courses for hospital managers

Course Modules	Course Topics	Trainers	Course Length
Hospital Strategic Management	Strategic location and choice of innovation management in hospitals under the new situation	Li Jingbo	3h
	Case: Strategic location, choice discussion, strategy implementation - brand building,operational advantages and integration of resources in Beijing Cancer Hospital	Zhang xiaopeng	2.5h
	Case: Strategic location, choice, strategy implementation - structure reengineering, process optimization and restructuring and regional medical collaboration in Huaxi Hospital	Shi Yingkang	2.5h
	Strategic management	Zhang yujie	
	Hospital strategic management	Chen shaofu	6h
Hospital Quality Management	Assessment and improvement in healthcare quality	Wang jishan	3-6h
	Hospital quality management tools and applications	Qian qingwen	4h
	Integration of hospital quality management system and the management of information indicators	Qian qingwen	2h
	Case: Healthcare quality improvement and process optimization in Huaxi Hospital	Shi Yingkang	2.5h
	Hospital process management	Pan Xilong	3h
Human Resource Management	Hospital performance and salary management	Qian qingwen	3h
	Case: Innovative human resource management system in Huaxi Hospital	Shi Yingkang	
	Case: Innovative human resource management system in Beijing Cancer Hospital		
Hospital Communication Management	Management communication modes	Wang zhiyun	0.5
	Communication process and barriers		1
	The art of communication		2 - 3
	The improvement of management communication		2 - 3
Hospital Culture Building	The establishment of core values and spirit in hospitals	Pan Xilong	1.5
	The building of hospital ethics and culture	Pan Xilong	1.5-3
	The evaluation system and evaluation method of hospital culture	Pan Xilong	1 - 1.5
	The service system of patient satisfaction and the image of the hospital	Pan Xilong	1.5-3
	The system and environment of hospitals	Pan Xilong	1.5
Construction of Hospital Information	The implementation of hospital information system	He Yusheng	6
	HIS subsystem design and construction	He Yusheng	3
	Standardization of the hospital information system	He Yusheng	3
	Progress in the hospital information system technology in China	He Yusheng	3
	The application of information technology in hospitals in the United States	Yu zhiyuan	3
Hospital Process Management	The significance of process optimization and program implementation	Pan Xilong	
	The test and evaluation of process optimization	Pan Xilong	
	Process optimization and CS (customer satisfaction)	Pan Xilong	
	The staff participation and satisfaction in process optimization management	Pan Xilong	

Course Modules	Course Topics	Trainers	Course Length
	Case: The benefits brought by process optimization in hospitals	Pan Xilong	

Table 2 trainers and courses for middle managers in health institutions

Course Modules	Course Topics	Teachers	Course Length
Basic Theory of Management	Fundamentals of management	Lu zhiming	12h
	Theory and practice of organizational behavior	Dong ming	12h
Personal Accomplishment and Leadership	Rebuilding administrator - art of leadership	Wang dazheng	12h
	Situational leadership	Song zhenqin	3h
	Appreciation of classic poetry and human accomplishment	Cheng yuzhui	3h
	Business etiquette and communication arts	Jin zhengkun	3h
	The art of communication	Wang zhiyun	3h
Hospital Quality Management	Assessment and improvement in healthcare quality	Wang jishan	3-6h
	Hospital quality management tools and applications	Qian qingwen	4h
	Integration of hospital quality management system and the management of information indicators	Qian qingwen	2h
	Case: Healthcare quality improvement and process optimization in Huaxi Hospital	Shi yingkang	2.5h
	Hospital process management	Pan xilong	3h
Management of Human Resource	Hospital performance and salary management	Qian qingwen	3h
	Case: Innovative human resource management system in Huaxi Hospital	Shi yingkang	3h
	Case: Innovative human resource management system in Beijing Cancer Hospital	Zhang xiaopeng	3h
	The building of health human resource: Creativity and successful team	Wang zhiyun	3h
	Talent is the key to the survival and development of hospitals	Liu yucun	3h
	Hospital human resource development and management	Song zhenqiang	12h
	Hospital human resource development and management	Liu yi	6h
	Hospital human resource development and management	Guo chi	6h
Health Economics	Health Economics	Wu ming	12h
Doctor-patient Communication and the Settlement of Medical Malpractice	Doctor-patient communication science	Yin mei	6h
	Doctor-patient communication arts	Gu jin	6h
	Medical law	Wang yue	6h
	Medical dispute resolution techniques and case studies	Chen zhihua	6h
	Media accomplishment and response to the media	Tu guangjin	6h
Hospital Marketing	Hospital marketing and management	Wu chunrong	6h
	Hospital brand management	Hu baijing	6h
	Hospital service marketing	Pan xilong	6h
Hospital Financial Management	The financial management of non-financial staff	Huang huixin	6h
	The financial management of non-financial staff	Yuan li	6h
	Hospitals' full cost accounting and management	Du shuwei	3h

Course Modules	Course Topics	Teachers	Course Length
	Hospital cost accounting and cost analysis	Cheng wei	3h
	Hospital capital operation	Du lexun	6h
	Healthcare financial management	Qian qingwen	12
Topics of Department Building	The operation management of departments in modern hospitals	Chen shaofu	
	To be a successful hospital department manager	Song zhenqin	3h
	The construction and development of departments in hospitals	Li ning	3h
	How to be a competent division director	Shen lin	3h

ANNEX D: LOGFRAME

Program Level	Narrative Summary	Verifiable indicators	Responsibility	Means of verification	Assumptions
Goal	**To improve the health of the people of Tibet**	MMR, IMR	TRBH	Tibet HIS routine data collection	Data is up to date
Purpose	More efficient and better quality health service delivery	• Improved resource allocation • Reduced case-fatality rates in pilot sites	CLTAs	TRBH and program data Hospitals, health centres, CDC data	Data is able to be collected from existing or program sources
Component 1	**Health Human Resource Management (HHRM)**				
Objective 1 **Outcomes**	Improved HR management practices at the strategic & operational levels • Senior managers at regional level turning the 12th Five Year Tibet Health Human Resources Plan into implementable strategies • At regional level managers display improved HR skills and practices • At prefecture and county level managers display improved HR skills and practices	• Improved staff distribution across services • new HR policies developed and implemented • Increase in % of trainees initiating/implementing HRH projects ▪ Improved staff recruitment processes ▪ Increase in % of staff receiving annual supervision assessment • Increasing number of divisions in TRBH taking lead in program activities as part of the implementation of Tibet 12th Five Year HRH Plan • Increased staff satisfaction with jobs & the organisational environment	CLTA HHR	Workforce surveys Facility surveys, records HR surveys; case studies Case studies HR records Most Significant Change stories Staff satisfaction survey (THSSP)	Support from senior management to implement change Systems barriers don't impede change All beneficiaries receptive to organisational change
Output 1.1	Capacity building in HHRM undertaken for Bureau managers at regional level	Comprehensive capacity building completed	CLTA HHR/PM	Project/training reports	Trainers available when required Trainees able to be released from work place
Output 1.2	Follow up support to Bureau managers at Regional level to implement improved HHRM knowledge and skills.	• Supportive follow-up occurring • HR policies, procedures informed/ developed by project research	CLTA HHR/PM	Project reports	System enables learning set and workplace project approach

Program Level	Narrative Summary	Verifiable indicators	Responsibility	Means of verification	Assumptions
Output 1.3	Capacity building in health management undertaken for Bureau managers at prefecture/county level	Comprehensive capacity building completed	CLTA HHR/PM	Project/training reports	Trainers available when required Trainees able to be released from work place
Output 1.4	Follow up support to Bureau managers at prefecture and county level to implement improved health management knowledge and skills.	• Supportive follow-up occurring • HR policies, procedures informed/ developed by project research	CLTA HHR/PM	Project reports	System enables learning set approach
Component 2	**Technical and Clinical Practices**				
Objective 2 **Outcomes**	Improved priority technical & clinical practices of the workforce in pilot sites • Improved functioning of prefecture CDC laboratories • Pilot county hospitals and township health centres providing better health services • Improved capacity to contain infectious disease outbreaks.	• Increased accuracy rate for laboratory check • Increased accuracy rate of diagnosis • Decreased hospital infection rate • Improved recovery rate for severe cases • Increased patient satisfaction with services • Improved epidemiological and emergency response capacity : % of National CDC reporting requirements met	CLTA HS CLTA Laboratory	Facility surveys in pilot sites Laboratory surveys, records Yearbook data collection method Patient satisfaction survey in target program facilities (THSSP?) Case studies National CDC reporting checklist	
Output 2.1	Training of prefecture CDC laboratory staff conducted	Training completed	CLTA Laboratory	Training report	Laboratory technicians released for training Labs have functional equipment to support improved practice
Output 2.2	Guidelines for County Hospital and Township Health Centre developed	Finalised County Hospital and Township Health Centre Guidelines New service items developed	CLTA HS	Project reports	System support is optimal Review group membership is active
Output 2.3	A pool of technical health trainers developed	Trainers trained	CSTA Training	Training reports	
Output 2.4	Training of technical staff for identified priority areas	Training completed in identified areas	CLTA HS	Training reports	Systems support is optimal

Program Level	Narrative Summary	Verifiable indicators	Responsibility	Means of verification	Assumptions
	conducted				Staff released for training?
Output 2.5	Building preparation and response capacity for containing disease outbreaks	Simulation exercises undertaken Any infectious disease outbreak quickly contained	TL	Project reports	Expert assistance can be found quickly

CLTA HHR: Chinese Long Term Adviser – Health Human Resources
CLTA HS: Chinese Long Term Adviser - Health Systems

ANNEX E: DETAILED DESCRIPTION OF PROGRAM ACTIVITIES

COMPONENT 1: HEALTH HUMAN RESOURCE MANAGEMENT (HHRM)

Objective: Improved HR management practices at the strategic and operational levels

Indicators:

- Improved staff distribution across services
- New HR policies developed and implemented
- Increased % of trainees initiating/implementing HRH projects
- Improved staff recruitment processes
- Increased % of staff receiving annual supervision assessment
- Increasing number of divisions in TRBH taking lead in program activities as part of the implementation of Tibet 12th Five Year HRH Plan
- Increased staff satisfaction with jobs and the organisational environment

Geographical focus: The whole of TAR

Output 1.1 Capacity building in HHRM undertaken for Bureau managers and Directors at regional level

Target group: Regional Bureau Managers and Directors of institutions under direct leadership of BOH, including managers and directors of CDC, Health supervision centre, Hospital and Traditional hospital at Provincial/Regional level.

Output narrative

This output will result in Bureau managers at regional level with improved capacity, skills and ability to understand, develop and implement HR policy, and to undertake HR planning in the health system, including developing and implementing the TAR 12th Five Year HR Plan.

Activities will include an experiential Bureau Management HR Development Program (BMHRDP) (with senior Bureau managers as participants- approximately 60 in total) in the first two years of the program, and well-planned study tours to counterparts in other Provinces/Regions, and where relevant, internationally. As a lesson learned from THSSP, and to limit any constraints imposed by language barriers, all training and learning set will be held within TAR or nationally. Capacity will subsequently be sustained through a mentored learning set approach[23]. BMHRDP content will promote sustainable system change and co-ordinated implementation of the TAR HR Plan, and will link to the HR elements of prefecture/county level management development (see Component 1.3), to support for developing guidelines for technical services in pilot sites (Component 2.2), and to training provided in key technical areas (Component 2.4).

The design and content of the BMHRDP will be based on findings from the initial technical analyses which is undertaken at start up of the program, and from the key elements of the TAR 11th Five Year Plan. It develops an understanding of key concepts and elements of HR policy and planning adapted to GOTAR's needs, is flexible, individually tailored and highly interactive, based on best practice adult learning methods through facilitated delivery, includes a complex scenario planning exercise, and encourages critical thinking and problem solving. The initial training would be a 10-15 day course based in TAR. This would be complemented by follow-up training and individual mentored support. The CLTA HHR will co-ordinate activities, with support from national experts as required. BMHRDP is likely to have

[23] A learning set is a work based group, usually of 4- 8 people that meets regularly in order to explore solutions to real workplace problems and decide on the related action which should be taken

15-20 contact days spread over 18 months, plus 5 days study tour, and will subsequently be supported by a facilitated learning set meeting approximately 4- 6 times a year (see Output 1.2 below).

There are well-planned national study tours with clear and relevant learning objectives which are linked to the program objectives of improved HR management, and with formal processes for passing on learning on return to TAR. Aims of the study tours include new knowledge and understanding of HR concepts, policies and planning, and sustainable new networks for ongoing technical exchange. Study tours are to other Provinces/Regions and Ministries in China, with the first planned as an integral part of the overall delivery of training and development in the first year.

Participants on BMHRDP and the study tours are selected on merit to ensure the most appropriate people attend, and reflect gender and ethnicity balance. Selection for training will include assessment of willingness and ability of the trainee to further develop and share new knowledge and apply it in the workplace with colleagues, through collaborative practice, joint project work, etc.

Likely activities:
1.1.1 Objectives of BMHRDP developed
1.1.2 BMHRDP training institution(s) selected
1.1.3 BMHRDP trainees selected
1.1.4 BMHRDP assessed, planned and delivered
1.1.5 Study tours to other Regions/nationally/internationally conducted

Output 1.2 Follow-up supports to Bureau managers and Directors at Regional level to implement improved HHRM knowledge and skills.

Target group: Regional Bureau Managers and Directors of institutions under direct leadership of BOH.

Output narrative
Once initial training and development of the Bureau managers has been completed, their ability to think and act effectively within the work context will be supported by the program through mentoring and by group and individual work based projects, involvement in applying HR policy, and continued exposure to new ideas and HR related research, both in Tibet and nationally.

A formal learning set approach will be developed and supported across the timeframe of the program, to support a shared understanding of HR developments and challenges, and to enable BMHRDP participants to share knowledge and develop effective team work. The learning set will meet formally approximately 4-6 times a year and its activities will be supported by the CLTA HHR, with support from national experts as required. In advance of each meeting, an HR policy or planning topic will be selected to be the focus of that meeting of the set. Members of the set will also serve as a source of expert advice within TAR in support of further implementation of improved HR management, policy and practice.

The implementation of the 12th Five Year HR Plan for TAR (2011-2015) will be supported by the program, through targeted technical assistance from national experts, with support drawn from all related Divisions, and experts from within TAR (e.g. Tibet University Medical College [TUMC]). There will also be input from members of the BMHRDP, and the annual HHR Forum (see below) will provide a mechanism for analysis and discussion of progress with implementation.

A TAR Health Sector HR Forum will be held annually, to broaden understanding of critical HR issues in the health sector in TAR, present key findings of HR surveys and policy analysis, and assess progress with the 12th Five Year HR Plan. The forum will be hosted by the TRBH, and forum members will include all BMHRDP participants, other managers from the health system (including managers from the pilot sites developed for Component 2), other relevant stakeholders from TAR, and national and international HR experts.

Meetings of the HHR Forum should take a regional, national and international perspective, to provide the opportunity for TAR based managers to gain insight into how other regions and countries are addressing similar challenges of scaling up, task shifting and incentives for improving retention in remote areas.

In support of the annual HHR Forum, HR policy research projects will be conducted on critical issues of HR policy and planning; the findings and results of these projects will be used to inform the focus of the annual Forum. The program will provide support to TAR-based (e.g. TUMC) and other national research institutes to undertake these projects. These projects should focus on aspects off HHR that have the potential to deliver positive change and improvement in the health system- for example, the use of non financial incentives to motivate and retain staff; the use of local performance management approaches, effective management of staff absenteeism.

Likely activities:

1.2.1 BMHRDP mentored learning set
1.2.2 Support to the implementation of the 12th Five Year HR Plan
1.2.3 Annual TAR HHR Forum established
1.2.4 HR research supported

Output 1.3 Capacity building in health management undertaken for Bureau managers at prefecture/county level

Target group: Prefecture BoH Directors, hospital directors, CDC directors and division chiefs, hospital technical division chiefs); county BoH Directors, hospital directors, CDC directors, hospital technical division chiefs.

Narrative description:

Activities will result in prefecture and county level health managers having the capacity to apply standard management skills, knowledge and practice, particularly in HR management and in support of the implementation of the 12th Five Year Plan. At the end of the program these managers will be using standard approaches to aspects of HR management such as managing performance of staff and management of change, and will have developed an understanding of the HR policy context at TAR and national level.

The development of the detailed program content is informed by a training needs analysis (TNA) undertaken at program start-up which assesses the current skill levels of the target groups of managers in the module areas (see below), reviews existing approaches to training provision, identifies critical training gaps and develops a flexible approach to training delivery. A working group comprised of national experts, Bureau management and representatives of county, prefecture management will use the results of the TNA to develop a best practice approaches to training delivery for TAR. Training providers at TAR and national level will be identified. This initial TNA will also assess the availability of existing training modules elsewhere in China, developed by the Health Human Resources Development Centre that can be used or adapted in TAR. This activity will be supported by the CLTA HHR.

Managers to be targeted for the training will be at prefecture level (BoH Directors, hospital directors, CDC directors and division chiefs, hospital technical division chiefs) and at county level (BoH Directors, hospital directors, CDC directors, hospital technical division chiefs). In total it is anticipated that 600 participants will be trained and developed .There will be joint training for the two groups.

Trainees will be selected on merit to ensure the most appropriate people attend, and reflect gender and ethnic equity. Training will focus on experiential management development programs for prefecture and county health managers. The content of programs is linked to the Bureau Management HR

Development Program (Output 1.1) to enable sustainable system change and support understanding and achievement of the objectives of the 12th Five Year HR Plan.

Whilst detailed content will be informed by the TNA, and where appropriate will utilise or adapt current training modules, there are likely to be four core areas in which training should cover: (i) understanding relevant national health policies; (ii) HR policy and management; (iii) financial management; and (iv) facilities and logistics management. Whilst training in HR management is the priority, skills in this area cannot be developed in isolation from other critical linked components of the management of services. The HR management module will include training and development in national HR policy (including the 12th Five Year HR Plan if available), change management, managing teams and staff performance, operational level staff planning, allocation and rostering, attendance management and the use of information/data. It will be linked closely to the content of training and development being provided at TAR level under Output 1.1.

Training provision will be flexible and adaptive to meet the needs of participants. Not all participants in the training will require training in all four modules, and the detailed content of each module will be varied, depending on the organisational level of the managers (there will be separate training for prefecture and for county level managers). The first two modules (understanding relevant national health policies, and HR policy and management) will be "core" for all participants. Some participants will also take the other modules, depending on the relevance of training to their job role. Initial core training will be a two-week course based in TAR.

The training modalities used are informed by the TNA, and will be a blended approach to enable delivery of training at the workplace, combined with periods of off-the-job training. These will include in-service/on-the-job training, work placements, short course/workshops and distance learning. The CLTA HHR will participate in the initial TNA and training design and will then provide ongoing support in the training activities.

Output Activities:

1.3.1 Training needs analysis – (identifies the training providers, priority component for training)
1.3.2 Select management trainees
1.3.3 Train prefecture and county managers (BoH Directors, hospital directors, CDC directors, hospital technical division chiefs)

Output 1.4: Follow up support to Bureau managers at prefecture and county level to implement improved health management knowledge and skills.

Target group: Prefecture BoH Directors, hospital directors, CDC directors and division chiefs, hospital technical division chiefs); county BoH Directors, hospital directors, CDC directors, hospital technical division chiefs.

Narrative description:

Once initial training and development of the 600 Bureau managers at prefecture and county level has been completed, their ability to think and act effectively within the work context will be supported by the program through group and individual work based projects, involvement in local application of HR policy, and continued exposure to new ideas and HR related projects.

The focus will be on follow-up support, which will assist implementation and monitoring of changed practice. This will be enabled through a formal learning set approach which will be developed and supported across the timeframe of the program, to support a shared understanding of HR developments and challenges, and to enable managers at prefecture and county level to share knowledge and experiences and develop effective team working. The learning sets will be organised at prefecture level and will meet formally approximately 4 times a year. Their activities will be supported by the CLTA HHR, with support from regional and national experts as required. In advance of each meeting, an HR management topic will be selected to be the focus of that meeting of each set.

Selected learning set members at prefecture/county level will also be involved in the TAR Health Sector HHR Forum (see above) which will broaden their understanding of critical HR issues in the health sector in TAR, and sensitise them to new national and regional HR developments.

In support of the local application of new HR management skills and ideas into practice the program will make available small funds and technical support for local HR projects on issues identified as priorities by participants. These projects would assess current HR issues and lead to clear outputs, either the development of new HR tools and procedures at a local level, or the identification of practical solutions to local solutions.

Output activities:
1.4.1 Prefecture level mentored learning sets
1.4.2 Participation in Annual TAR HR Forum
1.4.3 Local HR practice projects supported

<u>COMPONENT 2:</u> TECHNICAL AND CLINICAL PRACTICE

Objective: Improved priority technical and clinical practices of the workforce in pilot sites

Indicators:
- Increased accuracy rate for laboratory check
- Increased accuracy rate of diagnosis
- Decreased hospital infection rate
- Improved recovery rate for severe cases
- Patient satisfaction with services
- Improved epidemiological and emergency response capacity

Geographical focus: Three pilot prefectures (except for 2.1, which will be TAR wide)

The focus of Component 2, for Outputs 2.2 to 2.5 will be in three pilot prefectures, which will be selected as "good", "medium" or "poor" based on level of resources, and degree of geographical remoteness. The objective is to develop new approaches to training delivery in these pilot prefectures, based on training needs analysis, the development of a data base of trainers, and the development of guidelines for functions to be provided in typical ("model") country hospitals and townships health centres, with the aim of then rolling out to the rest of the TAR if these approaches are found to be effective.

In each of the selected prefectures, 2-3 counties will be selected on the basis that they are motivated to participate in the program. In addition, 4-6 townships in each county will also be included in the pilot, in the main to enable assessment of county level management and practice outreach and support to township level.

The three chosen prefectures will be asked to nominate the selected counties and townships for inclusion as pilots. Motivation of management and staff will be a key factor in selection.

The timing of delivery of the different outputs is planned so as to ensure that there is optimum use of program resources across the time period of the program, with alignment between different aspects of training delivery. The schedule is designed to avoid any planned training delivery in the winter period, when travel is difficult and many staff are on leave.

<u>Output 2.1</u> Training of prefecture CDC laboratory staff conducted

Target group: Technical staff working in prefecture CDC laboratories

Geographic coverage: TAR wide

Narrative description:

This Output should result in health services being improved, through increased staffing skills and capacity in laboratory testing at prefecture CDC level. This is a critical step in the process of effective health service delivery. Strong laboratory capacity ensures accurate and timely testing, rapid and correct diagnosis and treatment. Inadequate staffing and skills in laboratories has been identified as one critical issue constraining health service effectiveness.

Laboratory technical skills gaps will be identified by training needs analysis and will then be met by provision of relevant technical training,

Training strategies to improve skills of laboratory staff will use sustainable formal training programs, on-the-job reinforcement of skills and knowledge, and continuing education. Training will be provided in TAR and on-the-job support and mentoring will be supported by a CLTA Lab affiliated with a relevant Chinese institution. A small amount of basic essential laboratory equipment may be procured during the training provision to support effective delivery of training and sustainable impact.

The initial target group for laboratory training may be about 30-50 health workers at prefecture CDC level. Trainees will be selected from laboratory sites on the basis of current skills level and potential for up-skilling.

Training delivery and outcome will be evaluated after the first year of delivery, and curricula content and delivery modes adapted as necessary.

Activities

2.1.1 Conduct training needs analysis in prefecture CDC labs
2.1.2 Identify training providers supplemented by national experts
2.1.3 Develop training program
2.1.4 Develop selection criteria for trainees, and select trainees
2.1.5 Undertake training
2.1.6 Ongoing support to trainees
2.1.7 Evaluate the training program

Output 2.2 Guidelines for County Hospital and Township Health Centre developed

Target group: Pilot County Hospitals and Township Health Centres

Narrative description:

This Output will result in guidelines that identify the minimum level of service to be ideally provided at the county hospital and township health centre level, and the related staffing profile required to provide these services.

Some relevant national and provincial guidelines exist, but there is no overall set of function descriptions or guidelines for county hospital and township health centres. Recent financial support for "hardware" at these levels (e.g. new buildings) now places an even greater emphasis on the need to determine the appropriate "software" (e.g. staffing). Guidelines will be developed that relate to "model" county hospital and township health centres, i.e. these will describe the full complement of functions that should be provided by a fully established county hospital or township health centre. These guidelines will specifically identify the functions to be provided in the facilities, and the related staffing skills required to fulfil these functions.

A Guidelines Technical Group will first be established to review current guidelines, and then to build on the lessons from this review to develop new guidelines which focus specifically on functions that should exist in a "model" county hospital, and related township health centre. The required staffing profiles would also be identified. These guidelines, once fully developed and agreed, could be used to assess

the extent to which actual functions provided, and related staffing, fall short of the model, hence enabling critical gaps in functions and related staffing to be identified.

The Guidelines Technical Group will comprise of representatives of regional, prefecture and county level management facilitated by the CLTA HS, with support from national experts as required.

Once developed, the feasibility of the guidelines will be tested in selected county hospitals and township health centres, managers are supported in their use, and they are then evaluated and modified as necessary. Finally, within the program, the potential for regional rollout of guidelines will be assessed by the Guidelines Technical Group. Any subsequent decisions on rollout of the guidelines would be the responsibility of TRBH.

Activities

2.2.1 Establish Guidelines Technical Group
2.2.2. Group review current guidelines
2.2.3. Guidelines are developed
2.2.4 The feasibility of the guidelines are tested in county hospitals and township centres
2.2.5 Guidelines are evaluated/modified as necessary
2.2.6 Assess the potential for regional rollout of guidelines

Output 2.3 A pool of technical health trainers developed

Target group: regional and prefecture clinical and technical staff in pilots; for TOT training, staff from training centres of hospitals and TUMC.

Narrative description:

This output will result in a pool of approximately 50-100 GOTAR trainers skilled in and applying adult teaching and learning methods, for example work based learning, workshops, and off-the-job training courses across identified priority technical areas. The pool supports the delivery of training at technical level (Output 2.4) and is comprised of existing trainers and the beneficiaries of a new train-the-trainers (TOT) program.

The health system in TAR currently has only limited capacity to provide training to technical staff, and much of this capacity is located within less effective approaches, such as classroom based lectures. The pool will increase overall training capacity, and will comprise technical staff skilled in appropriate and effective modes of training delivery.

The overall approach will lead to an increased pool of trainers available to support improved technical skills in defined priority areas within the pilot prefectures. The pool will comprise of current skilled trainers, supplemented by new cohorts trained in a train-the-trainer exercise supported by the program. This pool will be expanded as new priority technical areas are identified, and pool members will receive updating skills training as necessary. They will continue working at their normal place of work but will be available for short term deployment in support of technical training.

The identified initial critical areas for this pool will be based on guidelines development (Output 2.2), and training needs analysis where applicable.

The first activity is to identify existing trainer capacity in identified critical areas, and develop an outline of the training objectives, along with identification of TAR and national training provider(s).

The relevant Divisions in the TRBH working with the PMT will then select appropriate trainees for the TOT program, using agreed selection criteria. A TOT training program will then be developed, and training provided to an initial cohort of 30-50 in the first year. The objective of the training is to develop the participants as effective trainers. Training will focus on developing the training skills and abilities of the trainees in a range of relevant training modalities; they will already be experienced practitioners in

their area(s) of technical and clinical skills. Training will be based on two periods of three weeks, mainly off the job.

This will be co-ordinated by the CLTA HS, with a "package" of training of trainers delivered by external national level technical experts, including initial training, and follow up support and monitoring as necessary. The CLTA HS would provide the ongoing mentoring and support, and may do some of the outreach trainee support.

The Division of Science and Education is the TAR focal point for this technical capacity building and the related TOT activity. The outside experts may work with TUMC staff and other TAR training institutes, and co-ordinate mentoring and longer term support to the pool of technical trainers. Subsequent rounds of TOT to new cohorts of recipients will be undertaken on an as needed basis, to broaden the technical areas covered by the pool, once these new technical priority areas have been identified, and to maintain numbers of trainers. Refresher training is provided by the CLTA HS as required to the existing pool, to update skills.

The training program in the first year is evaluated and lessons from the evaluation are used to make any necessary improvements to content and approach in subsequent years.

Output Activities

2.3.1 Identify existing trainer capacity
2.3.2 Develop an outline of the training objective
2.3.3 Identify training providers
2.3.4 Develop selection criteria and select trainees
2.3.5 Develop training program
2.3.6 Undertake training
2.3.7 Ongoing support to trainees
2.3.8 Evaluate the training program

Output 2.4 Training of technical staff for identified priority areas

Target group: Technical staff in the identified priority areas, at prefecture, county and township

Geographic coverage: Pilot sites

Narrative description:

This should result in health services in identified priority technical areas being improved, through increased staffing skills and capacity. Precise indicators will be developed once baseline assessments are made, using government data systems where available.

Program activities in this Output will complement rather than duplicate current training activities being provided by TAR, such as to township doctors/GPs, to ensure additional benefits to the health system. Activities will be differentiated from, but aligned with other current and planned training provision and will focus on technical skills areas of unmet need. The program will provide support for identified technical training priorities; this support will be managed by the CLTA HS, and will be a flexible resource to respond to priority training gaps identified through guidelines development in Output 2.2 and/or by training needs analysis. Flexible funding will include provision for support of trainers drawn from the training pool, complemented where necessary by additional specialist trainers brought into TAR on a short term basis. This will be coordinated by the CLTA HS.

Training strategies and activities might include sustainable formal training programs, on-the-job reinforcement of skills and knowledge, and continuing education. Trainees will be selected on the basis of their current skills levels and work location within the pilot areas.

Trainers with relevant technical skills will be drawn from the trainer pool, supplemented as necessary by additional TAR and national experts. Training will be provided in the pilot prefectures. After initial off-the-

job training, trainees will then be provided with additional follow-up mentoring and review. Learning materials may require development or may be available through INGOs or from other projects in TAR.

Training delivery and outcome in initial identified technical areas will be evaluated after the first year of delivery, and curricula content and delivery modes adapted as necessary.

Activities
2.4.1. Conduct training needs analysis in identified technical areas
2.4.2. Identify training providers from the training pool supplemented by national experts
2.4.3. Develop training program
2.4.4. Develop selection criteria for trainees, and select trainees from pilot sites
2.4.5. Undertake training
2.4.6. Ongoing support to trainees
2.4.7. Evaluate the training program

Output 2.5 Building preparation and response capacity for containing infectious disease outbreaks

Target group: Most likely CDC and others as public health emergencies emerge

Output narrative:

During the design process TRBH identified the need for the program to support preparedness and responses to disease outbreaks. This was a highly-valued feature of THSSP. After THSSP assistance, the accuracy of disease control work done by the Linzhi county CDC increased markedly. CDCs not supported by THSSP achieved only 30% of the national reporting requirements, compared to Linzhi's 80%.[24] The capacity building from THSSP helped equip Linzhi CDC to rapidly contain an outbreak of the plague in 2008.

The new program will improve epidemic preparedness, promotion, response and reporting in the three target prefectures. It will tie in with the prefecture CDC laboratory staff training under Output 2.1. Activities will include training in epidemiology, field studies, and simulation exercises.

The funding available for this Output will decrease over the timeframe of the program with a view to TRBH taking greater responsibility for responding to these needs within its own budget before the program concludes, thus increasing the likely sustainability of this intervention.

Activities:
2.5.1 Infectious disease response drills carried out
2.5.2 Rapid response to containing infectious disease outbreaks.

[24] Case Study #2 on Health System Change (Page 107 of THSSP ACR).

ANNEX F: POSITION DESCRIPTIONS/TERMS OF REFERENCE

There are four long-term members of the rogram Team. The Team is led by a Team Leader who is responsible for the co-ordination and delivery of all program funded inputs and activities and also for taking the lead on effective liaison with all stakeholders. The TL requires a background in senior-level health system reform and change management in the health sector, as well as strong interpersonal and communication skills; ideally including experience of project management and of human resource development. Ideally, the TL has capacity for analysis of management skills.

Three Chinese Long Term Advisers (CLTA) support the TL to deliver Components 1 and 2. The first two CLTAs focus primarily on Health Systems and on HHR training. These two CLTA require management experience, and a range of relevant skills to support each component, e.g. health systems and management for Component 1, and management and delivery of training to clinical staff for Component 2. Ideally the skills of the two CLTA, and the TL, will complement each other, each contributing across components, to enable the required program approach, as distinct from a vertical approach. A CLTA Laboratory will be engaged for a continuous period of 27 months to support delivery of Output 2.1. This person will be affiliated with an appropriate Chinese institution/laboratory.

The CLTA position descriptions are provided below.

Position Description

Team Leader

Responsibilities

The Team Leader (TL) is responsible for in-country program leadership and management.

The TL reports to the Program Technical Director who has overall responsibility for the success of the program. The TL will manage, monitor, and evaluate the activities of all in-country team members, establishing an excellent team approach, and ensuring strong linkages and synergies between and across Components.

The TL leads the establishment of relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; leads consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; monitors the consultations of team members; provides technical input according to professional expertise; assures reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all program activities and processes; and manages the program budget to the highest level of financial accountability.

Experience

The TL will have a recognised and valued track record in:

- Senior health system policy and management.
- Change management and effective communication.
- Strategic thinking and planning.
- Effective personnel management based on creating effective teams.
- Budgeting and budget management.
- Complex report writing.
- Success achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The TL's personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills.
- Effective consultation skills.
- Problem solving skills.
- Taking accountability and responsibility for their own, and their team's, actions.
- A track record of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The TL's professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- Health systems and health system reform, including policy, financing, and management issues.
- Policy development and review
- Health system analysis.
- Strategic planning
- Project management
- Health information and indicator monitoring.
- Cross-cultural communication.
- A track record of building capacity with counterparts.
- Facilitating multisectoral collaboration and building partnerships

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Training design, delivery and evaluation, including participative methodologies
- Human resource management and planning
- Hospital and primary care management
- Project design, monitoring and evaluation.
- Gender analysis.
- Cultural analysis.
- Qualitative analysis.
- Quality assurance.
- Rational planning for resource allocation and use
- Socio-cultural and behavioural research

Position Description

Chinese Long Term Adviser (CLTA):

Health Human Resources (HHR)

Responsibilities

The CLTA Health Human Resources (CLTA HHR) reports to the TL, and is responsible for the technical and management leadership for Component 1, and its successful planning and implementation, and for contributing actively to linkages and synergy across Components.

Under the leadership of the TL, the CLTA HHR establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership and input to Component 1; manages inputs of any short term consultants; facilitates counterpart capacity building including of M&E; ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all Component activities and processes; and manages the Component budget to the highest level of financial management accountability.

Experience

The CLTA HHR will have a recognised and valued track record in:

- Senior level health policy /management development and implementation.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Budgeting and budget management.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CLTA HHR personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's actions.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CLTA HHR professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- International thinking on lessons learned and current approaches to health systems organisation and management.
- Health systems policy development and review
- Health systems management development
- Strategic planning
- Project management
- A track record of building capacity with counterparts.
- Qualitative analysis.
- Cross-cultural communication.

- Facilitating multisectoral collaboration and building partnerships.

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Monitoring and evaluation
- Human resource planning and management
- Training needs analysis, planning and delivery.
- Cultural analysis.
- Quality assurance.
- Training, including adult learning and participative methodologies.
- Project design.
- Rational planning for resource allocation and use.

Position Description

Chinese Long Term Adviser (CLTA):
Health Systems

Responsibilities

The CLTA Health Systems (CLTA HS) reports to the TL, and is responsible for the technical and management leadership for Component 2, and its successful planning and implementation.

Under the leadership of the TL, the CLTA: HS establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership and input to clinical/technical training and development activities in Component 2; plans and manages the work of short term consultants and other trainers; manages the development of the "pool" of trainers; facilitates counterpart capacity building including of M&E; ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all Component 2 activities and processes; and manages the Component 2 budget to the highest level of financial accountability.

Experience

The CLTA: HS will have a recognised and valued track record in:

- Planning, management, delivery and evaluation of training and development activities
- General health care policy and management.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Budgeting and budget management.
- Complex report writing.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CLTA: HS personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Good writing skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's, actions.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CLTA: HS professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- Training needs analysis for health technicians and clinicians
- Effective modes of training delivery for health technicians and clinicians
- Managing long term staff development programs
- Health policy and management.
- Mentoring
- A track record of building capacity with counterparts.
- Behavioural change.

- Strategic planning
- Project management
- Training and health indicator monitoring.
- Qualitative analysis.
- Cross-cultural communication.
- Facilitating multisectoral collaboration and building partnerships

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Monitoring and evaluation
- Gender analysis.
- Cultural analysis.
- Qualitative analysis.
- Quality assurance.

Position Description

Chinese Long Term Adviser (CLTA):

Laboratory Specialist

Responsibilities

The CLTA Lab reports to the TL, and is responsible for the technical leadership for Output 2.1, and its successful planning and implementation.

Under the leadership of the TL, the CLTA Lab establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership and input to Output 2.1; manages input of any short terms consultants to that Output; ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all Output 2.1 activities and processes; and manages the Output budget to the highest level of financial management accountability.

Experience

The CLTA Lab will have a recognised and valued track record in:

- Senior level laboratory policy development and management.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Training expertise.
- Budgeting and budget management.
- Complex report writing.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CLTA Lab personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's actions.
- A track record of building capacity with counterparts.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CLTA Lab professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- International thinking on lessons learned and current approaches to laboratory organisation and management.
- Laboratory policy development and review
- Laboratory management development
- Strategic planning
- Project management
- Qualitative analysis.
- Cross-cultural communication.

- Facilitating multisectoral collaboration and building partnerships.

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Monitoring and evaluation
- Training needs analysis, planning and delivery.
- Quality assurance.
- Training, including adult learning and participative methodologies.
- Rational planning for resource allocation and use.

Position Description

Chinese Short Term Adviser (CSTA):

Monitoring and Evaluation (M&E)

Responsibilities

The CSTA M&E reports to the TL, and is responsible for establishing the M&E mechanisms for the whole program, identifying and establishing data collection mechanism, working closely with TRBH counterparts and CLTAs to foster ownership and understanding of the program's M&E approach.

Under the leadership of the TL, the CSTA M&E establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program's M&E approach; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership on M&E; works closely and cooperatively with the International M&E STA, ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all M&E activities and processes; and manages the M&E budget to the highest level of financial management accountability.

Experience

The CLTA M&E will have a recognised and valued track record in:

- M&E of large health programs.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Mentoring expertise.
- Budgeting and budget management.
- Complex report writing.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CSTA M&E personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's actions.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CSTA M&E professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- International thinking M&E approaches to assessing health program effectiveness.
- Project management for M&E.
- Qualitative and quantitative analysis.
- Gender analysis
- Cross-cultural communication.
- Facilitating multisectoral collaboration and building partnerships.

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Training, including adult learning and participative methodologies.

ANNEX G: DETAILED BUDGET

1. DETAILED BUDGET IS A SEPARATE FILE UNTIL FINALISED

2. COST ASSUMPTIONS

A. COSTING OF TRAINING PACKAGES

Component 1
Output 1.1 and 1.2

- How many participants?
  1) Generally, there are 20 departments/divisions in BOH (general office, HR division, rural health, MCH, community health, medical administration, disease control, health supervision, traditional medical, financial dept, science & education, international, health policy & regulation, health emergency, pharmacy, health care for senior, Committee of the Communist Party, retired personnel, SDA, health info. Etc.) There are 2-3 division directors usually. So 40-60 totally (maybe less in Tibet for some division incorporated).
  2) In addition, the CDC, Health supervision centre, Hospital and Traditional hospital at Provincial/Regional level are directly under BOH. 4-6 directors usually in each institution, totally 16-24 persons, whom are in same level/position with the division directors from BOH, are preferred to be included.
  3) Sum up, and considering the shortage in Tibet, a rough number is about 60.
  4) Besides above, there are usually 40-60 employees in BOH A decision will need to be made on their involvement.
- 12 (10-15) persons for a learning set. So 12 persons * 5 = 60
- 10-15 day course in TAR with national experts providing input and facilitation (10 day course, two half day lecture)
- follow-up training and individual mentored support from the national experts - 15-20 contact days spread over 18 months,
- 5 days study tour
- Supported by a learning set facilitated by a national expert and meeting approximately 4- 6 times a year (facilitated by national expert for 18 months, perhaps CLTA for remainder of program.

  So for one learning set (12 persons), the cost rough estimated:
  -- Personnel:
    - National expert(half from TAR, half from other province) : **60000** RMB yuan (including accommodation, food, consulting fee)
  -- Transport:
    - National expert from other prov.: **36000** (6 person * 6000)
  -- Food and accommodation for trainee
    - 200yuan/day*12 persons *11 days = **26400**
  -- Classroom and location (including teacher facility)
    - **15000**
  -- Following up action
    - **36,000** (3000yuan*12 persons)
  -- 5 day study tour
    - **100,000** (transport: 6000yuan*12 persons; food & accommodation: 400/day * 12 person *5 day)

TOTAL (for 12 persons): RMB 273,400 (AUD 44,600)
TOTAL (for 60 persons): RMB 1,367,000 (AUD 223,000)

Output 1.3 and 1.4

- How many participants:
    1) Prefecture level: there is 4-6 institution including BOH, CDC, Hospital, Health supervision, MCH centre, and traditional hospital. Each institution 4-6 directors. So totally 16-36 persons. Considering the shortage of HHR in Tibet, I estimate 26 persons.
    2) County level: 4 institutions including BOH, CDC, MCH, Hospital. Each have 2-3 directors (even if the hospital and CDC and MCH incorporated a health service centre, there still have different directors). So totally 8-12.
    3) There are 7 prefectures, 73 counties in Tibet. So the total number of the potential trainees is: 912 (182 in prefecture and 730 in county).
- Suggest 60 persons for a class. Approximately, for each prefecture, 2 classes may cover all. (Shigatse is the biggest, which has 18 counties, maybe 3 classes)
    - A working group comprised of national experts and TAR representatives to use the results of the TNA to design the training program
    - Core training – 2 weeks everyone
    - Remaining 2 modules
    - Learning sets meet 4 times a year at prefecture level

  For one class (60 persons, 2 weeks), the cost rough estimated:
  Personnel:
    - Trainers (TAR experts) : **20000** RMB (consulting fee)
    - Subsidy for participants: **336,000** (400/person, including accommodation, food, etc.)

  Transport:
    - Transportation from prefecture to Lhasa (out and home): **60,000** (average 1000/person)

  Classroom and location (including teacher facility)
    - **15000**

  Following up action
    - 120,000 (2000yuan* 60 persons)

TOTAL COST (for 60 persons): RMB 551,000 (AUD90, 000)
TOTAL COST (for 912 persons): RMB 8,265,000 (AUD1, 350,000)

HHR FORUMS

- Participants likely to include:
    1) Regional level:
       Relative department including Bureau of HR, quota, finance, education etc: about 10
       Relative division director of BOH: 6-10.
       The director and HHR division director from CDC, hospitals: about 10.
    2) Prefecture level: the director and HHR division director from BOH, 14.
    3) Representatives from typical county BOH and health institutions, about 20
    4) National and local experts on health policy and HR management: about 10

    Total about 70-80.
- Cost of each (2 days)
    1) transport: 6000*10 + 1000*34 = 94000
    2) food & accommodation: 400*80*3 days =96000
    3) meeting room & facility: 5000*2 days =10000
    4) material: 10000
    5) other incidental expenses: 50000

Total about RMB 260,000 (AUD 42,000)

Component 2

About technical training, the effective mode is going to higher institution to advanced study. If sb. go to hospitals in Beijing to continue study (usually half or one year), about 10,000-20,000 RMB is needed (hand to the hospital, not including his living-expenditure).

If having classes, the cost "standard" can be referred to above.

Output 2.2 Guidelines Technical Group Meetings

- 5-6 meetings
- Cost of a meeting: one day for each meeting. About 20 participants, including some representative from hospital, national and local experts.

TOTAL RMB 60,000 (**AUD 12,000)**

Output 2.3 Budget for TOT Training

- Approximately 50-100 participants.
- 12 (10-15) persons for one training class.
- 5 days' course in TAR with national level experts for each period.
- 2 periods are needed.

For one training class (12 persons), the cost rough estimated:

--National level experts:

- Fee: **200,000-400,000** RMB yuan (5,000/day * 5 days * (4-8 classes)* 2 period)
- Per diem: **40,000-80,000** RMB yuan (1,000/day * 5 days * (4-8 classes) * 2 period)
- Flight: 20,000 RMB yuan

-- TOT:

- Subsidy for participants: **200,000-400,000** RMB Yuan (400/person * (50-100) * 5 days * 2 period)

TOTAL (for 100 persons): RMB 880,000 = approximately AUD 134,000

B. PMO SET UP COSTS

Insufficient time was available during the design mission to cost PMO set up costs. Costs provided in the THSSP PDD have been used, with roughly 5-10% added on to those costs. THSSP costs are provided below as a rough guide.

Items	Unit cost	Number	Total
Office Furniture Sets			
Chair	200	5	1000.0
Chair (Meeting)	100	4	400.0
Cupboard	250	1	250.0
Desk	100	5	500.0
Shelf	500	2	1000.0
Safe	750	1	750.0
Electric Heater	100	1	100.0
Total			**4000.0**
Total Cost '000			**4.0**
Computer Sets			
Desk Top Computers	2500	7	17500.0
Lap Top	3000	2	6000.0
UPS	350	10	3500.0
Cabling and Extension Cords	10	5	50.0

Items	Unit cost	Number	Total
Total			**27050.0**
Total Cost '000			**27.1**
Office Equipment Sets			
Photocopier	6000	1	6000.0
Laser Printer	3000	1	3000.0
Fax Machine	1000	1	1000.0
Mobile Phone	300	3	900.0
Whiteboard	100	3	300.0
New Phone Sets and Line	400	2	800.0
Total			**12000.0**
Total Cost '000			**12.0**
Office Running Costs			
Stationary (monthly)	1000	60	60000.0
Printer Cartridges	250	40	10000.0
Photocopier Cartridges (monthly require)	250	60	15000.0
Paper 70gm (monthly require)	160	60	9600.0
Phone (International monthly)	1000	60	60000.0
Phone (Domestic monthly)	500	60	30000.0
Mobile (Domestic monthly)	500	60	30000.0
Sundry items (monthly)	300	60	18000.0
Total Monthly			**3876.7**
Total Monthly Cost '000			**3.9**

Vehicle Running Costs			
Insurance for 4 vehicles (annual)	20000	5	100000.0
Registration for 4 vehicles (annual)	3000	5	15000.0
Monthly road toll for 4 vehicles	800	60	48000.0
Fuel and maintenance (annual)	10700	5	60000.0
Total			223000.0
Total Monthly Costs			3716.7
Total Monthly Cost '000			3.7

C. LABORATORY

Until an assessment if undertaken (at project start-up) it is unknown what the requirements will be for support to laboratories. Thus, a “ball park” figure has been identified. The flexibility of the program will allow for this to be adjusted and sound information becomes available to the program.

ANNEX H: RESOURCES SCHEDULE

			LOP	Year 1 Quarter				Year 2 Quarter				Year 3 Quarter				Year 4 Quarter				Year 5 Quarter			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	Program Management																						
PM1	Establish Program - staff, equipment, admin systems			x																			
PM2	Confirm Annual Plan for Yr 1				x																		
PM3	Develop/implement program planning, M&E & reporting systems					x																	
	Milestones																						
M1	Y1 Annual Plan				x																		
M2	6-monthly reports					x				x				x				x				x	
M3	M&E Plan					x																	
M4	Annual Report & Annual Plan							x				x				x				x			
M5	Activity Completion Report																						x
	Personnel																						
	LTA: Team Leader	Person Months	50	3	3	3	1	3	3	3	1	3	3	3	1	3	3	3	1	1	3	3	3
	STA: Program Technical Director	Person Days	207	16	9	16	16	6	6	9	9	10	10	10	10	10	10	10	10	10	10	10	10
	International STA: Monitoring and Evaluation	Person Days	300	30	30	30			30		30		30		30				30			30	30
	CSTA: Monitoring and Evaluation	Person Days	540	60	30		30	30	30	30	30		30	30	30		30	30	30		30	60	30
	Translators/Interpreter [1]	Person Months	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Driver [1]	Person Months	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Driver [2]	Person Months	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Office Manager/Accounts Clerk	Person Months	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Procurement																						
	Office Furniture Regional Office	Set	2	2																			
	Computer Sets	Set	1	1																			
	Computer Software	Suite	1	1																			
	2 4x4 Wheel Drive Vehicles	Unit	2	2																			
	Office Equipment sets	Set	2	2																			
	Team Radio Communication Set	Set	2	2																			
	Training																						
	In-Country Orientation Meeting	Meeting	1	1					1				1				1						
	Program Orientation Workshop	Meeting	1	1																			
	Program Planning Workshops (Annual Planning)	Workshop	5			1				1				1				1				1	
	PCC Meetings	Meeting	6		1		1				1				1				1				1
	M&E Workshop	Workshop	5			1				1				1				1				1	
	Ad Hoc Program Meetings	Meeting	20	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
	TAG	Mission	3																				

			LOP	Year 1 Quarter				Year 2 Quarter				Year 3 Quarter				Year 4 Quarter				Year 5 Quarter			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	Other																						
	Office Running	Month	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Translation Facility	Month	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Vehicle Running Costs	Month	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Unallocated M&E studies	Lump sum	1			1																	
	Program promotion	**Lump sum**	**1**	**1**																			
	IPR	**Review**	**1**												**1**								
	ICR	**Report**	**1**																		**1**		
C1	**Health Human Resource Management (HHRM)**																						
	Personnel																						
	CLTA: Health HRM/Training	Person Months	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	CSTA: Training	Person Days	600					90	90	90	90	90	90	60									
	Training																						
	BMHRDP training package	Package	1					1	2	1	1												
	Prefecture, county training	Package	1						1	2	2	2	2	2	2	1	1						
	Learning sets (1.2, 1.4)	meeting	1					4	4	4	4	4	3	3	3	3	3	3	3	3	3	3	3
	Unallocated planning meetings and workshops	Lump sum	1					1															
	Unallocated training activities	Lump sum	1					1															
	Supervisory visits by CLTA HRM	Lump sum	1					1															
	Other																						
	Health Forums	Forum	5			1				1				1				1				1	
	Funds for HR projects	Lump sum	1					1															
C2	**Technical and Clinical Practices**																						
	Personnel																						
	CLTA: Health Service Delivery/Training	Person months	60	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	CLTA: Laboratory specialist	Person months	27		3	3	3	3	3	3	3	3	3										
	CSTA: Unallocated	Person days	200						200														
	Procurement																						
	Unallocated laboratory equipment/supplies	Lump sum	1		1																		
	Training																						
	Laboratory training	Lump sum				1																	
	TOT training package	Lump um	1					1															
	Infectious Disease Drills and Response (2.5)	5 tranches	5			1		1				1				1				1			
	Unallocated funds for other priority areas (2.4)	Lump sum										1											

			LOP	Year 1 Quarter				Year 2 Quarter				Year 3 Quarter				Year 4 Quarter				Year 5 Quarter			
				1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	Unallocated planning meetings and workshops	meeting			1		1	1				1				1				1			
	Other																						
	Guidelines Technical Group meetings (2.2)	Pool of funds		1																			

ANNEX I: Program Management & Implementation Arrangements

Management and Governance Arrangements and Structure

The leading counterpart agency for the overall program is the Tibet Regional Bureau of Health (TRBH). The governance of the program will rest with the **Program Coordination Committee (PCC)**, comprising representatives of the Government of the People's Republic of China (MOFCOM), the Government of the Tibet Autonomous Region (DOFCOM, TRBH) and the Government of Australia (AusAID). It is the main formal committee for GOPRC and GOA discussion and decision-making. The role of this committee will be to provide strategic direction to the program. It will be responsible for reviewing progress toward achieving the objectives; reviewing and addressing matters affecting the program performance; approving annual plan and budgets; and approving the program M&E and reporting approaches. It will meet at least twice in the first year, and annually thereafter. Secretariat support will be provided by the MC. The MC will attend meetings but not be a member of the PCC.

A **Program Management Team (PMT)** will be established at start-up.

The **PMT** comprises the Chinese team and the MC team. The Chinese team will comprise the Director General (DG) or Deputy Director General (DDG) as the Chinese Team Leader, to be nominated by the TRBH. In addition, two full time staff, nominated by the TRBH, will have responsibility for supporting and coordinating the Components. The MC team will comprise the TL, and three Chinese Long Term Advisers (CLTA). These Advisers will between them have significant Health Human Resource Management skills and Health Service Delivery expertise, plus Laboratory and M&E expertise, to cover off Component 1 and Component 2. They will be complemented by Chinese short term Advisers with training expertise, M&E expertise and relevant technical and clinical expertise, identified as Component 2 rolls out and additional priority areas are identified.

The function of the PMT will be to develop annual plans, implement the program, coordinate activities, report on progress, and inform the PCC of progress. Roles of all key stakeholders will be clearly articulated.

The PMT will work with representatives from Divisions in the Regional Bureau of Health – Human Resource, Disease Control, Medical Administration (includes Science, Technology and Education), Rural Health, Finance, MCH and Community Health and Emergency Response Office. Other Divisions may be added when additional technical priority areas have been confirmed.

The PMT will meet regularly to assess progress, identify barriers, and ensure that activities are consistent with GOTAR priorities, that they feed into the development of Annual Plans and ensure that the program remains responsive.

Stakeholders, Roles and Responsibilities

The management stakeholders in THPCBP are MOFCOM, DOFCOM TRBH, AusAID and the Managing Contractor.

MOFCOM

MOFCOM's main responsibility is as Central coordinating agency for the program, ensuring that program activities are occurring in line with national policies and agendas.

DOFCOM

DOFCOM's main responsibility is as Regional coordinating agency for the program.

TRBH

TRBH is the implementing agency for the program. It will nominate a senior manager who will coordinate TRBH's inputs into the program, and TRBH's engagement to meet the following responsibilities:

- effective and efficient communication with GOTAR and the MC;

- promote internal TRBH, GOTAR and government agency coordination and reporting;
- seek advice on the program strategy and approaches from relevant local and national departments, or assist the MC with introductions and advice to obtain it;
- integrate the program's M&E and research activities into TRBH M&E and research participating actively in all levels of M&E of the program;
- support the program's engagement in TRBH planning and coordination activities;
- ensure TRBH regular participation as a standing member of the PCC; and
- act on recommendations from the PCC.

AusAID

AusAID will identify an activity manager for all aspects of the program. This person will coordinate AusAID's inputs to meet the following responsibilities:

- effective and efficient communication with AusAID and the MC;
- joint appointment with MOFCOM of additional members of the PCC;
- internal AusAID coordination and reporting plus financial management, including advice on annual allocations;
- seek advice on program activities from other relevant AusAID sectoral programs, or assist the MC to obtain it;
- ensure AusAID's participation as a standing member of the PCC (refer Section 3.1.3);
- monitor and report on the performance of the MC and TAG (if appointed);
- act on recommendations from the PCC; and
- manage the contracts with the MC and the TAG.

The Managing Contractor

The MC's responsibilities include:

- Fielding a team of key Advisers;
- Preparing agreed documents for AusAID;
- Supporting the TL in country; and
- Ensuring MC participation as a standing member of the PCC.
- Providing Secretariat support to the PCC

ANNEX J: Implementation Plan

	Component	Year 1 Quarter				Year 2 Quarter				Year 3 Quarter				Year 4 Quarter				Year 5 Quarter			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
	Program Management																				
PM1	Establish Program- staff, equipment, admin systems																				
PM2	Confirm Implementation Plan for Yr 1																				
PM3	Develop/implement program planning, M&E and reporting systems																				
	Milestones																				
M1	Year 1 Annual Plan																				
M2	6-monthly reports																				
M3	M&E Plan																				
M4	Annual Report & Annual Plan																				
M5	Activity Completion Report																				
C1	**Health Human Resource Management (HHRM)**																				
Output 1.1	**Capacity building in HHRM undertaken for Bureau managers at regional level**																				
1.1.1	Objectives of BMHRDP developed																				
1.1.2	BMHRDP training institution(s) selected																				
1.1.3	TNA undertaken & BMHRDP trainees selected																				
1.1.4	BMHRDP assessed, planned and delivered																				
1.1.5	Study tours to other Regions/nationally conducted																				
Output 1.2	**Follow up support to Bureau managers at Regional level to implement improved HHRM knowledge and skills.**																				
1.2.1	BMHRDP mentored learning set																				
1.2.2	Support to development and implementation of the HHR 12th Five Year Plan																				
1.2.3	Annual TAR HHR Forum established																				
1.2.4	HHR research supported																				
Output 1.3	**Capacity building in health management undertaken for Bureau managers at prefecture/county level**																				
1.3.1	Training needs analysis – (identifies the training providers, priority component for training)																				
1.3.2	Select management trainees																				
1.3.3	Train prefecture and county managers (BoH Directors, hospital directors, CDC directors, hospital technical division chiefs)																				
Output 1.4	**Follow up support to Bureau managers at prefecture, county level to implement improved health management knowledge and skills.**																				
1.4.1	Prefecture level mentored learning sets																				
1.4.2	Participation in Annual TAR HHR Forum																				

	Component	Year 1 Quarter				Year 2 Quarter				Year 3 Quarter				Year 4 Quarter				Year 5 Quarter			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1.4.3	Local HHR practice projects supported																				
C2	**Technical and Clinical Practices**																				
Output 2.1	**Training of prefecture CDC laboratory staff conducted**																				
2.1.1	Conduct training needs analysis in prefecture CDC labs																				
2.1.2	Identify training providers supplemented by national experts																				
2.1.3	Develop training program																				
2.1.4	Develop selection criteria for trainees, and select trainees																				
2.1.5	Undertake training																				
2.1.6	Ongoing support to trainees																				
2.1.7	Evaluate the training program																				
Output 2.2	**Guidelines for County Hospital & Township Health Centre developed**																				
2.2.1	Establish Guidelines Technical Group																				
2.2.2	Group review current guidelines																				
2.2.3	Guidelines are developed																				
2.2.4	Feasibility of guidelines tested in county hospitals & township health centres																				
2.2.5	Guidelines are evaluated/modified as necessary																				
2.2.6	Assess the potential for regional rollout of guidelines																				
Output 2.3	**A pool of technical health trainers developed**																				
2.3.1	Identify existing trainer capacity																				
2.3.2	Develop an outline of the training objective																				
2.3.3	Identify training providers																				
2.3.4	Develop selection criteria and select trainees																				
2.3.5	Develop training program																				
2.3.6	Undertake training																				
2.3.7	Ongoing support to trainees																				
2.3.8	Evaluate the training program																				
Output 2.4	**Training of technical staff for identified priority areas conducted**																				
2.4.1	Conduct training needs analysis in identified technical areas																				
2.4.2	Identify training providers from the training pool supplemented by national experts																				
2.4.3	Develop training program																				
2.4.4	Develop selection criteria for trainees, and select trainees from pilot sites																				
2.4.5	Undertake training																				
2.4.6	Ongoing support to trainees																				

	Component	Year 1 Quarter				Year 2 Quarter				Year 3 Quarter				Year 4 Quarter				Year 5 Quarter			
		1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
2.4.7	Evaluate the training program																				
Output 2.5	**Building preparation and response capacity for containing infectious disease outbreaks**																				
2.5.1	Infectious disease response drills carried out																				
2.5.2	Rapid response to containing infectious diseases																				

NOTES:

Output 1.3.
1.3.4: Prefecture and county managers are trained together; easy to organize, e.g. the training class for Shigatse (including prefecture and county), Naqu, and other prefectures occurs one by one.

Output 2.1:
2.1.3: timing is based on availability of an off-the-shelf program, therefore not too much time is allocated to preparing a program
2.1.6: length of time accommodates distance to travel

Output 2.4
This will be a rolling program of support to technical/clinical areas as the need is identified. The same sequence of activities will be followed for any one training that is done.

ANNEX K: MONITORING AND EVALUATION FRAMEWORK

Method for tracking progress toward meeting objectives

Progress with the program will be monitored continuously by the TL, the Chinese M&E Adviser and the three long term Advisers, by the PMT through its regular meetings, and by the PCC through its annual meetings.

A preliminary Program Monitoring Tool has been developed (see below). This will be an important tool to document progress at the Output and Activity level in particular. All key stakeholders will become familiar with this tool, its purpose and use at the first M&E Workshop, and it will be updated for every Annual PCC meeting.

Proposed baseline data collection approaches

Baseline data will be generated using the TRBH HIS which provides Yearbook data, surveys and records of facilities, and surveys of trainees, staff and patients. There are already examples of survey instruments that were used in prefectures during THSSP related research and assessment. These can be adapted. The overall approach used for these surveys can also be examined for replication. Baseline surveys can provide data that would not otherwise be available on patient/client experience and on staff profile, careers, experiences, views of management, and experience of training and development. And can then be used to benchmark change across the program timelines. In addition, after initial review by the M&E Team, any routinely collected data that are judged to be relevant and verifiable will also be considered for use.

Both quantitative and qualitative data will be used in developing an assessment of the outcomes of the program. In particular, it is recognised that case studies will be used in order to capture the context and complexities of the pace of change in managerial and technical/ clinical practice. This could also include a modified MSC (Most Significant Change) Approach (which was reported in the THSSP ACR) and has potential to reveal the assessment of key individuals and stakeholders who are involved in the change process.

Such a mixed methodology approach will provide scope for feedback and reflective management and practice, and will give rich data which could also be used in a compendium of "success stories" – this was a stated requirement of country counterparts during early discussion of the program.

Roles and responsibilities of key participants in the M&E process

The M&E Team at the program start-up phase will contribute to (i) the selection and design of technical analyses, including baseline data; and (ii) evaluation of the Logframe and its indicators to ensure that they are true indicators of the stated objectives. The M&E Team will also work with key stakeholders to identify M&E needs over the life of the program, and for the annual planning phase; in this activity one key objective will be to have counterparts very actively engaged in all levels of the M&E process to ensure a transfer of evaluation skills, and "buy in" from country counterparts.

Use of existing government systems for M&E

There is only limited health service, health outcome and HHR data collected on a routine basis in the TAR health sector, and only limited capacity to undertake additional data generation. It is also relevant to M&E design for this program that the THSSP final report (ACR) noted that "Fundamental to the original design of the M&E system was access to TRBH health information system (HIS) for health status data, which mostly proved impossible due to its sensitivity". THSSP therefore focused on case studies and interviews to generate the necessary information for evaluation.

Where possible, after initial review by the M&E Team, data will be collected from existing GOTAR data sources. However, it is recognised that there may be limitations in relying on this source. In addition, there will be a need to meet evaluation requirements of program activities which are new and could not be assessed readily through existing systems and current data sources.

During the start-up phase relevant change indicators, based on the assessment of the M&E Team, may be developed for goal, purpose and outcomes. Additional sources of data across the life of the program will be interviews and case studies.

Development of specific M&E arrangements for subsidiary activities

A flexible funding mechanism will be established to support delivery of Output 2.5. This will be managed by the MC (TL) and paid on a reimbursable basis. The management arrangements will be simple in nature but will meet the requirements of AusAID.

Other lump sums e.g. for laboratory equipment, will be managed by the TL and team, and meet AusAID requirements.

Feedback M&E mechanisms

The aim is to have monitoring activities embedded in system improvement so that they can be used to improve performance of individuals, teams and organisations during the lifetime of the program. As such, the approach to monitoring will be inclusive and based on involvement of, and timely feedback to, staff and management to enable them to reflect on practice, and change practice. Initial baseline survey data would be aggregated and fed back to relevant stakeholders at an early stage in the program.

The developmental focus of training provision will be enhanced by the use of learning sets and mentored work based projects, which will act as conduits for feedback to individuals and teams.

Evaluation will be used as a continuous quality improvement tool as a feedback mechanism, to ensure: (i) a clear and strategically oriented program; (ii) ongoing technical analyses as relevant and required; (iii) feedback to stakeholders and participants, for reflective management and changed practice; and (iv) program impact.

Monitoring and evaluation methods will be selected based on relevance, cost-effectiveness, common sense, and available resources.

An independent midterm review will be undertake by Year 4, and funded by AusAID. This will provide feedback to the in-country team and stakeholders on progress and lessons learned.

Monitoring cross cutting issues

Gender will be a focus throughout the program, and responsibility for monitoring gender equity in the program will occur at a number of times:

- During the annual planning process, in order to monitor strategies, monitor progress towards targets and gender impacts, and to review strategies and targets;
- During PCC meetings to review project design strategies and resource needs in the light of progress towards milestones and gender impacts
- During program evaluations and reviews, to assess the progress, efficiency, effectiveness, impact and sustainability of particular projects and programs, including from a gender perspective.
- Particular gender perspectives to be monitored/evaluated will include: men/women entering management roles; gender distribution in TOT training; gender participation in succession planning (if relevant). Other indicators can be identified during the evaluability assessment.

Thus a number of key stakeholders involved in each of these exercises have responsibility for keeping abreast of progress toward gender equity.

Information on access to training opportunities by men and women, including inclusion in TOT training will be captured in all reports, ensuring that men and women have equal access to these opportunities in the same proportions as they are found in the health services. Case studies will attempt to capture experiences of both men and women as a result of the training to which they have been exposed.

Monitoring risks

A risk matrix has been developed, that identifies potential risks, and their possible impact on the program. These will be monitored by the responsible people (see Risk Matrix table) and will be reported

against at each PCC meeting.

Resourcing M&E

About ten percent of the budget has been allocated to M&E. This includes significant input by an international and a Chinese M&E Specialist, and adequate funding (lump sum) for M&E studies including baseline and follow up surveys, and studies.

Program Monitoring Tool

Status: The status of the activity
A: On Track – activity is on track to be completed as proposed
B: Delayed/Revised – The activity has been rescheduled and will not be completed as proposed – describe a revised plan for next year
C: Completed – The activity has been completed. Work may continue on this activity in excess of the expectation and this continues to be recorded in the Comments column.
D: Unable to proceed – The activity is delayed and is deemed unachievable due to key dependencies and/or obligations unable to be met.
E: Not yet scheduled

Narrative Summary	Verifiable indicators	Means of verification	Responsible for collection, reporting	Timing of reporting	Status	6 monthly summary progress, comments
GOAL: TO IMPROVE THE HEALTH OF THE PEOPLE OF TIBET	MMR, IMR	TRBH HIS	TRBH	Baseline & end of program		
PURPOSE: More efficient and better quality health service delivery	• Improved resource allocation • Reduced case-fatality rates in pilot sites	• TRBH HIS; Yearbook data • Health facility data	CLTAs	Baseline & end of program		
COMPONENT 1: HEALTH HUMAN RESOURCE MANAGEMENT (HHRM)						
OBJECTIVE: Improved HR management practices at the strategic & operational levels	• Improved staff distribution across services • new HR policies developed and implemented • Increased % of trainees initiating/implementing HRH projects ▪ Improved staff recruitment processes ▪ Increased % of staff receiving annual supervision assessment • Increasing number of divisions in TRBH taking lead in program activities as part of the implementation of Tibet 12th Five Year HRH Plan • Increased staff satisfaction with jobs & the organisational environment	Workforce surveys Facility surveys, records Trainees' surveys HR surveys Case studies HR records Staff satisfaction survey (THSSP) Most Significant Change stories	CLTA HHR	Baseline & end of program		
Output 1.1: Capacity building in HHRM undertaken for Bureau managers at regional level	Comprehensive capacity building completed	Project/training reports	CLTA HHR/PM			

Narrative Summary	Verifiable indicators	Means of verification	Responsible for collection, reporting	Timing of reporting	Status	6 monthly summary progress, comments
Activities						
1.1.1: Objectives of BMHRDP developed					Y1 – 6mo	
					Y1-12mo	
					Y2 – 6mo	
					Y2-12mo	
					Y3 – 6mo	
					Y3-12mo	
					Y4 – 6mo	
					Y4-12mo	
					Y5 – 6mo	
					Y5-12mo	
1.1.2: BMHRDP training institution(s) selected					Y1 – 6mo	
					Y1-12mo	
					Y2 – 6mo	
					Y2-12mo	
					Y3 – 6mo	
					Y3-12mo	
					Y4 – 6mo	
					Y4-12mo	
					Y5 – 6mo	
					Y5-12mo	
1.1.3: TNA undertaken & BMHRDP trainees selected					Etc.	
1.1.4: BMHRDP assessed, planned and delivered					Etc.	
1.1.5: Study tours to other Regions, nationally conducted						
Output 1.2: Follow up support to Bureau managers at Regional level to implement improved HHRM knowledge and skills.	• Supportive follow-up occurring • HR policies, procedures informed/ developed by project research	Project reports	CLTA HHR/PM			
Activities						
1.2.1: BMHRDP mentored learning set						
1.2.2: Support to development of the 12th Five Year Plan						
1.2.3: Annual TAR HR Forum						

Narrative Summary	Verifiable indicators	Means of verification	Responsible for collection, reporting	Timing of reporting	Status	6 monthly summary progress, comments
established						
1.2.4: HR research supported						
Output 1.3: Capacity building in health management undertaken for Bureau managers at prefecture/county level	Comprehensive capacity building completed	Project/training reports	CLTA HHR/PM			
Activities						
1.3.1: Training needs analysis – (identifies the training providers, priority component for training)						
1.3.2: Select management trainees						
1.3.3: Train prefecture, county managers (BoH Directors, hospital directors, CDC directors, hospital technical division chiefs)						
Output 1.4: Follow up support to Bureau managers at prefecture and county level to implement improved health management knowledge and skills.	• Supportive follow-up occurring • HR policies, procedures informed/ developed by project research	Project reports	CLTA HHR/PM			
Activities						
1.4.1: Prefecture level mentored learning sets						
1.4.2: Participation in Annual TAR HR Forum						
1.4.3: Local HR practice projects supported						
COMPONENT 2: TECHNICAL AND CLINICAL PRACTICES						

Narrative Summary	Verifiable indicators	Means of verification	Responsible for collection, reporting	Timing of reporting	Status	6 monthly summary progress, comments
OBJECTIVE: Improved priority technical & clinical practices of the workforce in pilot sites	• Increased accuracy rate for laboratory check • Increased accuracy rate of diagnosis • Decreased hospital infection rate • Improved recovery rate for severe cases • Increased patient satisfaction with services • Improved epidemiological and emergency response capacity : % of National CDC reporting requirements met	Facility surveys in pilot sites Laboratory surveys, records TRBH HIS; Yearbook data Patient satisfaction survey in target program facilities (THSSP?) National CDC reporting checklist Case studies	CLTA HS CLTA Lab	Baseline & end of program		
Output 2.1: Training of prefecture CDC laboratory staff conducted	Training completed	CLTA Lab	Training report			
Activities						
2.1.1: Conduct training needs analysis in prefecture CDC labs						
2.1.2: Identify training providers supplemented by national experts						
2.1.3: Develop training program						
2.1.4: Develop selection criteria for trainees, and select trainees						
2.1.5: Undertake training						
2.1.6: Ongoing support to trainees						
2.1.7: Evaluate the training program						
Output 2.2 : Guidelines for County Hospital and Township Health Centre developed	Finalised County Hospital and Township Health Centre Guidelines New service items developed	Project reports	CLTA HS			
Activities						
2.2.1: Establish Guidelines Technical Group						

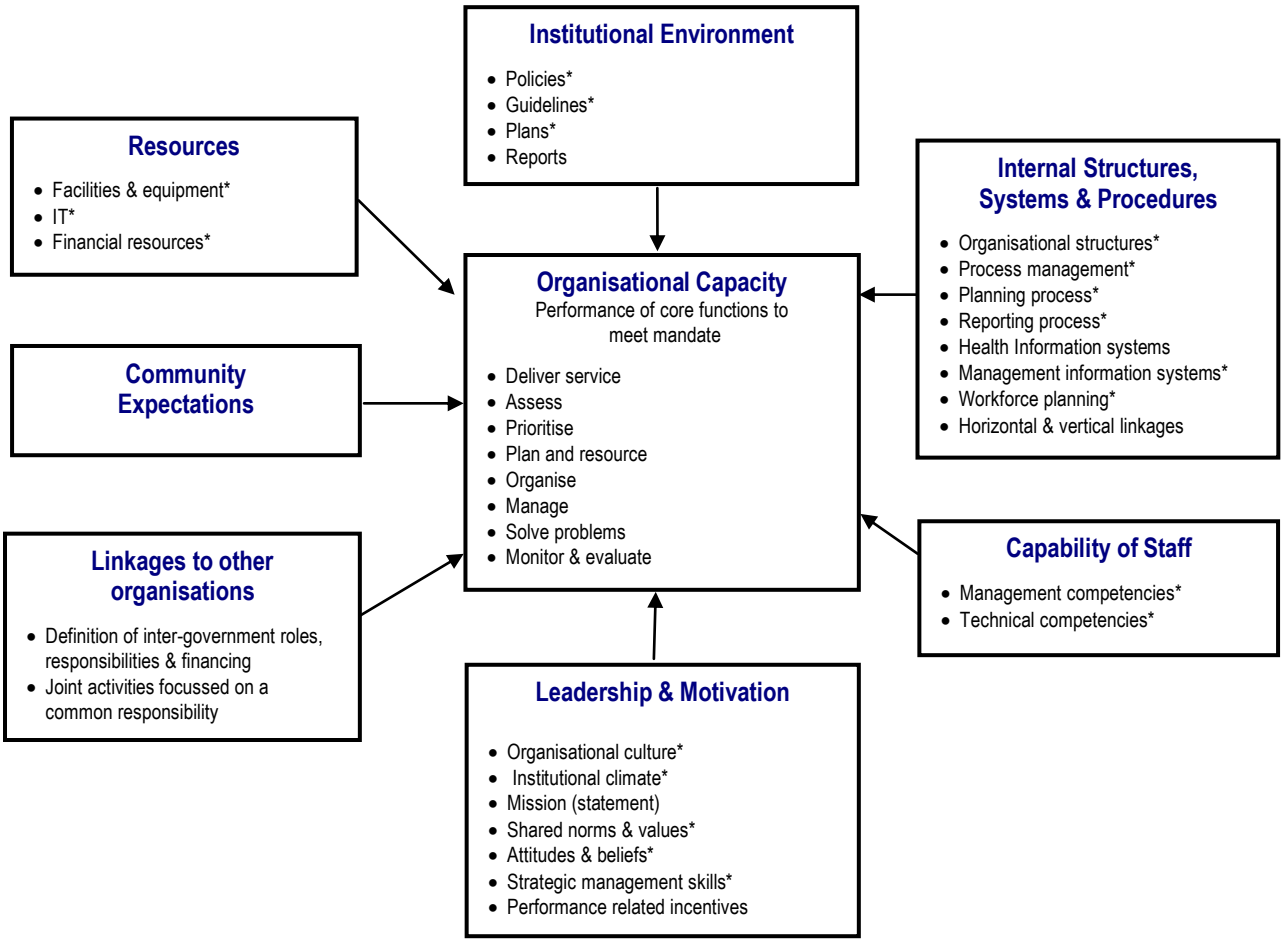
Narrative Summary	Verifiable indicators	Means of verification	Responsible for collection, reporting	Timing of reporting	Status	6 monthly summary progress, comments
2.2.2: Group review current guidelines						
2.2.3: Guidelines are developed						
2.2.4: Feasibility of the guidelines are tested in county hospitals and township centres						
2.2.5: Guidelines are evaluated/modified as necessary						
2.2.6: Assess the potential for regional rollout of guidelines						
Output 2.3: A pool of technical health trainers developed	Trainers trained	Training reports	CLTA Training			
Activities						
2.3.1: Identify existing trainer capacity						
2.3.2: Develop an outline of the training objective						
2.3.3: Identify training providers						
2.3.4: Develop selection criteria and select trainees						
2.3.5: Develop training program						
2.3.6: Undertake training						
2.3.7: Ongoing support to trainees						
2.3.8: Evaluate the training program						
Output 2.4: Training of technical staff for identified priority areas conducted	Training completed in identified areas	Training reports	CLTA HS			
Activities						
2.4.1: Conduct training needs analysis in identified technical areas						
2.4.2: Identify training providers from the training pool supplemented by national experts						
2.4.3: Develop training program						
2.4.4: Develop selection criteria for						

Narrative Summary	Verifiable indicators	Means of verification	Responsible for collection, reporting	Timing of reporting	Status	6 monthly summary progress, comments
trainees, and select trainees from pilot sites						
2.4.5: Undertake training						
2.4.6: Ongoing support to trainees						
2.4.7: Evaluate the training program						
Output 2.5: Building preparation and response capacity for disease outbreaks	Simulation exercises undertaken Any infectious disease outbreak quickly contained	Project reports	TL			
Activities						
2.5.1: Infectious disease response drills carried out						
2.5.2: Rapid response to containing infectious disease						
CROSS CUTTING ISSUES						
1. Gender						
Men and women in management	• Increase in men/women entering management roles • Gender participation in succession planning					
Access to training	• Gender distribution in TOT training					
2. Capacity building						
To be developed by M&E team and counterparts						

ANNEX L: PROGRAM APPROACH TO CAPACITY BUILDING

A capacity building strategy is at the core of the program approach and conceptually underpins the program. It will guide implementation and monitoring/evaluation and will also inform the overall management of this program. It builds on the approach developed for THSSP and is focussed primarily on building capacity of organisations and systems. The capacity building framework [Figure 1 below][25] is derived from international development models, and was adapted by THSSP for the health system in Tibet. The framework focuses on organisational/system capacity determined by seven factors. It was fully developed and the end result of THSSP and highlighted in the THSSP ACR. This new program (THPCBP) builds further on this capacity building approach, but is a smaller program and will not cover all of the elements depicted in this framework. Figure 1 presents options and opportunities for entry point for capacity building in this program without duplicating what has been done in THSSP. The focus of THPCBP will be on the elements in the Figure which are marked with an asterisk (*) and the emphasis of this new program will be on achieving improvements in organisational capacity and performance by improving the capabilities of staff.[26] It is recognised in program design that this can only be achieved in a sustainable manner by input in other areas such as the development of appropriate policies and guidelines, and the use of training needs analysis to identify skills gaps. As with THSSP, this new program is designed to strengthen the existing health system rather than initiate new (and thus potentially unsustainable) streams of activities. All outputs and outcomes are therefore firmly situated within the health structures and policy framework of the GOTAR.

Figure 1:



[25] Source: THSSP Activity Completion Report, 2010

[26] The * in the Figure identifies elements being addressed in THPCBP

Issues of sustainability are integral to the strategy, in particular:

- Planning and activities that emphasise local ownership;
- Working within existing systems and only seeking to affect system capacity when there is a clear mandate and invitation;
- Working for organisational change within existing institutions through specific streams of activities, including support for the work based projects, learning sets and action learning of operational research;
- Providing technical support and other resources but relying on health staff to drive and implement change;
- Forging linkages with the limited number of TAR and national institutions which have relevant expertise on specific outputs by hiring technical expertise and training support through those institutions.

Capacity building will build on the approach developed for THSSP and will involve three main types of activities:

(i) Advocacy and support to implement program-related GOPRC policies; for example: support in implementation of the 12thFive Year Plan (Output 1.1)

(ii) Activities with specific outputs to improve the management and technical capacity of staff as individuals or teams; for example: (Output 2.3).

(iii) Operational research to assist GOTAR policy development and the establishment of operational activities to respond to health challenges. For example, support for Bureau level management learning sets (Output 1.2).

In (ii) above, capacity building will be supported and reinforced by approaches which enhance the skills of counterparts. CLTAs will provide technical leadership within their streams of activity and will build relationships with regional technical experts during training analysis and delivery and workplace learning. In (iii) above operational research will sustain new capacity (e.g. where participants have been encouraged to use new knowledge and skills, perhaps from a training course or learning set, in work based projects and research to investigate areas of concern and/or priority for change). The use of operational research as a learning and advocacy tool was a core element of the THSSP program and will continue to be utilised in the new program. The THSSP approach had provided a “safe space” for small-scale, action-oriented investigations into areas of specific interest/concern. Confidence was built and contextual lessons learnt that could then be applied more broadly within the system. In THPCBP this operational research will be aimed at achieving policy objectives through supporting a program of activities that include as appropriate on the-job training, focused study tours, short courses, and learning sets.

ANNEX M: GENDER AND HEALTH IN TAR

Gender Policies

Australia's aid program is guided by a specific policy on Gender and Development, which seeks to promote equal opportunity for women and men as participants and beneficiaries of development.[27] China also has a long tradition of promoting equality of opportunity for women, and official policies have been implemented for several decades. As a result, national policies on the promotion of equal opportunity for women, the protection of women's rights and promoting the role of women in government administration, filter down through the various layers of government. For example, the document *Women's Development Plan for Lhasa Municipality (2001-2010)* sets out strategies to encourage the participation of women in economic and social development of the Municipality.

Gender and Health Care Provision

This program will target men and women in (i) management roles and (ii) technical or clinical positions. There is not a lot of information relating to the roles of men and women in delivering health care in the TAR. However, men generally form a greater proportion of the higher/managerial positions within the health system, while women are more frequently represented in clinical positions. Table 1 below shows that the proportion of men and women in health care provider roles and within the Bureaus are similar for both men and women. Conversely Table 2 shows disparities between men and women, with men dominating at township and village facilities.

Table 1: Gender composition of different groups in the workforce in sample areas （n, %）

gender	total	Prefecture	County	Township hospitals
Health care workers				
Male	696 36.3)	310 31.3)	163 34.1)	223 49.8)
Female	1221 63.7)	680 68.7)	315 65.9)	226 50.2)
CDC workers				
gender	male	109 (52.9)	70 53.8)	39 51.3)
	female	97 (47.1)	60 46.2)	37 48.7)
BoH workers				
gender	male	61 47.7)	30 50.8)	31 44.9)
	female	67 52.3)	29 49.2)	38 55.1)

Source: *Study on Health Resource Allocation and Utilization in Tibet Autonomous Region.* THSSP, Tibet University Medical School, Shandong University Health Management and Policy Study Center, June 2010
Note: data is not available for Linzhi Prefecture

Table 2: Gender composition of the staff of health facilities in three TAR counties

County	Qushui			Nimu			Linzhou		
	County	Township	Village	County	Township	Village	County	Township	Village
Male	21	15	3	19	18	39	28	38	53
Female	36	5	10	28	2	10	36	24	15
Total	**57**	**20**	**13**	**47**	**20**	**49**	**64**	**62**	**68**

Source: THSSP

[27] *Gender Equality in Australia's Aid Program – Why and How*. AusAID 2007

Table 3 however (for the whole of China) shows large disparities depending on the health profession, though at managerial levels gender representation is similar. What is needed is local TAR data to confirm any statements about how men and women are distributed in the health workforce, both in clinical/technical positions and in management positions. This should be a focus of discussion during the orientation workshop and in the first year of the program.

Table 3: China: % of health professionals by gender 2005

	health professional						**other technical**	**manager**
	total	**doctor**	**nurse**	**pharmacist**	**laboratory**	**others**		
total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
gender								
male	35.7	57.1	1.7	39.6	37.5	46.3	44.7	49.1
female	64.3	42.9	98.3	60.4	62.5	53.7	55.3	50.9

Source: Chinese Health Statistical Yearbook 2009

Gender Issues relevant to the Program

Training and capacity building activities are a major part of both program components. The program must ensure women have equitable access to training and development opportunities for reasons of equal opportunity, and to redress the gender imbalance in the staffing of the health institutions in TAR if that is indicated based on initial analysis.

ANNEX N: RISK MATRIX

Source of Risk	Risk	Impact of Risk on Program and Sector	L	C	R	Risk Mitigation Strategy	Responsibility	Timing
Risks to program implementation and outcomes	Poor coordination between key stakeholders and implementers	Could slow implementation significantly Loss of motivation	3	4	H	A strong and cohesive PMT led by TRBH will be essential to ensure that the necessary coordination of activities occurs. Continuity of both Chinese and Australian/expatriate team members will contribute to minimising this risk.	PMT	Continuous
	Availability of key groups for training	Impact of program reduced	3	4	M	The program will be providing a range of capacity building opportunities for a potentially large number of people; it will be important that annual planning identifies when training is to occur and beneficiaries can be supported by management to incorporate these activities into their schedules.	CLTAs, CSTAs	Lead up to training events
	Availability of trainers at required times	Impact of program reduced	2	4	L	Annual planning and effective communication with trainers will contribute to reducing this risk.	CLTAs, CSTAs	Annually Lead up to training events
	Lack of engagement and/or support from key regional stakeholders	Effectiveness of activities jeopardised	1	4	L	The annual planning process, the annual Regional HR Forum, follow-up support and relationship building by members of the PMT will all attempt to reduce this risk.	PMT	Continuous
	Delay in full development and implementation of the HR Five Year Plan and other relevant policies	Delays rollout of Component 1	3	3	M	Maintain engagement with key people Monitor progress to check that development of the Plan is on track Negotiate program involvement in the HR Five Year Plan development/implementation process itself	PMT	Continuous
	Imbalance between demand and supply side mechanisms	if all elements of the demand/supply framework are not simultaneously being addressed by TRBH	3	3	M	Address these factors in training Bring to discussion of PCC	PMT	

Source of Risk	Risk	Impact of Risk on Program and Sector	L	C	R	Risk Mitigation Strategy	Responsibility	Timing
		and the TAR then the likely impact of this program will be compromised.						
	Quality of existing data collections for M&E may be of poor quality and difficult to change	Jeopardises their potential to show change	3	3	H	Ensure key Adviser relationships with counterparts is strong to engender trust	TL, CLTAs, CSTA,	Continuous
	Delays in set up of program office and start up meetings/events	Delays rollout of program Loss of motivation	1	2	L	The timetable for program action is predicated on timely support to set up office, administration and start up meetings, and takes account of winter travel constraints. It will be important to work with stakeholders to maintain timing, and review delivery and impact of start up meetings.	TL	At start-up
Scope to influence change	Beneficiaries don't progress to changing practices	Impact not achieved	3	4	M	Careful selection of key program positions Emphasis on relationship building Sound follow up	TL, CLTAs, CSTAs	Continuous
	Systems barriers impede implementation of improved practice in the workplace	Impact not achieved	3	4	M	This needs to be monitored as part of the M&E of the program PMT uses its regular coordination mechanism to negotiate addressing systems barriers	PMT	Continuous
	Lack of full engagement of some pilot sites	Ineffective outcomes	3	4	M	Motivation as a site selection criterion will minimise this risk.	TL, CLTAs, CSTAs	Continuous
TL skills set	A suitable TL cannot be recruited	Program implementation is dysfunctional Team dynamics poor	3	4	H	Comprehensive and careful recruitment process	MC	During tendering process
External risks	Social instability	Could slow/halt	2	4	E	Keep a watching brief	TL, CTL	Continuous

Source of Risk	Risk	Impact of Risk on Program and Sector	L	C	R	Risk Mitigation Strategy	Responsibility	Timing
		activities and risk achievement of outcomes						
	Unanticipated disease outbreaks diverting staff from involvement in program:	Activities and schedules will be interrupted	2	3	M	The occurrence of outbreaks is out of the control of the program The flexibility that is inherent in the program will permit rescheduling activities should that be needed	TL	Continuous

Ranking and Analysis of Risk Levels

L = Likelihood

5 (Almost certain) – expected to occur in most circumstances

4 (Likely) – will probably occur in most circumstances

3 (Possible) – might occur at some time

2 (Unlikely) – could occur at some time

1 (Rare) – may occur only in exceptional circumstances

C = Consequences

5 (Severe) – would stop achievement of functional goals and objectives

4 (Major) – would threaten goals and objectives; requires close management

3 (Moderate) – would necessitate significant adjustment to the overall function

2 (Minor) – would threaten an element of the function

1 (Negligible) – routine procedures sufficient to deal with the consequences

R = Risk level

Extreme (E) risk – most likely to occur and prevent achievement of objectives, causing unacceptable cost overruns or schedule slippage.

High (H) risk – could substantially delay the activity schedule or significantly affect technical performance or costs, and requires a plan to handle.

Medium (M) risk – requires identification and control of all contributing factors by monitoring conditions and reassessment at activity milestones.

Low (L) risk – normal control and monitoring measures sufficient

ANNEX O: Scope of Services and Basis of Payment

SCOPE OF SERVICES

Tibet Health Personnel Capacity Building Program (THPCBP)

1. BACKGROUND

(a) The Tibet Health Personnel Capacity Building Program (THPCBP) seeks to develop the ability of management to make more effective use of current staff, in order to improve access to and delivery of health care, and to enhance the skills of current workers by providing additional appropriate training in clinical and technical skills.

(b) In response to low teaching capacity (skills, and institutional and individual capacity) the new program will focus on improving health training capacity, by improving teaching methods and building up a pool of local appropriately skilled trainers.

(c) The program will build on the Lessons learned in THSSP, However, it will differ from the THSSP by being smaller and focusing more intensely and systematically on the development of health human resource management (HHRM) capacity at senior levels, on sustaining improved capacity to deliver technical/clinical training, and on the improvement in specific technical/clinical skills of current staff. A key difference is that it will engage with a variety of Divisions within the TRBH (not done under THSSP), to ensure their role in guiding the development of activities and increase the likelihood of TRBH rolling out activities more broadly and ultimately achieving greater impact. It will also use routine data collections of the TRBH for evaluation of outcomes and impact.

2. PROGRAM DESCRIPTION

(a) The program **goal** is to improve the health of the people of Tibet.

(b) The program **Purpose** is to provide more efficient and better quality health service delivery

(c) To achieve this the program will have two Components

  (a) **Component 1:** Health Human Resource Management, with the objective of improving HR management practices at the strategic and operational levels.

  (b) **Component 2:** Technical and Clinical Practice, with the objective of improving priority technical and clinical practices of the workforce in selected pilot sites

(d) THPCBP will build on past activities and lessons learned from THSSP to further strengthen management and clinical/technical capacity of the TRBH and its services.

(e) Principles underpinning the program will ensure there is complementarity with TAR processes, policies and resources, that activities are counterpart driven, there is flexibility to respond to local needs as they arise, and that capacity building is core to the program.

3. **COORDINATION**

(a) A Program Coordination Committee will be established and will be composed of representatives of the Government of the People's Republic of China (MOFCOM), the Government of the TAR (DOFCOM, TRBH) and the Government of Australia (AusAID),

3.2 MOFCOM, together with AusAID will be responsible for appointing members to the Program Coordinating Committee. The PCC is the main formal committee for GOPRC and GOA discussion and decision-making. The role of this committee will be to provide strategic direction to the program. It will be responsible for reviewing progress toward achieving the objectives; reviewing and addressing matters affecting the program performance; approving annual plan and budgets; and approving the program M&E and reporting approaches. It will meet at least twice in the first year, and annually thereafter.

4. **SERVICES**

4.1 The Contractor shall perform the following Services in accordance with the terms and conditions of this Contract:

Program Management and Governance

(a) The Contractor will establish the Program Management Team (PMT), identifying key partners and stakeholders for each of the elements of the program, likely to include

(i) The Chinese team: the DG or DDG as the Chinese Team Leader, to be nominated by the TRBH; two full time staff, nominated by the TRBH, to have responsibility for supporting and coordinating the Components;

(ii) The PMT will work with representatives from Divisions in the Regional Bureau of Health – Human Resource, Disease Control, Medical Administration (includes Science, Technology and Education), Rural Health, Finance, MCH and Community Health. Other Divisions may be added when additional technical priority areas have been confirmed.

(iii) The MC team will comprise the Team Leader, and three Chinese Long Term Advisers (CLTA): Health Human Resources (HHR) Adviser (60 months), Health Systems (HS) Adviser (60 months), and Laboratory Specialist (27 months).

(iv) Key stakeholders include the Regional Human Resource Bureau in relation to the development of the Five Year Regional HR Plan, and the Regional Education Bureau in relation to engagement with training institutes. Training institutes will be identified as the program rolls out.

(v) Other important stakeholders will include targeted prefecture, county and township groups and individuals who will be direct beneficiaries of program activities.

(b) develop effective and efficient program planning, management and business processes for the implementation of the program;

(c) provide strategic direction and technical guidance and guide the prioritisation and phasing of the activities required to deliver the outputs;

(d) provide program documentation and reporting as detailed in Clauses 7 and 8 (below);

(e) manage the performance of sub-contractors and service providers engaged in the implementation of the program;

(f) recruit and contract short-term advisers (STA) as required to support and implement the activities detailed in Components 1 & 2;

(g) undertake human resource management including:

(i) undertaking recruitment and establish staffing for program implementation, including employing and managing all program personnel and advisers (including the Team Leader, CLTAs, CSTAs, International STAs, and Program Office staff;

(ii) developing and conducting an induction program and regular training for all advisers and program staff;

(iii) completing annual performance appraisals for all advisers and staff, including gathering and providing feedback from counterparts;

(iv) ensuring staff for the program have Terms of Reference in accordance with the Position Descriptions in Appendix A of this Schedule;

(v) ensuring all program staff have annual work plans (which are reviewed every six months) that contain explicit capacity building strategies appropriate to the position;

(vi) reviewing the roles and responsibilities of personnel, including developing and updating TOR as required for the effective implementation of the program;

(vii) ensuring the program is supported by those administrative, logistics and other support staff necessary for the effective and efficient management of the program; and

(viii) ensuring all program personnel and sub-contracted personnel behave ethically and appropriately at all times including developing a Program Code of Conduct and ensuring personnel are briefed on and comply with AusAID's policies on cross-cutting issues including, gender, disability, fraud and anti-corruption, HIV and AIDS, child protection and the environment;

(h) establish and maintain an effective Program Office in Lhasa with appropriate administrative and financial systems and ensure the office is sufficiently resourced (including security, logistics, communications);

(i) plan, organise and deliver Quarterly Coordination Meetings for program personnel;

(j) manage and conduct the procurement of all program assets;

(k) coordinate and manage relationships including:

(i) working in partnership with the TRBH, and stakeholder institutions;

(ii) promoting regular meetings between program staff, their program colleagues and senior management working in the same or related functional areas to ensure integration within the TAR response, evaluate program performance, and review risks and assumptions;

(iii) building commitment to the program by involving all key stakeholders in program planning and implementation in ways that are consistent with 'bottom-up' stakeholder-centred planning and implementation;

(iv) maintaining regular communication and consulting regularly with all key stakeholders and AusAID;

(l) implementation of AusAID's Gender, Disability, Fraud and Anti-corruption, HIV and AIDS, Child Protection and Environmental policies including:

(i) mainstreaming and monitoring (as appropriate) gender, disability, fraud and anti-corruption, HIV and AIDS, child protection strategies; and

(ii) ensuring advisers and counterparts review work plans to actively address gender, disability, fraud and anti-corruption, HIV and AIDS, child protection, the environment and other cross-cutting development issues;

(m) support the work of the Technical Advisory Group and respond to requests for information;

(n) support the Program Coordinating Committee (PCC), including:

(i) organising meetings of the PCC at least twice in the first year and annually thereafter;

(ii) developing and delivering a detailed and comprehensive induction to all members of the PCC including briefing and training in the policies and procedures of the program;

(iii) developing and disseminating PCC Guidelines so as to contribute to high standards of transparency, accountability and integrity in the management and administration of the program;

(iv) provide support to PCC meetings including:

(A) providing all PCC members with at least 14 days' notice of the time and place of the meeting, if practical;

(B) distributing draft and final agendas for the meeting to all PCC members;

(C) at least seven (7) days in advance of the meeting, provide all members with any other information required to enable the PCC to perform effectively;

(D) distributing minutes of the meeting to all PCC members within seven (7) days of the meetings; and

(E) performing other tasks as required to enable the PCC to function effectively;

(o) financial management of the program, including:

(i) establishing and implementing a financial management system that supports half yearly financial reporting in a format acceptable to AusAID and document this system in the Program Operational Manual;

(ii) developing and implementing systems for managing, disbursing and acquitting all funds necessary for the implementation of the program;

(iii) providing an acquittal of expenditures against the budget, and a forward projection of funding on a quarterly basis;

(iv) establishing and managing the program financial management systems; and

(v) developing a Program Audit Regime and organising an independent annual audit of the program as a whole;

(p) Monitoring and Evaluation including:

(i) establishing and maintaining a Monitoring and Evaluation Framework that undertakes quantitative and qualitative assessment of key program outputs, based upon the indicators as developed in the approved Annual Plan and quantitative and qualitative assessment of desired program outcomes;

(ii) developing and implementing an integrated M&E arrangement key implementers including sub-contractors that delivers a judgement about outputs and outcomes and the quality of inputs and processes and at:

(A) activity level: works with the implementer to deliver a judgment about their achievements – even if only for one key indicator;

(B) program level: addresses broader questions related to process evaluation and effectiveness; and

(C) implementation and management level: contributes to an assessment of the Contractor's performance in managing the program, and contributing to its strategic direction;

(iii) ensuring results and lessons learned from M&E are incorporated into the program as appropriate;

(iv) actively participating in external review processes (for example an Independent Progress Review) as directed by AusAID; and

(v) undertaking field or site visits as necessary to support activities, monitor progress and undertake analysis towards outcomes at facilities or departments;

(q) encourage, support and facilitate participation by program counterparts and stakeholders including:

(i) working closely with program counterparts, and the appropriate regional, prefecture county and township bodies, personnel from key national agencies, donors and related AusAID activities, and other service providers, to implement program activities;

(ii) facilitating transfer of knowledge and skills between program personnel and their counterparts;

(iii) ensuring that implementation is carried out in a manner that facilitates the development and emergence of a medium to longer term in-Tibet based implementation arrangement;

(iv) ensuring all program plans, guidelines, manuals, studies, reviews, capacity building, monitoring, research and evaluations are to be the result of collaboration with counterparts and consultation with stakeholders, Where appropriate, counterparts should be involved in the writing of program related documentation, and supported in these activities;

(v) allowing participants the opportunity for discussion and involvement in decision-making and delivery of training; and

(vi) encouraging program counterparts to facilitate at training, including workshops and provide support to participants in workshop planning and preparations;

(r) ensure the program is Tibet-centred, and works in partnership with local institutions including ensuring:

(i) it is locally planned, negotiated and implemented;

(ii) Sites/facilities are provided with sufficient resources to conduct and monitor appropriate activities;

(iii) it is locally led and sensitive to local culture;

5. COMPONENT SERVICES.

5.1 The Contractor shall be responsible for the implementation of two key project components as follows:

5.2 Component 1: Health Human Resource Management

(a) ensure that the Health Human Resources Adviser takes main responsibility for delivery of Outputs associated with Component 1 as follows:

(i) Output 1.1: Capacity building in HHRM undertaken for Bureau managers at regional level

(ii) Output 1.2: Follow up support to Bureau managers at Regional level to implement improved HHRM knowledge and skills

(iii) Output 1.3: Capacity building in health management undertaken for Bureau managers at prefecture/county level

(iv) Output 1.4: Follow up support to Bureau managers at prefecture and county level to implement improved health management knowledge and skills

(b) Refer to the approved PDD for detail of Outputs and deliverables.

(c) Ensure capacity building is undertaken:

(i) through the purchase of "packages" of training from appropriate Chinese institutions offering recognised training in human resource management and planning;

(ii) ensure the cost included in the packages will include fees for trainers, some follow up supervision, study tours, training manual/notes;

(iii) ensuring that once formal training has been undertaken, follow-up support to trainees will be provided by the CLTA HHR in conjunction with the training institutions, and will include individual and group mentoring, establishing a learning set approach, support to individual work based projects, involvement in applying HR policy, and continued exposure to new ideas and HR related research through attendance at annual Heath Forums in Tibet and supported by the program.

(d) ensure expected outcomes with support of the program for Component 1 include:

(i) Bureau managers at regional level will have improved capacity, skills and ability to understand, develop and implement HR policy;

(ii) Prefecture and county level health managers will have the capacity to apply management skills, knowledge and practice, using standard approaches to aspects of HR management such as managing performance of staff and management of change; they will have developed an understanding of the HHR policy context at TAR and national level.

(iii) Support will have been provided to the implementation of the Tibet 12th Five Year Health HR Plan;

5.3 Component 2: Technical and Clinical Practice

(a) ensure that the Health Systems Adviser will take main responsibility for delivery of Outputs associated with Component 2 as follows :

(i) Output 2.1: Prefecture CDC laboratory staff trained

(ii) Output 2.2: Guidelines for County Hospital and Township Health Centre developed

(iii) Output 2.3: A pool of technical health trainers developed

(iv) Output 2.4: Technical staff for priority areas trained

(v) Output 2.5: Technical staff for rapid responses to public health emergencies trained

(b) Refer to the approved ADD for detail of Outputs and deliverables.

(c) ensure improving clinical and technical skills will be undertaken as follows:

(i) For laboratory (Output 2.1) using an "off-the-shelf" package modified for Tibetan CDC laboratory needs; the Laboratory Specialist should be affiliated with an appropriate Chinese institution.

(ii) To provide guidance to the types of services to be provided in County Hospitals and Township Health Centres, guidelines will be developed that articulate the types of services required, and the staff skills mix to do this; guidelines available for the rest of China (where available) will be used as a starting point, and modified for Tibetan appropriateness; the CLTA HS will take main responsibility for coordinating this development engaging appropriate stakeholders through the Guidelines Technical Group.

(iii) A pool of highly skilled trainers will be developed from within Tibet to increase and improve the training capacity for the health sector; this will be co-ordinated by the CLTA HS, with a "package" of training of trainers delivered by external national level technical experts, including initial training, and follow-up support and monitoring as necessary; the CLTA HS would provide the ongoing mentoring and support, and may do some of the outreach trainee support.

(iv) Technical staff in the identified priority areas, at prefecture, county and township levels will receive training in technical skills areas of unmet need (informed by guidelines development in Output 2.2 and/or by training needs analysis); the Contractor will ensure that activities complement rather than duplicate current training activities being provided by TAR; activities will include sustainable formal training programs, on-the-job reinforcement of skills and knowledge, and continuing education; the CLTA HS will be responsible for coordinating this effort; trainers with relevant technical skills will be drawn from the trainer pool (Output 2.3), supplemented as necessary by additional TAR and national experts; training delivery and outcome in initial identified technical areas will be evaluated after the first year of delivery, and curricula content and delivery modes adapted as necessary.

(v) Improving capacity to respond to unanticipated public health emergencies will be supported by establishing an Emergency Response Fund, managed by the Contractor; the fund will be kept simple to facilitate a quick response when needed and will be managed from within the Contracted team. Payments will be on a reimbursable basis.

(c) Ensure through Component 2 that participants in the program are applying improved technical or clinical practices through:

(i) Improved laboratory capacity which will result in more accurate and timely testing, and rapid and correct diagnosis and treatment;

(ii) The development of guidelines that identify the essential functions of service to be ideally provided at the county hospital and township health centre level, and identify the related staffing profile required to provide these services;

(iii) Development of a pool of highly trained trainers skilled in and applying adult teaching and learning methods;

(iv) Increased staffing skills and capacity in additional priority technical or clinical areas as the program rolls out;

(v) Should public health emergencies arise, the program will support building skills to result in an effective response.

5.4 The Contractor will ensure that all training will be informed by initial training needs analysis, undertaken by the long or short-term specialist/adviser in the relevant field.

5.5 the Contractor will ensure the geographical focus of the program is as follows:

(a) Component 1 will focus on the whole of the TAR.

(b) Component 2: Output 2.1 focuses on CDC laboratories across the TAR; remaining Outputs are undertaken in three pilot prefectures, with a view to developing and testing models that can be replicated across the TAR.

6. PHASING AND TIMING

6.1 There are no Implementation Phases for this program.

6.2 With respect to timing of activities, flexibility will be required in the first instance to accommodate the constraints that the winter months impose on implementing program activities; this will apply particularly to activities under Outputs 1.1 and 1.3, and associated Outputs 1.2 and 1.4.

6.3 There are fewer dependencies in Component 2. It is proposed that Activities under Output 2.1 commence early; Output 2.1 is not dependent on activities within other Outputs, but the constraints of winter weather on program delivery will have to be recognised.

6.4 This is also the case for Output 2.2, which is not dependent on any other activities for its occurrence.

6.5 Output 2.3 is to an extent dependent on the development of Guidelines in Output 2.2; should Output 2.2 be delayed, Output 2.3 could proceed based on a TNA.

7. PROJECT DOCUMENTS

7.1 The Contractor shall provide AusAID and the PCC with drafts of the following documents within three months of mobilisation unless otherwise specified:

(a) M&E Framework;

(b) Comprehensive THPCBP Introduction Booklet, including the THPCBP Code of Conduct, in plain English, Chinese and Tibetan;

(c) THPCBP Operational Manual, including a Security and Administration Manual;

(d) Program Coordinating Committee Operating Guidelines:

(e) Financial Management Handbook, including the THPCBP Audit Regime and a Fraud Control Plan which includes details of how the Contractor will deal with instances of fraud or suspected fraud in accordance with AusAID requirements and drawing on the findings of previous audit reports in earlier Projects and other project activities in Tibet;

(f) Child Protection Policy;

(g) Training Plan, including a Training Needs Assessment for staff;

(h) THPCBP Promotion Strategy;

(i) Risk Management Plan; and

(j) Handover Plan in accordance with Clause 14 in Standard Contract Conditions

8. REPORTING REQUIREMENTS

8.1 The Contractor must provide the following reports by the date, in the format and the number of copies indicated:

Ref	Payment Milestone	Means of verification for payment	Target quarter	Copies
M1	Y1 Annual Plan		Yr 1 Qtr 2	xx
M2	6-monthly progress reports		Annually Qtr 3	xx
M3	M&E Plan		Yr 1 Qtr 1	xx
M4	Annual Report & Annual Plan		Yr 2-5 Qtr 1	xx
M5	Activity Completion Report		Yr 5, Qtr 4	xx

(a) Half yearly Progress Reports in addition to providing information for the PCC, TRBH and AusAID will provide a basis for communicating with stakeholders, related programs of assistance and other donors. and will include:

(i) a summary of key issues;

(ii) identification of emerging policy issues;

(iii) a report on progress of the program by component and output during the reporting period that is consistent with the Annual Plan and the M&E Framework;

(iv) details of achievements with reference to the Contractor Performance Assessment Framework;

(v) a report on and update (if required) of the Risk Management Plan. Any issues affecting the progress of the project not included in the Risk Management Plan should be added;

(vi) cross-sectoral issues and inter-project/program coordination and cooperation;

(vii) a Statement of Expenditure for the reporting period;

(viii) a report on training against the Training Plan and update of the Training Plan;

(ix) comments on the management of stakeholder relationships;

(x) details of any variations from the Annual Plan; and

(xi) an update on expenditure in the previous half year and anticipated expenditure in the next quarter;

(b) Activity Completion Report: due two months before the end of the program. The Activity Completion Report should be prepared in accordance with AusAID current guidelines on such reports.

8.2 All reports must:

(a) be accurate and not misleading in any respect;

(b) be prepared as directed in writing by AusAID;

(c) allow AusAID to properly assess progress under the Contract;

(d) be provided in the format, number and on the media approved or requested by AusAID;

(e) not incorporate either the AusAID or the Contractor's logo

(f) be provided at the time specified in this Schedule; and

(g) incorporate sufficient information to allow AusAID to monitor and assess the success of the Services in achieving the objectives of AusAID's Gender and Development Policy.

8.3 The Contractor shall maintain a collection (Electronic and hard copies) of all reports, technical papers and publications produced by the program for and on behalf of AusAID.

8.4 Within fourteen days of receiving AusAID advice of any required amendments to the draft Work Plan or any other document, the Contractor will submit copies of the final documentation to AusAID (four hard copies and one soft copy).

8.5 Program reporting will, wherever possible, conform to standard reporting processes and formats developed for the overall AusAID program.

8.6 The Contractor shall provide copies of all reports to AusAID, the Program Coordinating Committee and GoPRC agencies as directed by AusAID.

9. PERSONNEL

9.1 The program will be directed by a Team Leader, who will lead a team of short and long term development specialists and staff based in a head office to be located in Lhasa.

9.2 The Team Leader shall be recruited by the Contractor in consultation with AusAID and the Program Coordinating Committee upon commencement of the Contract.

9.3 The Contractor shall provide the following key positions and key personnel to undertake the Services:

Position	Nationality	Month/Days
Long Term Advisers		**Months**
Team Leader	Australian, New Zealand or other	50
Health Human Resources Adviser	Chinese	60
Health Systems Adviser	Chinese	60
Laboratory Specialist	Chinese	27
Long Term Management Support		
Translator/Interpreter	Chinese	60
Driver [1]	Chinese	60
Driver [2]	Chinese	60
Administrative Assistant	Chinese	60
Short Term Advisers		**Days**
Program Technical Director	Australian, New Zealand or other	207
Program M&E Specialist	International	300
M&E Adviser	Chinese	540
Training Adviser	Chinese	600
Unallocated TA 20% of fixed short term	Chinese	240

9.4 Position descriptions are provided at Annex A to this Schedule 1 Scope of Services

APPENDIX A: POSITION DESCRIPTIONS

Position Description

Team Leader

Responsibilities
The Team Leader (TL) is responsible for in-country program leadership and management.

The TL reports to the Program Technical Director who has overall responsibility for the success of the program. The TL will manage, monitor, and evaluate the activities of all in-country team members, establishing an excellent team approach, and ensuring strong linkages and synergies between and across Components.

The TL leads the establishment of relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; leads consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; monitors the consultations of team members; provides technical input according to professional expertise; assures reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all program activities and processes; and manages the program budget to the highest level of financial accountability.

Experience
The TL will have a recognised and valued track record in:

- Senior health system policy and management.
- Change management and effective communication.
- Strategic thinking and planning.
- Effective personnel management based on creating effective teams.
- Budgeting and budget management.
- Complex report writing.
- Success achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities
The TL's personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills.
- Effective consultation skills.
- Problem solving skills.
- Taking accountability and responsibility for their own, and their team's, actions.
- A track record of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities
The TL's professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- Health systems and health system reform, including policy, financing, and management issues.
- Policy development and review
- Health system analysis.
- Strategic planning
- Project management
- Health information and indicator monitoring.
- Cross-cultural communication.

- A track record of building capacity with counterparts.
- Facilitating multisectoral collaboration and building partnerships

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Training design, delivery and evaluation, including participative methodologies
- Human resource management and planning
- Hospital and primary care management
- Project design, monitoring and evaluation.
- Gender analysis.
- Cultural analysis.
- Qualitative analysis.
- Quality assurance.
- Rational planning for resource allocation and use
- Socio-cultural and behavioural research

Position Description

Chinese Long Term Adviser (CLTA):

Health Human Resources (HHR)

Responsibilities

The CLTA Health Human Resources (CLTA HHR) reports to the TL, and is responsible for the technical and management leadership for Component 1, and its successful planning and implementation, and for contributing actively to linkages and synergy across Components.

Under the leadership of the TL, the CLTA HHR establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership and input to Component 1; manages inputs of any short term consultants; facilitates counterpart capacity building including of M&E; ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all Component activities and processes; and manages the Component budget to the highest level of financial management accountability.

Experience

The CLTA HHR will have a recognised and valued track record in:

- Senior level health policy /management development and implementation.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Budgeting and budget management.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CLTA HHR personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's actions.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CLTA HHR professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- International thinking on lessons learned and current approaches to health systems organisation and management.
- Health systems policy development and review
- Health systems management development
- Strategic planning
- Project management
- A track record of building capacity with counterparts.
- Qualitative analysis.
- Cross-cultural communication.

- Facilitating multisectoral collaboration and building partnerships.

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Monitoring and evaluation
- Human resource planning and management
- Training needs analysis, planning and delivery.
- Cultural analysis.
- Quality assurance.
- Training, including adult learning and participative methodologies.
- Project design.
- Rational planning for resource allocation and use.

Position Description

Chinese Long Term Adviser (CLTA):
Health Systems

Responsibilities

The CLTA Health Systems (CLTA HS) reports to the TL, and is responsible for the technical and management leadership for Component 2, and its successful planning and implementation.

Under the leadership of the TL, the CLTA: HS establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership and input to clinical/technical training and development activities in Component 2; plans and manages the work of short term consultants and other trainers; manages the development of the "pool" of trainers; facilitates counterpart capacity building including of M&E; ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all Component 2 activities and processes; and manages the Component 2 budget to the highest level of financial accountability.

Experience

The CLTA: HS will have a recognised and valued track record in:

- Planning, management, delivery and evaluation of training and development activities
- General health care policy and management.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Budgeting and budget management.
- Complex report writing.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CLTA: HS personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Good writing skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's, actions.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CLTA: HS professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- Training needs analysis for health technicians and clinicians
- Effective modes of training delivery for health technicians and clinicians
- Managing long term staff development programs
- Health policy and management.
- Mentoring
- A track record of building capacity with counterparts.
- Behavioural change.

- Strategic planning
- Project management
- Training and health indicator monitoring.
- Qualitative analysis.
- Cross-cultural communication.
- Facilitating multisectoral collaboration and building partnerships

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Monitoring and evaluation
- Gender analysis.
- Cultural analysis.
- Qualitative analysis.
- Quality assurance.

Position Description

Chinese Long Term Adviser (CLTA):

Laboratory Specialist

Responsibilities

The CLTA Lab reports to the TL, and is responsible for the technical leadership for Output 2.1, and its successful planning and implementation.

Under the leadership of the TL, the CLTA Lab establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership and input to Output 2.1; manages input of any short terms consultants to that Output; ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all Output 2.1 activities and processes; and manages the Output budget to the highest level of financial management accountability.

Experience

The CLTA Lab will have a recognised and valued track record in:

- Senior level laboratory policy development and management.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Training expertise.
- Budgeting and budget management.
- Complex report writing.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CLTA Lab personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's actions.
- A track record of building capacity with counterparts.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CLTA Lab professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- International thinking on lessons learned and current approaches to laboratory organisation and management.
- Laboratory policy development and review
- Laboratory management development
- Strategic planning
- Project management
- Qualitative analysis.
- Cross-cultural communication.

- Facilitating multisectoral collaboration and building partnerships.

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Monitoring and evaluation
- Training needs analysis, planning and delivery.
- Quality assurance.
- Training, including adult learning and participative methodologies.
- Rational planning for resource allocation and use.

Position Description

Chinese Short Term Adviser (CSTA):

Monitoring and Evaluation (M&E)

Responsibilities

The CSTA M&E reports to the TL, and is responsible for establishing the M&E mechanisms for the whole program, identifying and establishing data collection mechanism, working closely with TRBH counterparts and CLTAs to foster ownership and understanding of the program's M&E approach.

Under the leadership of the TL, the CSTA M&E establishes relationship with counterparts based on trust and mutual respect; facilitates counterpart ownership and leadership of the program's M&E approach; participates in consultations with GOPRC and GOTAR officials, INGOs, other donors, and other key stakeholders; provides technical leadership on M&E; works closely and cooperatively with the International M&E STA, ensures input to reports and milestones are completed on time to the required standard; ensures that the program principles are integrated into all M&E activities and processes; and manages the M&E budget to the highest level of financial management accountability.

Experience

The CLTA M&E will have a recognised and valued track record in:

- M&E of large health programs.
- Change management.
- Strategic thinking and planning.
- Effective human resource management based on creating effective teams.
- Mentoring expertise.
- Budgeting and budget management.
- Complex report writing.
- Successful achievements in sensitive, complex, and challenging environments.

Personal Competencies and Capabilities

The CSTA M&E personal competencies and capabilities will include:

- Leadership.
- Team player.
- Integrity.
- Strong interpersonal skills.
- Strong oral and written communication skills, including in English.
- Effective consultation skills.
- Strong ability to anticipate and solve problems.
- Taking accountability and responsibility for their own, and their team's actions.
- A history of meeting deadlines.
- Demonstrated capacity to work sensitively in an evolving policy context and in a coordinated fashion with key stakeholders.

Professional/Technical Competencies and Capabilities

The CSTA M&E professional competencies and capabilities will include up-to-date knowledge and technical proficiency in:

- International thinking M&E approaches to assessing health program effectiveness.
- Project management for M&E.
- Qualitative and quantitative analysis.
- Gender analysis
- Cross-cultural communication.
- Facilitating multisectoral collaboration and building partnerships.

Desirable Professional Technical Competencies and Capabilities

Desirable technical competencies and capabilities include one or some of the following:

- Training, including adult learning and participative methodologies.

BASIS OF PAYMENT

Tibet Health Personnel Capacity Building Program

1. TOTAL AMOUNT

1.1 The total amount payable by AusAID to the Contractor shall not exceed the sum of ***[XX]*** plus GST, if any to a maximum of ***[XX].***

1.2 AusAID shall not be liable for any Costs or expenditure incurred by the Contractor in excess of this amount.

2 FIXED FEES

2.1 The design recommends that the MC's basis of payment should be established around a traditional set of inputs and payment milestones type contract arrangement with the Contract Amount being fixed as:

Costs and Fees	Value
Reimbursable Costs	
Long Term Contractor Personnel (Core– emoluments & travel)	$A
Short term Contractor Personnel (Advisory Pool – emoluments & travel)	$B
Operational Costs (Program activities)	$C
Procurement Costs (Office start-up, annual running; approved program equipment; work related transport & in-country travel)	$D
Fees	= $A+$B+$C+$D
Profit and Management Fee	$E
CONTRACT TOTAL	**= $A+$B+$C+$D+$E**

Payment milestones should be of a hybrid nature with XX% payable on fixed outputs such as:

a) Year 1 Annual Plan

b) 6-monthly reports

c) M&E Plan

d) Annual Report and Annual Plan

e) Activity Completion Report.

3 MILESTONE PAYMENTS

The wording of these clauses will depend on the payment regime. The following wording is suited to a hybrid based payment regime.

3.1 A ***[insert percentage%]*** proportion of the Fees (the "Milestone Payments") payable to the Contractor will be paid progressively, within thirty (30) days of AusAID's acceptance of the satisfactory completion of identified outputs and a correctly rendered invoice.

3.2 The criteria for "satisfactory completion" of an identified output will be as specified in Annex 1 ***[refers to milestone payment table]*** as the "verifiable indicators".

3.3 Where a Milestone Payment is to follow acceptance of a report, AusAID shall not be obliged to make payment until all of the outputs to be achieved by the Contractor in the period covered by the report have been achieved.

3.4 It is AusAID corporate practice to inform Contractors as soon as reasonably possible, and in any case within 30 days of receipt of notice of the completion of an identified output or provision of a report whether or not that output or report is accepted.

4 REGULAR PAYMENTS

4.1 A ***[insert percentage%]*** proportion of the Fees (the "Regular Payments") payable to the Contractor will be paid progressively on a ***[monthly, quarterly]*** basis within thirty (30) days of AusAID's receipt of a correctly rendered invoice including certification that the inputs have been provided as required by the contract.

5 REIMBURSABLE COSTS

5.1 The Contractor will be reimbursed on the basis of the actual cost incurred for items identified as reimbursable, up to the specified limit, within thirty (30) days of AusAID's receipt of a correctly rendered invoice. ***[insert timeframe in which Contractor is able to invoice eg, same as Regular Payments.]***

6 PROCUREMENT FEE

6.1 The Contractor will be entitled to a Procurement Fee of ***[#%]*** on the actual cost of Project Supplies procured for the purposes of the Project and which are handed over to the Partner Country immediately. The procurement fee is inclusive of insurances.

7 ACTIVITY FEE

This may be appropriate for capacity building or managing contractor projects where there is significant sub-contracted activity. Note too, that clear definitions of when the contractor is eligible for the Procurement Fee and Activity Fee are required to ensure that they are not both paid on the same item.

7.1 The Contractor will be entitled to an Activity Fee of ***[#%]*** on the actual cost of sub-contracted activities. The Activity Fee is inclusive of the costs of all management and resources required to identify, tender, contract and monitor sub-contracted activities.

8 LEAVE

8.1 Leave accrued during the assignment for long term advisors shall be deemed to be taken in the year it falls due and cannot be accumulated or paid out.

9 CLAIMS FOR PAYMENT

9.1 The Contractor's tax invoice must be submitted when due pursuant to this **Schedule** in a form identifiable with the Services.

9.2 All tax invoices must include a certification by a Company director of the Contractor, or their delegate:

9.2.1 that the invoice has been correctly calculated; and

9.2.2 that the Services included in it have been performed in accordance with the Contract.

9.3 All claims for payment must be **made out to:**

Chief Finance Officer
Australian Agency for International Development

GPO Box 887
CANBERRA ACT 2601

9.4 Tax invoices should be sent to the above address. Alternatively, AusAID will accept electronic tax invoices. These can be sent to accountsprocessing@ausaid.gov.au

9.5 Invalid invoices will be returned to contractors. Information on what constitutes a valid tax invoice can be found at:

http://www.ato.gov.au/businesses/content.asp?doc=/content/50913.htm

ANNEX 1

No.	Reference	Milestone description	Work methodology	Means of verification	Quality Measurement & Basis of Payment	Estimated Claim period	Value
Sub Total (***insert claim period value for period)***							
TOTAL: (***insert total value of Milestones)***							

ANNEX P: DOCUMENTS CONSULTED

1. *Study on Health Resource Allocation and Utilization in Shigatse Prefecture*. THSSP, Tibet University Medical School, Shandong University Health Management and Policy Study Center. March 2010
2. *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.* WHO
3. AusAID China Country Program Strategy (2006-10)
4. National Guidance on Strengthening Capacity Building of Health Human Resources
5. TAR Health Human Resource Development Plan (2005 -2010)
6. Concept Paper of Tibet Health Human Resources and Management
7. Tibet Health Sector Support Program: Program Design Document March 2003
8. Activity Completion Report of THSSP
9. Independent Completion Report of THSSP
10. Gender Equality in Australia's Aid Program – Why And How. AusAID 2007