



**World Health  
Organization**

**Country Cooperation  
Strategy**

**Viet Nam  
2007-2011**

## **Executive Summary**

The World Health Organization (WHO) has been working with the Government and development partners in Viet Nam for more than 50 years and has played a critical role in disease control and prevention for decades. The Organization has been at the forefront of numerous public health efforts, assisting the Government in the elimination of poliomyelitis and neonatal tetanus, devising strategies to combat public health threats, and setting standards for various public health issues, including maternal and child health. While Viet Nam's health indices have improved substantially in recent years, the country is now facing a host of relatively new health problems, including rising incidences of noncommunicable or lifestyle-related diseases, an escalating HIV/AIDS epidemic and newly emerging diseases. These challenges require a less-fragmented health system with better strategies, stronger management and more strategic leadership and greater resources to cope effectively and efficiently with current demands.

The overall goal of WHO in Viet Nam is to improve the health of the country's people by supporting health development. The first WHO Country Cooperation Strategy (CCS) for Viet Nam, covering the period from 2003 to 2006, was initiated in 2002 and was developed as a broad framework for cooperation between the Organization and Viet Nam. With the WHO CCS 2003-2006 successfully implemented, that framework needs to be updated and adapted to future challenges that the health sector may face.

The WHO CCS for Viet Nam for 2007-2011, described in this document, articulates the commitment of WHO to health development and defines the priorities for WHO's work with the Government from 2007 to 2011. The key objective is to enable WHO to work towards its goal of improving health in Viet Nam by effectively assisting in the development of a pro-poor and decentralized health system that is equitable, fair, responsive and quality-focused. The CCS also represents WHO's intention to translate the 'One WHO' principle into practice in Viet Nam. Further, WHO and UN partners are strengthening their collaboration to ensure coherent UN support to health development in Viet Nam.

The CCS is built on the principles of equity, fairness and good governance and is based on a systematic assessment of the country's health needs and aspirations, on WHO's own corporate policy and priorities, and on the support and actions of other partners in health within the country. It represents a medium-term collaborative strategy for strengthening the health sector and aims to achieve a planned and progressive shift towards a more strategic role for WHO in terms of both what it does and how it does it, taking into account the roles and functions of other members of the broader health partnership.

WHO's strategic direction in Viet Nam will focus on six priority areas (or 'clusters'): (1) health policy, legislation and system development; (2) communicable disease surveillance, prevention and control; (3) promotion of a healthy environment and healthy

lifestyles and prevention of noncommunicable diseases; (4) family and community health and nutrition; (5) HIV/AIDS, and tuberculosis; and (6) partnerships and coordination.

In implementing these six priority areas, WHO will pay more attention to advocacy, policy development, norms and standards setting, monitoring and information-sharing, while support for routine implementation will be curtailed substantially. The CCS will guide more detailed programming of available resources as well as the assessment large programme areas, on a biennial basis. Programmes that have become self-sustaining (no longer require support from WHO) will be phased out, allowing the Organization to support new programme areas and deal with emerging health issues. WHO's key asset and strength is its technical resources and its ability to mobilize technical support from others. Over time, technical resources will be re-focused on areas of strategic importance for WHO and Viet Nam, and essential for the attainment of the country's health goals.

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## List of acronyms

<b>CCS</b>	<b>Country Cooperation Strategy</b>
<b>FAO</b>	<b>Food and Agriculture Organization of the United Nations</b>
<b>GAVI</b>	<b>The GAVI Alliance (formerly known as the Global Alliance for Vaccines and Immunization)</b>
<b>GDP</b>	<b>Gross Domestic Product</b>
<b>HCS</b>	<b>Hanoi Core Statement</b>
<b>HPG</b>	<b>Health Partnership Group</b>
<b>IHR</b>	<b>International Health Regulations (2005)</b>
<b>ILO</b>	<b>International Labour Organization</b>
<b>NCD</b>	<b>Noncommunicable disease</b>
<b>ODA</b>	<b>Overseas Development Assistance</b>
<b>SARS</b>	<b>Severe Acute Respiratory Syndrome</b>
<b>SWAP</b>	<b>Sector-Wide Approach</b>
<b>TB</b>	<b>Tuberculosis</b>
<b>THE</b>	<b>Total Health Expenditure</b>
<b>UNAIDS</b>	<b>Joint United Nations Programme on HIV/AIDS</b>
<b>UNDP</b>	<b>United Nations Development Programme</b>
<b>UNESCO</b>	<b>United Nations Educational, Scientific and Cultural Organization</b>
<b>UNFPA</b>	<b>United Nations Population Fund</b>
<b>UNICEF</b>	<b>United Nations Children's Fund</b>
<b>UNIDO</b>	<b>United Nations Industrial Development Organization</b>
<b>UNIFEM</b>	<b>United Nations Development Fund for Women</b>
<b>UNV</b>	<b>United Nations Volunteers</b>
<b>VND</b>	<b>Vietnamese Dong</b>
<b>WHO</b>	<b>World Health Organization</b>

## **Section 1: Introduction**

The World Health Organization (WHO) Country Cooperation Strategy (CCS) for Viet Nam outlines the strategic framework within which WHO will collaborate with the people and Government of Viet Nam over the period from 2007 to 2011. The CCS is based on a systematic assessment of the country's health needs and aspirations, on WHO's own corporate policy and priorities, and on the support and actions of other partners in health within Viet Nam. The Strategy aims to achieve a planned and progressive shift towards a more strategic role for WHO in terms of both what it does and how it does it, taking into account the roles and functions of other members of the broader health partnership in Viet Nam.

Until the end of the 1980s, the Government of Viet Nam financed and provided free health care services to the population. The economic crisis of 1986 caused the launch the *doi moi* (reforms) in an attempt to transform the country from a state-controlled to a market economy. In the health sector, wide-ranging reforms were introduced in 1989. A number of market-oriented measures, including user charges, private sector provision and liberalization of the production and sale of pharmaceuticals, were implemented. The impacts of these reforms are still affecting the health system today.

The *doi moi* renewal process is generally recognized as having helped to improve the well-being of Viet Nam's population by substantially reducing poverty and increasing per capita GDP growth to an average of more than 7% per annum in the past decade. Nonetheless, Viet Nam remains among Asia's low-income countries, with many inequalities, including growing health disparities between urban and rural, rich and poor, and different geographical areas.

Assuming that the current economic growth rate continues, Viet Nam is expected to move to middle-income status by 2010 to 2012. This will impact on the level of financial aid available to the country from donors and will also change the nature of support required from WHO in the future.

### **Background and justification for formulation of the WHO Country Cooperation Strategy (CCS)**

The World Health Organization is the United Nation's specialized agency for health. It has been working side by side with the Government and development partners in Viet Nam for more than 50 years. It has played a critical role in disease control and prevention for decades, including the battle to eradicate poliomyelitis. In 2000, Viet Nam was declared polio-free. In 2003, WHO collaborated successfully with the Government and other partners to contain the outbreak of severe acute respiratory syndrome (SARS), and has also worked closely with the Government and other partners in efforts to successfully prevent and control the spread of the highly pathogenic avian influenza (H5N1) since its first outbreak in December 2003.

In addition, WHO has been at the forefront of numerous public health efforts in Viet Nam, assisting the Government in the elimination of neonatal tetanus, devising strategies to combat public health threats, and setting standards for various public health issues, including maternal and child health. Its support helped to shape the country's highly successful malaria programme, which resulted in a 90% drop in deaths from the disease in the space of five years. Additional WHO-led strategies have led to the almost complete elimination of leprosy in Viet Nam.

Viet Nam's health indices have improved substantially in recent years, although it has had to face a host of relatively new health problems, such as avian influenza, which remains a serious public health threat to the country. Other new challenges to the health sector include: rising incidences of noncommunicable and lifestyle-related diseases, such as tobacco-related diseases and road accidents; the escalating HIV/AIDS epidemic, coupled with the simultaneous rise in tuberculosis; and the emergence of diseases such as dengue and lymphatic filariasis. These new challenges require a less fragmented health system with better strategies and more resources that can be mobilized to cope effectively and efficiently with current demands.

The first WHO CCS in Viet Nam, covering the period from 2003 to 2006, was initiated in 2002. It was developed as a broad framework for cooperation between WHO and Viet Nam. The document clearly articulated the WHO's commitment to health development and equity in health, and its intention to translate the WHO corporate strategy into practice in Viet Nam. With the WHO CCS 2003-2006 successfully implemented, it is necessary that it remain updated and relevant to future challenges that the health sector may face.

The new CCS for Viet Nam, built on the principles of equity, fairness and good governance, represents a medium-term collaborative strategy for strengthening the health sector. It spells out the principles and values of WHO in its commitment to support the improvement of the health sector as a whole and the realization of the right to health for all Vietnamese people. Furthermore, it defines the priorities for WHO's work from 2007 to 2011 and serves as the fundamental guiding document for the development of the Organization's technical programmes in the country.

The renewed CCS is based on the following principles of cooperation that guide WHO's work in and with Viet Nam:

- (1) More selective, focusing on upstream policy development and priority areas of work.
- (2) More strategic, with WHO playing the role of policy advisor and broker.
- (3) More responsive to global, regional and country needs and priorities in line with WHO's core functions and Viet Nam's health sector plans.

- (4) Stronger linkage between health actions and reduction of poverty, vulnerability and gender inequality.
- (5) A stronger catalytic role in health interventions and better measures of WHO's performance.

This document has been prepared by WHO staff in collaboration with the Ministry of Health and the Ministry of Planning and Investment. It has undergone extensive peer review by major development partners and has been the subject of wide consultation between the WHO Country Office in Viet Nam and the WHO Western Pacific Regional Office.

## Section 2: Country Health and Development Challenges

### General social and economic determinants

Viet Nam encompasses an area of 329 247 square kilometres and is administratively divided into 64 provinces, including centrally administered cities subdivided into 659 districts/precincts then 10 732 communes/wards. The population of 83.1 million (2004)<sup>1</sup> is growing at a rate of 1.4% per annum but, as a result of past high fertility rates, the current population structure is relatively young with nearly 55% under the age of 25 years. Eighty-seven per cent of the total population belongs to the Kinh ethnic group; the remainder belonging to 53 other ethnic groups scattered mostly in remote and mountainous areas. Although urban growth has increased significantly in recent years, most of the population remains rural, with just 27.2% residing in urban areas. Literacy is high, at over 93%.

Over the past decade, the country's economy has grown rapidly, at an average of 7% per year since 2000. If this level of economic growth continues, Viet Nam is expected to be reclassified as a middle-income country by 2010-2012. According to the World Bank, Viet Nam is one of the best examples of successful poverty reduction. The percentage of poor households declined by over two-thirds between 1991 and 2000 mainly as a result of the economic reform policy. Although per capita GDP was US\$ 722 in 2006 and poverty is still significant (the percentage of poor households below the new poverty standard set in 2006 is 19%<sup>2</sup>), the human development index (HDI) has continued to increase over the past ten years. In 2006, Viet Nam was ranked 109 out of 177 nations on the HDI (0.709)<sup>3</sup>, compared with 120 out of 177 in 1990 (HDI: 0.618), while its per capita GDP was ranked 118<sup>th</sup>. The HDI improvements demonstrate significant progress in education, health care and living standards — a level better than many countries with similar or even higher levels of income. On the gender-related development index which accounts for inequalities between men and women, however, Viet Nam ranked 80 out of 136 nations. While the Government is firmly committed to the promotion of gender equality and the advancement of women, many persisting traditional practices and attitudes prevent Vietnamese women from enjoying equal rights and health status.

The benefits of economic growth have not been evenly distributed throughout society. In 2002-2003, per capita income in urban areas was 2.2 times greater than that in rural areas, the income of the highest income quintile was 8.3 times greater than that of the lowest income quintile, the average expenditure per head in urban areas was 2.2 times greater than that of rural areas, and the expenditure of the highest quintile was 4.5 times more than that of the lowest income quintile.<sup>4</sup>

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<sup>1</sup> UNDP 2006 Human Development Report

<sup>2</sup> Report by Prime Minister Nguyen Tan Dung at the 11<sup>th</sup> session of the XI Legislature of the National Assembly. <http://www.cpv.org.vn/details.asp?id=BT2030738972>

<sup>3</sup> UNDP 2006 Human Development Report

<sup>4</sup> Tổng cục Thống kê (2006). *Động thái và thực trạng kinh tế xã hội 2001-2005*, NXB Tổng Cục Thống Kê, Hà Nội

## Health situation

Health in Viet Nam has improved rapidly in recent years (see Table 1).

**Table 1: Trends in key demographic and health indicators**

Indicator	1995	2000	2005
Life expectancy at birth	65y	67.8y	71.3y
Crude death rate (per 1000 population)	6.0	5.6	5.3
Crude birth rate (per 1000 population)	22	20.5	18.6
Infant mortality rate (per 1000 live births)	45.1	36.7	17.8
Under-five mortality rate (per 1000 live births)	61.6	42	27.5
Maternal mortality ratio (per 100 000 live births)	110	95	80
Malnutrition rate among under-five children	44.9%	33.8%	25.2%

Source: Health Statistics Year Book 1995, 2000, 2005 (interpolation method was applied).

The increased life expectancy due to low birth and death rates indicates that Viet Nam has entered the third stage of demographic transition. This transition, combined with rapid socioeconomic development and accelerating urbanization, has contributed to major changes in the country's epidemiological patterns. There are, however, considerable variations across the country and between sexes. For example, the under-one infant mortality rate ranges from 33.9 to 10.6 per 1000 live births among provinces,<sup>4</sup> while the under-five infant mortality rate is 34 per 1000 live births for girls compared to 31 per 1000 live births for boys (2002).<sup>5</sup>

The overall incidence of communicable disease has fallen in recent decades; however there has been a significant increase over the last thirty years in the proportion of morbidity and mortality due to noncommunicable diseases and injuries/accidents (Table 2). Viet Nam thus faces a "double burden" of communicable and noncommunicable disease. In addition, 25% of children under the age of five years are still malnourished.

**Table 2: Morbidity and mortality trends, 1976-2005**

Type of disease	1976		1986		1996		2005	
	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality	Morbidity	Mortality
Communicable	55.50%	53.06%	59.20%	52.10%	37.63%	33.13%	25.18%	16.53%
Noncommunicable	42.65%	44.71%	39.00%	41.8%	50.02%	43.68%	62.16%	61.14%
Accidents, intoxication, injuries	1.84%	2.23%	1.80%	6.10%	12.35%	23.2%	12.65%	22.33%

Source: Health Statistics Year Book 1995, 2000, 2005.

<sup>5</sup> Child Survival Profile, WHO and Unicef (2007)

### Communicable diseases

Acute respiratory infections, parasitic diseases, diarrhoea and gastroenteritis of presumed infectious origin were among the leading causes of communicable disease morbidity in 2004, while pneumonia, respiratory tuberculosis and HIV/AIDS have been among the leading causes of mortality in more recent years. Acute respiratory infections, diarrhoea and parasitic infections have remained the most common childhood diseases. Diseases such as dengue fever and Japanese encephalitis have emerged in recent years and continue to increase in incidence.

Tuberculosis remains a major public health problem; Viet Nam ranks 13<sup>th</sup> out of the 22 countries with the highest Tuberculosis (TB) burden. Although TB has been a national priority for more than 10 years and targets for 100% DOTS coverage and for case detection and cure have been met for the last few years, an average of more than 55 000 new respiratory TB patients and at least 14 000 new non-respiratory cases have been reported each year for the last five years. The impact of the National TB Programme has been mitigated by the rapid spread of HIV since the early 1990s; HIV/AIDS sentinel data show that 4.3% of TB patients were HIV-positive in 2004.

In 2005, an estimated 260 000 people were living with HIV, a 12-fold increase since 1995, although the annual incidence of HIV notifications in 2005 was 13 731, somewhat less than the peak of 16 980 in 2003. The estimated HIV prevalence among injecting drug users and female sex workers is 33% and 3.5%, respectively. The average prevalence among pregnant women increased twelve-fold from 0.03% in 1994 to 0.37% in 2005, exceeding 1% in a number of provinces. The need for care and treatment of HIV/AIDS patients has already become a challenge and is set to increase in the coming years. Approximately 42 000 people living with HIV in 2006 were in need of antiretroviral treatment, but only 8500 had access to it, and it is projected that the number in need of the treatment will increase rapidly in the next few years. Widespread stigma and discrimination against people living with HIV, including from the health care setting, prevent (potential) patients from accessing prevention and treatment, but the government has demonstrated an increasing interest in confronting this problem.

Recent years have seen the appearance of newly emerging infectious diseases. SARS was detected in its early stages in Viet Nam, but was rapidly controlled and mortality remained relatively low, with only five deaths out of 63 cases. Highly pathogenic avian influenza (H5N1) was first recognized in late 2003 and has subsequently caused five waves of extensive outbreak in poultry. Most provinces have been affected, resulting in the culling of millions of poultry. The H5N1 virus is also able to occasionally cause serious infection in humans, posing a risk for a new influenza pandemic. The experience of SARS and the ongoing threat of avian influenza highlight the need for both short-term and long-term prevention and control measures to combat emerging infectious diseases, including the strengthening of technical capacity in both human and animal health sectors.

The extended immunization programme in Viet Nam is considered a successful child health intervention that has resulted in large reductions in the rates of vaccine-preventable

diseases, the eradication of polio and the gradual elimination of newborn tetanus. Since 2001, the immunization coverage rate has increased from 89.7% to 95.2%, although there are still some areas with lower coverage that need specific attention.

Malaria control in Viet Nam in the last decade has also been extremely successful. Malaria cases and deaths have dropped by 60% and 97%, respectively, since 1996. Many localities have reported no malaria cases for the last few years. Only 18 malaria deaths were reported in 2005, and less than 10 for the first six months of 2006. However, the country is also highly endemic for several 'neglected diseases', such as lymphatic filariasis, fascioliasis, paragonimiasis and soil-transmitted helminthiasis, which affects over 70% of school children and is known to result in poor growth, reduced physical activity and impaired learning ability.

#### Noncommunicable diseases (NCD) and injuries

Increasing household income has changed dietary and eating habits, changing lifestyles have resulted in increasing physical inactivity, particularly in urban areas, and increasing environmental contamination is causing various health hazards. These factors have all played an important role in the alarming increase of NCD, including injuries and poisonings, as illustrated in Table 2. Men are more likely than women to be affected by NCD, and more likely to suffer from accidents or injuries.<sup>6</sup> This is reflected a lower life expectancy for men: 69 years in 2005, compared to 74 years for women.<sup>7</sup>

Of all of the changes in morbidity and mortality, the increase in injuries and deaths from traffic accidents is the most significant (5897 deaths occurred in 1994 from road traffic accidents compared with 12 230 in 2004), primarily affecting adolescents and young adults. Traffic accidents are among the most common and most serious type of accident, and have increased steadily in the last ten years.

The Government is well aware of the rising trends in NCD and the growing number of deaths and injuries due to causes such as traffic accidents, alcoholism and occupational hazards, and has initiated four major NCD programmes. These focus on controlling and preventing diabetes cancer, cardiovascular diseases and mental disorders. However, resources for such programmes are limited, with little external funding, and the current national programmes tend to be treatment-oriented rather than prevention- and community-focused. Being chronic, these diseases are expensive to treat. As resources are limited, a public-health and prevention-oriented approach would be more cost-effective and appropriate.

Various types of legislation for preventing or mitigating the impact of traffic and other types of accident already exist in Viet Nam. However, their enforcement is weak, leading to widespread non-compliance with safety measures such as wearing helmets on motorcycles, observing traffic lights and using protective gear on certain jobs. Moreover, the law on alcohol consumption and sales needs to be developed in a more comprehensive manner.

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<sup>6</sup> Vietnam Health Report 2006 (draft), table 2.4 page 15

<sup>7</sup> World Health Statistics 2007, WHO

## Health system

### Health financing

The Vietnamese health financing system is characterized by low total expenditure on health and a low proportion of total health expenditure from public sources (see Table 3). By the end of 2006, social health insurance (administered by the Viet Nam Social Security Agency) covered 41.2% of the population, and the annual expenditure of this scheme is currently 50% more than the funds available to pay for health services. Revenues collected from private enterprises (employers and employees) are limited since their compliance is low and their participation is not stable. Increasing coverage of the social health insurance scheme will be difficult as a large proportion of those not covered are in the informal sector.

**Table 3: Health finance indicators for 2003**

<b>Total health expenditure</b> (THE) (per capita per year)	US\$ 26
Total health expenditure as % of GDP	5.2% (estimated 5.6% in 2006)
<b>Public sources of health financing</b> , as % of THE, of which: - government budget - social health insurance - Overseas Development Assistance (ODA) spent on: prevention 31%; curative 63%; administrative 6%	30% 22.5% 4.8% 2.7%
<b>Private health expenditure: out-of-pocket payments</b> (% of THE), paid to: - public providers - private providers - pharmaceuticals	64% 7.7% 11.5% 44.8%
<b>Other private health expenditure</b> (% THE), including private health insurance, NGOs, voluntary payments	6%

Large out-of-pocket payments account for the greatest part (64%) of total health expenditure, and 70% of this (equal to almost 45% of total health expenditure) is for pharmaceuticals. This level of out-of-pocket expenditure resulted in 8.2% of households facing catastrophic expenditure in 2004.<sup>8</sup> The continuing expansion of the health infrastructure network, including increasing levels of sophisticated equipment (primarily for curative health services), the fee-for-service payment system, and a lack of cost controls have resulted in a rapid increase in health costs.<sup>9</sup> Rising incomes have increased demand for services, also contributing to a significant increase in total health expenditure (average annual household expenditure for health was VND 476 580 in 1992-93 and VND 1 322 020 in 2004, equivalent to 6.9% and 6.2% of total household average expenditure).

<sup>8</sup> Tran Tuan va Cong Su (2006). *Báo cáo nghiên cứu chỉ số CATA và tỷ lệ hộ gia đình nghèo đi do chi phí khám chữa bệnh ở Việt Nam qua điều tra mức sống dân cư ở Việt Nam giai đoạn 1993-2004*. Báo cáo tại Hội nghị Tài chính Y tế, do Tổ chức Y tế thế giới và Ban Khoa giáo Trung ương tổ chức tại Hải Phòng, 19/12/2006.

<sup>9</sup> See, for example, Sepehri at al. 2005 *Penalizing patients and rewarding providers: user charges and health care utilization in Viet Nam*.

### Health service provision

Viet Nam's health system retains its socialist basis, with the state health system playing a key role in health service provision. Services are delivered by both private providers and an extensive public network of village health workers, commune health stations, inter-communal polyclinics, district hospitals, district preventive health centres, provincial hospitals, and regional, central and specialist hospitals. Planning and management of the public network involves the national Ministry of Health, provincial departments of health and district health offices, which are responsible for village health workers and commune health stations.

The 1056 public hospitals provide 17.24 beds per 10 000 residents and deliver most inpatient care; the 49 private hospitals provide only 0.48 beds per 10 000 residents. Central-level public hospitals are overcrowded, with an occupancy rate of 116% in 2002, compared with 98% for provincial hospitals and 85% for district hospitals. This is largely due to patients bypassing lower levels of care (when they have the resources to do so) as there is a degree of distrust in the quality of services, particularly at district level. Evidence on quality standards is limited, but widely acknowledged to need improvement. In 2004, only 75% of cases referred to central hospitals by district and provincial clinics and only 59% of patients referred to clinics at the provincial level were diagnosed correctly.<sup>10</sup> Inequities are evident in the inpatient admission rate and the average length of hospital stay, both of which are nearly twice as high for the highest quintile compared with the lowest.<sup>11</sup> During Viet Nam's accession to the World Trade Organization, which occurred in January 2007, the country made commitments to open the health sector to foreign direct investment; however there are risks that such investments will serve only the wealthier groups unless adequate protective measures are taken by the Government.

A significant volume of outpatient services are provided by private hospitals and the 30 000 private general practitioner clinics. There is a serious imbalance in the distribution of private practitioners, with a higher concentration in areas with higher living standards. There are also many private practitioners without licenses, and up to 70% of private clinics are run by doctors who also work in public health clinics.

Recent decrees (2002 and 2006)<sup>12</sup> have granted autonomy to public health service providers, although this has yet to be substantially effected. In 2003, Decree 43 made institutions responsible for raising revenue themselves. Certain entities will, however, continue to receive partial, if not full subsidy from the Government. Nonetheless, there are still services, such as mental health, that are poorly resourced and have a serious shortage of trained personnel.

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<sup>10</sup> According to report of the Therapy Department, Ministry of Health, at the Conference held in 2003 on Professional guidance provided to clinics of lower line by higher line hospitals

<sup>11</sup> World Bank. *Viet Nam - Growing Healthy: A Review of Viet Nam's Health Sector*. Report No. 22210-VN. Document of the World Bank, June 29, 2001.

<sup>12</sup> Decree No 10/2002/ND-CP; Decree No 43/2006/ND-CP

### Pharmaceutical sector

Self-medication is currently the most common response to the need for care; two-thirds of health service contacts are with drug vendors, and 93% of these are without a prescription.<sup>13</sup> Moreover, drugs are frequently dispensed by unqualified staff. In general, pharmaceuticals are consumed inappropriately, in inadequate doses, and without sufficient information on product use and safety. Prescription medicines are equally problematic: public providers are under pressure to generate additional revenues which, combined with the current payment mechanisms (user fees and fee-for-service insurance reimbursements), encourages over-prescription with little concern for appropriateness and effectiveness. Since there is no information system that documents drug-related morbidity and mortality, health care workers are rarely held accountable for medical accident or errors in drug prescription and administration. Counterfeit and unsafe medicines are also an issue, as is the presence of illegal pharmaceuticals and chemicals in natural and processed foods.

### Blood services

There is an almost 50% shortage in the supply and usage of blood and blood components (e.g. plasma, red cells, platelets) across Viet Nam. The amount given by donation and the number of volunteer, unpaid donors need to be increased. In major cities, over 50% of blood is collected from volunteer, unpaid donors, but in the provinces, unpaid donations often account for only 10%, the remainder being supplied by paid or replacement (family) donors.

Across the country as a whole, the blood transfusion services are fragmented and there is no national governing body or structure, although the National Institute for Haematology and Blood Transfusion provides technical advice to the Ministry of Health. There is a loosely-connected network of regional blood centres, each of which provides products and services within its own area and, via provincial hospital blood banks, to neighbouring provinces. Many rural provinces, however, are not yet supported by regional blood centres.

### Health workforce

The human resource situation in Viet Nam is complex. In 2006, there were six doctors per 10 000 population, a higher ratio than in many middle-income countries. In contrast, the ratio of nurses to doctors (1.7) is low. There is also a shortage of specialists (particularly family physicians, psychiatrists, emergency medicine specialists and geriatricians), other health professionals (such as college-trained pharmacists, rehabilitation workers and public health workers) and trained managers. Many vacancies exist in rural and remote areas, where it is still difficult to attract and retain staff and migration from rural to urban settings is common. Official salaries are low, and hospital rewards are dependent upon the revenues collected from user fees. One key weakness of the current human resource system is the regulation of health professionals — there are no regulatory licensing councils and the health professional associations are fragmented

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<sup>13</sup> Lieberman S, et al. *Decentralizing Health: Lessons from Indonesia, The Philippines and Viet Nam*. University of The Philippines, 2004

and do not have strong roles in either continuing education or setting professional standards.

Various efforts have been made to improve the relevance and quality of the education and training given to health workers, including revision and standardization of curricula, teacher training in active teaching and learning methodologies, use of assessment tools, and development of guidelines and learning resources. More recently, private training institutions have been established to meet the same objectives. However these remain unaccredited as there is currently no system for accrediting private medical training from a health perspective.

#### Regulatory enforcement

'Inspection' is the principle mechanism used to monitor and enforce a wide range of policies including: checking of prices at all pharmaceutical vendors; food hygiene and safety; inspection/licensing of all facilities providing curative care, medical equipment and vaccine quality control; investigation of consumer complaints; and prevention of corruption. This wide range of functions is carried out by 230 full-time health inspectors, 1000 part-time inspectors with expertise in specific areas, and 30 personnel at the central level. Health inspectors are prohibited from engaging in private practice, but receive only 25% more than the standard public salary, creating significant difficulties in attracting and retaining staff at the central and provincial levels.

#### Health information systems development and management

Although there is a reasonable quantity of health data in Viet Nam, the health sector lacks quality, evidence-based information. The system that records and reports routine information for all state health facilities is limited, and there is no mechanism to collect health information from the private sector. Coordination of information collection and sharing between Ministry of Health's health information unit and various national health programmes is not adequate, and has resulted in multiple, overlapping sets of indicators, each with their own separate reporting systems.

Attempts to overhaul the outdated health information system have been unsuccessful, partly because there have been many new designs and pilot initiatives that have sometimes run for many years without being objectively evaluated and revised, nor expanded to other locations. Major financial and technical investment from both public and private sectors need to be made in the next few years to develop an effective, comprehensive and efficient health information system.

#### Disaster preparedness and response

Viet Nam maintains a well-developed natural disaster response mechanism that is over 300 years old. However, the system needs to adapt to new and evolving threats to public health and safety. A centralized command system is also needed, as responsibility is currently spread across many offices and units, with overlaps, gaps, poor oversight and weak coordination.

In terms of morbidity and mortality from disasters, major transport accidents, urban fires and toxic industrial spills are now much more significant in Viet Nam than natural hazards, which are largely water-related: floods, droughts and storms. While there is sufficient knowledge about the impact of hazardous elements on agriculture and water-resource management systems, little is known about the medium- and long-term health effects of recurrent exposure to droughts and floods or about the specific health service needs of communities frequently exposed to such natural hazards.

## Section 3: Development Assistance and Partnership for Health

### Levels of development assistance

Across all sectors, Viet Nam is one of the top ten recipients of overseas development assistance (ODA) in the world. Between 1993 and 2006, the country received commitments of US\$ 37 billion (more than US\$ 3.7 billion was pledged in 2006 alone), of which US\$ 16 billion was actually disbursed.<sup>14</sup> However, this is likely to change when GDP reaches US\$ 1000 per capita, predicted to occur around 2010 if current economic growth rates continue, and Viet Nam graduates to middle-income country status. ODA currently represents on average about 4.5% of GDP and less than 12% of the total government budget; 80% of all ODA is in the form of loans.

The annual level of ODA provided to the health sector was US\$ 86.86 million in 2004, US\$ 142.52 million in 2005 and US\$ 219.24 million in 2006<sup>15</sup>; roughly one-tenth of the size of the State budget contribution to the health sector.<sup>16</sup> ODA contributions were made by 42 development partners, with several partners contributing more than US\$ 10 million in total over that three-year period, including the Asian Development Bank, the European Commission, the Governments of Germany (through GTZ and KfW<sup>17</sup>), Japan (including its development agencies), Spain, the United States as well as WHO and the World Bank (through the International Development Association (IDA)). Almost all of the other development partners individually contributed at least US\$ 1 million over the three-year period. WHO provides the largest contribution to the health sector from the United Nations agencies: US\$ 5.3 million in 2004, US\$ 5.6 million in 2005 and US\$ 9.5 million in 2006.<sup>18</sup> However it is difficult to measure the exact amount of aid provided to the whole health sector because money channeled to national and international NGOs – which play an important role in service provision – is not always recorded.

Most health sector ODA is invested in five major areas: basic health care (19.3% of the total financial contributions over the three-year period from 2004 to 2006), infectious disease control (25.8%), medical services (11.0%) and basic health infrastructure (17.4%). Much of the last category is provided through development loans, which have so far mainly been used for buildings and equipment. In addition, both medical education/training and health education have received substantial amounts of funding over the past three years (7.1% and 8.9%, respectively). However, little has been invested in noncommunicable diseases, which continue to rise rapidly in Viet Nam. The lack of investment in this area has arisen in part through a misunderstanding by many development partners that noncommunicable diseases are only a problem in rich

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<sup>14</sup> Tran Manh Cuong, Vice Director Foreign Economic Relations Department, Ministry of Planning and Investment (MPI). Powerpoint presentation to Health Partnership Group, Hanoi, January 2007.

<sup>15</sup> Data from the Development Aid Database (DAD) of the Ministry of Planning and Investment

<sup>16</sup> Draft Viet Nam Health Report 2006. Medical Publishing House 2007. (Comparison is based on figures from 2004; figures for subsequent years are not yet available.)

<sup>17</sup> GTZ is Germany's development agency, KfW is Germany's development bank.

<sup>18</sup> These figures exclude contributions to WHO for specific projects funded by development partners, which are counted as contributions from those development partners.

countries or among wealthier population groups. Similarly, contributions towards nutrition activities remain small despite high levels of malnutrition among children and women in Viet Nam.

In addition, a number of global and regional health initiatives have started to provide resources to Viet Nam. These include GAVI, which will provide over US\$ 14 million for health systems strengthening between 2007-11; the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria, which has awarded five grants totaling more than \$84.2 million; PEPFAR; the Global Alliance for Health Workforce; and the Health Metrics Network.

### **Aid effectiveness and donor coordination**

The Vietnamese Government has embraced the *Paris Declaration on Aid Effectiveness*, and, with local partners, has adapted the Declaration to produce the *Hanoi Core Statement on Aid Effectiveness* (HCS). The HCS was adopted by the mid-term Consultative Group in June 2005 and approved by the Prime Minister in September 2005. The HCS includes a list of 14 indicators, along with indicative targets for 2010.

One of the key coordination and consultation mechanisms for the health sector is the Health Partnership Group (HPG). The HPG is co-chaired by the Ministry of Health and a development partner (periodically rotated), and attended by all major health partners. WHO provides secretarial and financial support to the HPG. The Group evolved from a health sector working group, attended by donors only. It has a number of sub-groups that discuss technical issues, of which the group on health financing is most active. However many partners have felt that the HPG does not work optimally since, in practice, its principal function has been information-sharing, with little time for discussion. Consequently there has been no real dialogue on strategic or policy issues and coordination. There has also been little follow-up between meetings. In addition, there is no clear relationship between the HPG and other coordination mechanisms such as the GAVI Interagency Coordinating Committee and The Global Fund Country Coordinating Mechanism. To address some of these concerns, the terms of reference of the HPG have been reviewed in 2007.

The Government has recently undertaken a Joint Annual Health Sector Review, the first of which was in late October 2007. The purpose of the review, which involved a collaborative process between partners and the Government, was to develop a joint understanding of the state of the health sector and current challenges and, based on this, priorities for the future, together with a joint monitoring framework. It is expected that this review will become a key mechanism for encouraging partnership and coordination in the health sector in coming years.

Despite the development of the HCS and the HPG, health aid in Viet Nam is still criticized as being uncoordinated and fragmented,<sup>19</sup> with over 40 active health partners and 240 separate projects. In part this is due to a lack of a comprehensive strategic plan

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<sup>19</sup> Bijlmakers L et al. *Feasibility of the programme approach in the health sector in Viet Nam*, 2006.

for the health sector, which would need to be developed, discussed and agreed with development partners. The plan should identify strategic priorities and gaps in the sector that could form the basis for a more coordinated response and contribution from partners.

Viet Nam's ability to move forward with approaches such as the sector-wide approach is currently constrained by the Government's financial regulations, which require ODA financing to be kept separate from government funding, although this is under review. Despite this limitation, projects are now being developed to trial provincial-level budget support for health (involving the European Commission), and a programme-based SWAP in TB (Netherlands). These different approaches, promoted by different partners, reflect a lack of consensus on the way forward.

### **UN reform**

WHO is one of 15 United Nations agencies that have an in-country presence in Viet Nam. UN work is currently co-ordinated through the United Nations Development Assistance Framework for Viet Nam, which covers the period 2006 to 2010. It is built around three desired outcomes: (1) government economic policies that support growth that is more equitable, inclusive and sustainable; (2) improvement of the quality of delivery and equity in access to social and protection services; and (3) policies, law and governance structures that effectively support rights-based development to realize the values and goals of the United Nations Millennium Declaration.

Viet Nam is also one of eight countries to pilot 'One UN' reforms. Reasonably rapid harmonization between the three United Nations Executive Committee agencies (UNDP, UNFPA, UNICEF,) as well as UNAIDS, UNIFEM and UNV is occurring in the first phase. Other United Nations agencies (including FAO, ILO, UNESCO, UNIDO and WHO) have all indicated their willingness to participate in the reform process. WHO involvement includes: participation in the One Plan and the One Plan Fund; as far as the WHO Constitution and regulations permit, participation in the One UN Leader in Viet Nam and the sharing of common management and administrative services (e.g. for procurement); and occupying joint United Nations premises if additional costs are not significant. WHO has also been participating in joint programming in specific areas of common interest (e.g. the Joint Programme on Avian and Pandemic Influenza and the Joint Programme on Gender Equality).

## **Section 4: Current WHO Country Programme**

WHO's financial resources for Viet Nam (as detailed in Table 4), are used to provide the following types of support:

1. Technical support for major programmes

Extensive technical support is provided to various priority programmes, including HIV/AIDS, health promotion, communicable disease control, noncommunicable disease control, TB, reproductive health, maternal and child health, injury prevention, tobacco control, blood safety, and the Expanded Programme on Immunization.

2. Support for health sector policy and strategy development

Several key areas, including health financing, health legislation, decentralization, health policy development, human resource development, management and organization of the sector, health insurance and programme planning, are supported by WHO with a focus on training, data collection and analysis, piloting new PHC initiatives, as well as the development of draft legislation and guidelines.

3. Advocacy and technical advice for emerging health priorities

Over the past few years, WHO has provided considerable resources to deal with the emergence of new diseases such as SARS, avian influenza and dengue. It is expected that the noncommunicable diseases that are fast becoming major health problems in the country will also require technical support from WHO.

4. Support to the donor community

Facilitating donor partners active in the health sector has been one of WHO's major roles in recent years. Several forms of support, including technical advice, joint collaboration in project planning and implementation, participation in programme assessment and evaluation missions, and provision of administrative facilities, are frequently provided.

5. Networking, partnership building and resource mobilization for the sector

To assist in the mobilization of resources for health, and to facilitate the coordination of joint intervention efforts and collaboration, WHO actively assists the Ministry of Health and the donor community to form networks and partnerships through a variety of mechanisms, both within and outside the country.

6. Identification of public health threats

This involves active support by WHO in areas of disease surveillance, health information system development, training in research techniques and epidemiology, strengthening of

laboratories, networking with external institutes, disease and health service mapping, and data verification and analysis.

7. General technical support and other inputs

WHO provides a range of types of support for a large number of programmes, including training, fellowships/study tours, technical meetings, short-term consultancies, and supplies and equipment. In future, such general support will be reduced, since it can be provided by the many donor partners.

8. Support for emergency response and preparedness

Viet Nam is prone to natural disasters, such as floods and typhoons. WHO provides technical support and limited financial assistance to strengthen the disaster-preparedness system.

9. Piloting of health initiatives

Catalyzing change through piloting of health initiatives within the country and expanding them to larger areas is a frequently used mechanism to introduce new ideas to the health sector. Every biennium, at least 5-10 initiatives are piloted in Viet Nam.

**Table 4: Contributions to principal programme areas and related technical assistance in 2004-2005 and 2006-2007**

Principal programme area	2004-2005 Contribution (US \$)	2006-2007 Contribution* (US \$)	% change from 2004- 2005
Health policy, legislation and system development	2 220 332 (TA: 34.12%)	2 482 826 (TA: 36.67%)	+ 12%
Communicable disease surveillance, prevention and control	2 366 863 (TA: 25.29%)	3 234 498 (TA: 34.21%)	+ 37%
Promotion of a healthy environment and healthy lifestyles, and noncommunicable diseases	2 434 560 (TA: 38.65%)	2 574 297 (TA: 20.46%)	+ 6%
Women and children	2 087 405 (TA: 49.39%)	1 790 786 (TA: 35.02%)	- 14%
HIV/AIDS and tuberculosis	6 981 944 (TA: 30.15%)	5 029 691 (TA: 48.13%)	- 28%
Partnerships and coordination	1 622 698 (TA: 60.58%)	2 334 700 (TA: 52.43%)	+ 44%
<b>Total</b>	<b>17 713 802</b> <b>(TA: 36.22%)</b>	<b>17 446 798*</b> <b>(TA: 39.06%*)</b>	<b>- 1%*</b>

TA = Technical assistance (staff and consultant support)

\*This figure reflects only the confirmed contribution in the biennium to 31 December 2006. Additional voluntary contributions are expected in 2007.

## **Number of programmes supported**

WHO has established a large number of collaborative programmes with the Government of Viet Nam in a wide range of areas. The Organization plays an important role in the country's health sector and national development. As the health system has become increasingly complex and diverse in recent years, WHO's collaboration has grown and resources have been used to cover an increasing number of projects in new programme areas. At the same time, support has been maintained for some activities and programme areas that are either becoming routine, or for which national capacities have already been established. As a result, WHO's resources are at risk of being spread too thinly and not achieving impact. In an earlier attempt to reduce the number of small projects and programmes, WHO, in collaboration with the Ministry of Health, introduced "umbrella" programmes in 2004-2005 to accommodate a number of small programmes. Each umbrella programme covers a number of sub-programmes. However, in real terms, the number of "projects" or sub-programmes continues to grow, with each sub-programme being managed by a separate focal point or institute appointed by the Ministry. In the 2006-2007 biennium, a total of 26 programmes are being implemented to cover more than 50 sub-programmes, and the administrative and project support costs are now exerting a heavy burden on the WHO Viet Nam Country Office.

## **Geographical distribution of resources**

A very large percentage of WHO resources for fellowships/study tours are utilized by officials from Ha Noi. The northern and southern provinces, which suffer from resource disadvantages, receive few benefits from WHO's human resource development programmes. A similar situation is observed in the WHO supplies and equipment component: few institutes and provinces outside the Ha Noi metropolitan area benefit. Most of the meetings and training workshops are held in the Ha Noi area. This situation is not satisfactory and needs attention.

## **Staff and office resources**

Government and partner requests for long-term technical assistance from WHO in different technical areas have led to a substantial increase in staffing in the WHO Country Office in the last three years. In key areas, staff positions have been established through shared funding, using both the regular budget and voluntary contributions, reflecting the Government's commitment to a greater level of long-term country-based WHO technical support. The significant increase in staff has placed pressure on office infrastructure and space, necessitating expansion to a second WHO office in Ha Noi and additional office support, including an IT person to maintain the integrity of the computer systems and network. From time to time, satellite offices have also been used for specific projects. For example, where work with counterparts has required staff to be located on-site within specific institutes (e.g. the Luxembourg-funded blood safety project) or when a project has been of such a size that additional office space was necessary (e.g. the DFID-funded HIV/AIDS prevention project). As part of the 'One UN' initiative, common premises for all United Nations agencies are proposed. WHO will re-locate to 'UN House' as long as the move does not entail a significant increase in cost for the Organization.

WHO has established a small technical office in Ho Chi Minh City (HCMC), which provides support to some programmes and serves as a local information and resource centre on public health issues. The office is also used to host meetings between WHO, local government and development partners based in HCMC.

## **Section 5: WHO Policy Framework: Global and Regional Directions**

In May 2006, the World Health Assembly approved the Eleventh General Programme of Work, covering the 10-year period from 2006 to 2015 and outlining a strategic framework and direction for the work of WHO (both Member States and the Secretariat) and a platform for dialogue with WHO partners in global health. The Eleventh General Programme of Work examined the current global health problems and the challenges they imply, and proposed measures for an international community response. It identified four global health challenges:

- gaps in social justice;
- gaps in responsibility;
- gaps in implementation; and
- gaps in knowledge.

In response to these challenges and gaps, WHO outlined the following strategies for its global health agenda:

- investing in health to reduce poverty;
- building individual and global health security;
- promoting universal coverage, gender equality and health-related human rights;
- tackling the determinants of health;
- strengthening health systems and equitable access;
- harnessing knowledge, science and technology;
- strengthening governance, leadership and accountability.

In addition, to further its agenda, WHO set out the following priorities and strategic directions in its Medium-term Strategic Plan 2008-2013:

- providing support to countries in moving to universal coverage with effective public health interventions;
- strengthening global health security;
- generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
- increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
- strengthening WHO's leadership at global and regional levels and supporting the work of governments at country level.

These priorities and strategic directions were formulated into 13 strategic objectives in the Medium-term Strategic Plan 2008-2013, providing an organization-wide, multi-biennial framework to guide and ensure continuity in the preparation of programme budgets and operational plans across biennia.

The 13 strategic objectives are to:

1. reduce the health, social and economic burden of communicable diseases;
2. combat HIV/AIDS, tuberculosis and malaria;
3. prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries;
4. reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals;
5. reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact;
6. promote health and development and prevent or reduce risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex;
7. address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human-rights-based approaches;
8. promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health;
9. improve nutrition, food safety and food security, throughout the life-course and in support of public health and sustainable development;
10. improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research;
11. ensure improved access, quality and use of medical products and technologies;
12. provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfill the mandate of WHO in advancing the global health agenda, as set out in the Eleventh General Programme of Work; and
13. develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.

Within the strategic objectives, several specific areas are particularly pertinent to WHO in Viet Nam during the period covered by this CCS, including:

- implementing the International Health Regulations (2005) in order to respond rapidly to public health emergencies of international concern (including those caused by outbreaks of emerging and epidemic-prone diseases) and to build on the eradication of poliomyelitis to develop an effective surveillance and response infrastructure;
- addressing the epidemic of chronic noncommunicable diseases, with an emphasis on measures to reduce risk factors such as tobacco consumption, improper diet and physical inactivity;
- addressing the broader aspects of health and its interaction with other sectors with the use of the report of the Commission on Social Determinants of Health;
- reducing maternal mortality by scaling up activities aimed at universal access to, and coverage with, effective interventions, and strengthening health services; and
- improving health systems, focusing on human resources, financing and health information.

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<sup>20</sup> Document SSA1/DIV/6.

## **Section 6: The Strategic Agenda for Viet Nam**

### **Overall goal of WHO in Viet Nam**

The overall goal of WHO in Viet Nam is to improve the health of the country's people by supporting health development. The key objective of this CCS is to enable WHO to work towards that goal by effectively assisting the Government to develop a pro-poor and decentralized health system that is equitable, fair, responsive and quality-focused. Furthermore, the health system must be capable of: developing sound evidence-based policies, plans and strategies; establishing effective and efficient management mechanisms at policy and operational/institutional levels; planning and coordinating the inputs for a well-functioning health system; and equitably financing essential preventive and curative health services.

It is important to recognize that this strategy must enable WHO to be an effective partner for the Government in a complex and rapidly changing environment. A significant part of expected change in the next few years will relate to economic growth. While there are significant issues related to the unequal distribution of resources and how this affect the lives and health of individuals and communities, it is hoped that growth will result in greater public resources being contributed to the health system. This would have the potential to significantly improve the availability, quality and effectiveness of health services over the next few years, and would result in a greater ability to implement and manage health programmes at the local level. At the same time, however, economic growth is expected to result in Viet Nam graduating to middle-income status and, as a result, the resources available to the Government from donors and multilateral funding institutions, for health and other sectors, is likely to reduce significantly.

### **Six principal clusters**

WHO's strategic direction in Viet Nam will focus on six priority areas (or 'clusters'):

1. Health policy, legislation and system development
2. Communicable disease surveillance, prevention and control
3. Promotion of a healthy environment and healthy lifestyles and prevention of noncommunicable diseases
4. Family and community health and nutrition
5. HIV/AIDS, and tuberculosis
6. Partnerships and coordination.

#### **Cluster 1: Health policy, legislation and system development**

The health system must now respond to a number of key challenges: decentralization and other public sector reforms; rising concerns about management weaknesses at institutional level; the need for re-evaluation and re-development of current health

policies and legislation, including the effective regulation of health professionals; and the structure of the health system, including the role of the central Ministry of Health. Shortages of nurses, some specialists and trained managers continue, and there are many vacancies in rural and remote areas. Service delivery quality also requires serious attention. The need for strengthened health system financing remains a key issue, with 64% of total health expenditure coming from out-of-pocket payments at the time of service use, affecting equity and access and causing poverty in some cases. Greater sectoral and policy coordination is needed, and interventions need to integrate a pro-poor, gender-responsive and human-rights-based approach, with a view to enhancing health equity for all.

Key directions:

1. Strengthen leadership, governance and the evidence base of health systems.
2. Improve the organization, management and provision of health services including the development of a regulated national blood service.
3. Ensure the availability of a trained health sector workforce.
4. Extend social protection through the development of a sustainable, equitable and efficient health financing system that provides universal access to health services and financial protection against unaffordable health care expenditures.
5. Ensure improved access to, and improved quality and use of, medical products and technologies.

Strategic interventions:

1. Strengthen leadership, governance and the evidence base of health systems:
  - Support the development of a longer-term, more strategic vision for the health sector.
  - Promote and support the development of appropriate governance and accountability structures and systems for the management of public sector institutions.
  - Support the development, implementation and enforcement of health-related legislation.
  - Strengthen health policy capacity, including that related to international trade regulation, human rights and gender.
  - Support the Ministry of Health to redefine and strengthen its role and function in a decentralized context and in line with public sector reforms.
  - Support the development of a comprehensive quality strategy, particularly in relation to the safety of services and products.
  - Strengthen the capacity of health management information systems to appropriately use and disseminate relevant data and information in order to

- promote evidence-based policy and management decision-making.
- Build capacity and networks for national health-policy-related research and mechanisms for prioritizing the resources available for research.
2. Improve the organization, management and provision of health services including the development of a regulated national blood service:
    - Strengthen leadership and the capacity for autonomous management of public sector health service delivery institutions.
    - Support more flexible use and organization of private and public sectors for service delivery.
    - Support the development and implementation of continuous quality improvement systems at all levels and in all health institutions.
    - Establish the structures, governance and regulations for a national blood service.
    - Strengthen operational management within regional blood centres and develop a sufficient supply of blood from low-risk (i.e. voluntary) donors
    - Develop evidence-based policies to support the appropriate clinical use of blood and blood products
  3. Ensure the availability of a trained health sector workforce:
    - Support the development of a strategy for ensuring the quality, sufficiency and appropriate deployment of the health workforce, including appropriate incentive systems.
    - Support the role of the Ministry of Health in strategic planning and management of human resources, including re-examination of the roles of different types of health worker and appropriate oversight of training institutions.
    - Support the development of national council(s) for regulation/licensing of health professionals.
    - Strengthen institutional capacity for human resource planning and management at all levels.
    - Support the development of an accreditation system for health training institutions, including development of appropriate training curricula.
  4. Extend social protection through the development of a sustainable, equitable and efficient health-financing system that provides universal access to health services and financial protection against unaffordable health-care expenditures:
    - Support the Government to develop and implement a comprehensive health-financing strategy.
    - Strengthen government capacity in collecting and analysing health-financing data in order to set health-financing priorities and monitor and evaluate health-

financing policies. This includes institutionalizing national health accounts.

- Strengthen government capacity in health-financing policy-making and implementation, including management of the national health insurance system.
5. Ensure improved access to, and improved quality and use of, medical products and technologies:
- Strengthen the regulatory framework by supporting further development of appropriate policies and regulations and capacity-building of responsible authorities to improve inspection, licensing and enforcement.
  - Improve quality assurance through the development and introduction of internationally accepted norms and standards and capacity-building within control laboratories.
  - Build capacity and systems for the development and promotion of evidence-based clinical practices and appropriate use of medicines and technologies.
  - Strengthen the capacity for trade and health policy coherence to ensure better access to medicines.

## **Cluster 2: Communicable disease surveillance, prevention and control**

Although communicable diseases are generally on the wane in Viet Nam, outbreaks of new diseases such as SARS and avian influenza have, in recent years, become a major cause for concern, not least because of their potential negative impact on the national economy. The Viet Nam Administration for Preventive Medicine of the Ministry of Health has successfully dealt with many serious outbreaks to date. However, the need remains for a pro-active and adaptable communicable disease control system that can rapidly detect and respond to the public health threats posed by infectious diseases. This system must include mechanisms to reduce the risk to both the Vietnamese people and the global population, as some outbreak-prone diseases have the potential to spread rapidly across borders.

In order to assist the Government to reduce the impact of outbreak-prone communicable diseases, WHO will work with the Ministry of Health in the following areas: communicable disease surveillance; outbreak response; assessment and management of zoonotic diseases; hospital and community infection control; public health laboratory diagnostic techniques and biosafety measures; risk communication; pandemic influenza preparedness; and compliance with the revised International Health Regulations (IHR) 2005.

At the same time, while malaria is presently under control in Viet Nam, measures to avoid a rapid resurgence of the disease must be maintained. In addition, Viet Nam is one of the worst-affected countries in the world by intestinal parasites (soil-transmitted

helminths and foodborne trematodes) due to the hot and humid climate, overpopulation and the lack of sanitation structures. Parasitic infestations contribute to malnutrition and reduce intellectual development among children.

Key directions:

1. Assist the Government in reducing the impact of outbreak-prone communicable diseases through improved preparedness, prevention, detection, containment and control of existing and emerging infectious diseases.
2. Support the implementation of large-scale public health measures for parasite control.

Strategic interventions:

1. Assist the Government in reducing the impact of outbreak-prone communicable diseases through improved preparedness, prevention, detection, containment and control of existing and emerging infectious diseases.

The Government is already addressing several subcomponents of this area of work. For example, an early warning and response system (EWARS) is being piloted in selected provinces to enhance the communicable disease surveillance system. Rapid response teams have been created and are undergoing training to improve their ability to respond to outbreaks. Other activities are ongoing or planned via the various communicable disease initiatives being funded in Viet Nam by the Asian Development Bank, the United Nations Joint Programme on Avian and Pandemic Influenza, the World Bank and numerous bilateral donors. WHO, in its role as both adviser and focal point for communicable disease system strengthening, provides structure and guidance to these initiatives. Specific strategic interventions that WHO is following and which should be implemented in the coming years include:

- Support both a comprehensive review of the communicable disease surveillance system as well as subsequent activities to strengthen routine and event-based surveillance.
- Support training of rapid response teams for outbreak control.
- Facilitate mechanisms for communication and collaboration between the animal health and human health sectors. Review capacity for zoonotic disease risk assessment and management.
- Advocate for improved infection control practices in health-care facilities through revision of national infection control guidelines and nationally-standardized infection-control training of health professionals.
- Provide technical advice on strengthening the public health laboratory system, including standards for laboratories of different functions, and establish national guidelines and programs for laboratory quality control, quality assurance and bio-safety standards.

- Provide technical guidance to strengthen behavior change and risk communication campaigns for avian and pandemic influenza, and community infection control.
  - Provide support to establish a national field epidemiology training programme.
  - Provide support to achieve compliance with IHR (2005).
2. Support the implementation of large-scale public health measures for parasite control:
    - Maintain high coverage of impregnated mosquito nets and maintain the availability of effective treatment at health services.
    - Continue regular de-worming for population groups at risk (i.e. children and women of child-bearing age).

**Cluster 3: Promotion of a healthy environment and healthy lifestyles, and prevention of noncommunicable diseases**

Recent data have indicated that noncommunicable diseases (NCD) are fast becoming the major cause of death and morbidity in Viet Nam. Rapid socioeconomic changes, changing lifestyles and dietary habits, reduced physical activity associated with urban life, and population ageing are all factors in the increase. This situation is aggravated by rapid industrial and urban growth, which has led to increased health-harming environmental pollution, as well as occupational and traffic accidents.

Key directions:

1. Support policy for the promotion of healthy lifestyles and healthy environments and address the determinants of NCD and other lifestyle-related diseases.
2. Improve public health through health-promoting and risk-prevention efforts using community-based and integrated approaches.
3. Support the gathering of strategic information, including through research, establishment of surveillance systems and monitoring of NCD and other lifestyle-related diseases and environmental risk factors.
4. Build the capacity of institutions and organizations to support the development of policy and to design and implement health promotion and NCD-prevention initiatives.

Strategic interventions:

1. Support policy for the promotion of healthy lifestyles and healthy environments and address the determinants of NCD and other lifestyle-related diseases:
  - Advocate and lobby for strong political commitment from the Government and development partners for a national NCD prevention and control policy and

increased investment in finance, organization and human resources for the NCD programme.

- Advocate for NCD to become a priority national programme, including implementation of the Framework Convention on Tobacco Control.
  - Further develop smoke-free settings in all indoor workplaces and public places, as well as on public transport.
  - Strengthen national capacity for the prevention and control of NCD, by introducing the integrated NCD approach and making the NCD programme into a national targeted programme.
  - Support the finalization and implementation of the National Environmental Health Plan to ensure a focus on healthy environments as well as individual behavior change to prevent NCDs.
2. Improve public health through health-promoting and risk-prevention efforts using community-based and integrated approaches:
- Mobilize resources for health promotion and prevention of NCD risk factors.
  - Support the development of national programmes for the promotion and prevention of NCD and lifestyle risk factors, including public education and awareness-raising campaigns (tobacco, alcohol use, injury, etc.).
  - Develop demonstration projects around community-based health service interventions, including prevention programmes.
3. Support the gathering of strategic information, including through research, establishment of surveillance systems and monitoring of NCD and other lifestyle-related diseases and environmental risks factors:
- Develop a national NCD surveillance system.
  - Support policy-relevant research on tobacco-related economic costs.
  - Conduct research on air pollution and environmental health.
4. Build the capacity of institutions and organizations to support the development of policy and to design and implement health promotion and NCD-prevention initiatives:
- Strengthen national capacity for prevention and control of NCD focusing on setting up and strengthening a national NCD office and establish a centre of excellence for disease prevention/health promotion.
  - Pilot and appropriately expand a cost-effective and comprehensive, integrated approach to NCD, with a primary-health-care and community-based focus.
  - Use results from pilot projects as evidence to strengthen and promote PHC management of NCD at the community level.
  - Advocate for increased investment in prevention and risk-factor elimination.

#### **Cluster 4: Family and community health and nutrition**

Over the last decade, Viet Nam has made considerable progress in maternal and child health. Coverage of key public health interventions is good, including institutional deliveries assisted by skilled birth attendants, vitamin A supplementation and immunization. Nevertheless, the agenda is far from finished. Maternal mortality remains unacceptably high and a very high proportion of pregnancies are terminated voluntarily, indicating failure in the use of modern family planning methods. Despite the steep decline in the under-five and infant mortality rates, neonatal mortality has hardly changed, and Viet Nam remains one of the 42 countries in the world estimated to account for 90% of all under-five deaths. Every fourth child (25.2%) is undernourished and anaemia persists in women of child-bearing age and young children. There are also considerable variations throughout the country, depending on geographical area, ethnicity and overall socioeconomic status. The population is also one of the most infested by intestinal parasites in the world. This unfinished public health agenda needs to be tackled as a matter of urgency.

##### Key directions:

1. Support the child survival programme (0-5 years of age) with the aim of achieving universal coverage for high-impact public health interventions and addressing inequities, with a focus on the reduction of neonatal mortality.
2. Support safe motherhood programmes aimed at the reduction of maternal mortality by providing skilled care for every pregnancy, at every birth and for all post-partum mothers and newborn infants, with emphasis on achieving universal coverage of skilled birth attendance, comprehensive obstetric care and safe abortions, and by improving the availability, accessibility and quality of those services.
3. Support the programme for improving the availability, accessibility, gender equity and quality of reproductive health services, including family planning, prevention and treatment of reproductive tract and sexually transmitted infections and cervical cancer.
4. Support public health programmes addressing nutrition, including infant and young child feeding, micronutrient supplementation and parasite control.

##### Strategic interventions:

1. Support the child survival programme (0-5 years of age) with the aim of achieving universal coverage for high-impact public health interventions and addressing inequities, with a focus on the reduction of neonatal mortality:
  - Implement a national strategic plan of action for child survival leading to universal coverage of high-impact, public health interventions for newborn babies and children under five years of age, including:

- promoting, supporting, protecting and improving infant and young child feeding practices;
  - maintaining high coverage of high-impact preventive interventions such as measles and tetanus immunization, vitamin A supplementation for children 0-59 months and the use of impregnated mosquito nets in malarious areas;
  - implementing the Integrated Management of Childhood Illness strategy to ensure integrated case management of high-burden diseases, with a particular focus on acute respiratory infections and diarrhoeal diseases;
  - improving essential newborn care.
2. Support safe motherhood programmes aimed at the reduction of maternal mortality by providing skilled care at every pregnancy, at every birth and for all post-partum mothers and newborn infants, with emphasis on achieving universal coverage of skilled birth attendance, comprehensive obstetric care and safe abortions, and by improving the availability, accessibility and quality of those services:
- Ensure skilled birth attendance at every birth by:
    - improving the health system response, and the access to and quality of essential and emergency care, including logistics and supplies, monitoring and evaluation;
    - improving health workers' skills and competencies through up-to-date guidelines, training and follow-up;
    - health education and promotion, and community mobilization and support.
  - Ensure safe abortion care, including the quality of clinical services and counseling.
3. Support the programme for improving the availability, accessibility, gender equity and quality of reproductive health services, including family planning, prevention and treatment of reproductive tract and sexually transmitted infections and cervical cancer:
- Combat sexually transmitted infections, including HIV, reproductive tract infections and cervical cancer, by promoting integrated service delivery for reproductive health care and by addressing access barriers through participatory approaches, information, education and communication.
  - Develop programmes for cervical cancer screening and early treatment in low-resource settings.
4. Support public health programmes addressing nutrition, including infant and young child feeding, micronutrient supplementation and parasite control:

- Ensure regular de-worming of the population groups at risk.
- Combat childhood malnutrition and micronutrient deficiencies in all age groups by:
  - maintaining high-coverage levels of vitamin A supplementation for post-partum mothers and all children under five years of age, while moving towards universal coverage;
  - improving iron/folate supplementation for women of child-bearing age and exploring other public health interventions to reduce the prevalence of anaemia;
  - improving the implementation of programmes aimed at reducing the number of children who are underweight and of women with low body mass index.

### **Cluster 5: HIV/AIDS and tuberculosis**

The rapid expansion of the HIV epidemic and the number of people living with HIV/AIDS in recent years, coupled with the increase in the prevalence of tuberculosis in the country, is a major public health concern. Joint efforts have been made by development partners, United Nations agencies and the Government to control the further spread of these two diseases and to provide care to the victims. In response to this, WHO in Viet Nam has formulated a set of strategic objectives and a number of key interventions.

#### Key directions:

1. Create a supportive environment for the health sector response to HIV/AIDS.
2. Develop and revise policies, guidelines and other tools for accelerating the health sector response to HIV/AIDS.
3. Support implementation of the health sector response to HIV/AIDS.
4. Strengthen strategic information for a more effective response.
5. Develop and implement the National Strategic Plan on TB Control for 2005-2010.
6. Reduce the burden of TB and TB/HIV co-infection.

#### Strategic interventions:

1. Create a supportive environment for the health sector response to HIV/AIDS:
  - Support capacity-building of Party commissions, the National Assembly and other political bodies in support of the health sector response to HIV/AIDS.
  - Support the health sector to mobilize resources for HIV/AIDS from national and international funding bodies.
  - Support the mobilization, involvement and obtaining of commitment from relevant sectors for the health response to HIV/AIDS at national and local levels.

2. Develop and revise policies, guidelines and other tools for accelerating the health sector response to HIV/AIDS:
  - Support the development and revision of policies, guidelines, training curricula and other tools in the areas of: (i) counseling and testing; (ii) harm reduction for most-at-risk populations; (iii) prevention of mother-to-child transmission; (iv) prevention targeting youth; (v) care and treatment, including anti-retroviral treatment for adults and children; (vi) collaboration between HIV/AIDS and TB programmes; (vii) integrated prevention, care and treatment, linking closed settings and health facility/community-based services; (viii) ensuring access to HIV medicines and other commodities; and (ix) laboratory services.
3. Support implementation of the health sector response to HIV/AIDS:
  - Support the capacity-building of national institutions, including Vietnam Administration on AIDS Control (VAAC) and the Provincial AIDS Centres, in managing the health sector response and in coordinating the various internationally and nationally funded projects.
4. Strengthen strategic information for a more effective response:
  - Support the strengthening of HIV and STI surveillance systems.
  - Support implementation of the National M&E Framework on HIV/AIDS.
  - Support the development of a monitoring, support and supervision system for core health services, such as counseling and testing, harm-reduction interventions, prevention of mother-to-child transmission, anti-retroviral treatment and TB/HIV.
  - Support the establishment of HIV drug-resistance surveillance and monitoring systems.
  - Support operational research.
5. Develop and implement the National Strategic Plan on TB Control for 2005-2010:
  - Support implementation of the DOTS<sup>21</sup> strategy and its monitoring and evaluation.
6. Reduce the burden of TB and TB/HIV co-infection:
  - Support the development of the national TB/HIV framework and implementation plan.
  - Support the development of guidelines on managing TB/HIV.
  - Support the establishment of coordination mechanisms between TB and HIV/AIDS programmes at national and local levels.
  - Support the establishment of a monitoring, supervision and support system for TB/HIV collaborative activities and services.

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<sup>21</sup> DOTS is the WHO recommended strategy to control TB

## **Cluster 6: Partnerships and coordination**

Building partnerships in health and coordinating joint efforts in disease control and prevention will continue to be the major tasks of the WHO country team. Assisting the Government to mobilize health resources, and facilitating development partners and other UN agencies to coordinate their inputs in health partnerships will also continue to be important roles for the Organization.

### Key directions:

1. Promote inter- and intra-sectoral cooperation for health development.
2. Mobilize external and internal resources to support Viet Nam's health sector, ensuring resources are provided coherently and efficiently.
3. Place health at the centre of national development.
4. Mobilize 'One WHO' and 'One UN' support for Viet Nam's health sector development.

### Strategic interventions:

1. Promote inter- and intra-sectoral cooperation for health development:
  - Promote inter-programme collaboration within the Organization.
  - Strengthen communication, coordination and collaboration with various ministries and government functionaries on health matters.
2. Mobilize external and internal resources to support Viet Nam's health sector, ensuring resources are provided coherently and efficiently:
  - Strengthen WHO's role in implementing the aid effectiveness agenda in the health sector.
  - Develop and implement the WHO Country Cooperation Strategy.
  - Improve WHO programme planning, management and administrative capacity.
  - Improve collaboration and coordination of health sector support with other UN agencies.
3. Place health at the centre of national development:
  - Strengthen the advocacy role of the Organization.
  - Strengthen the sustainable partnerships with government and non-government agencies, including the private sector, to bring health to the centre of national development.
4. Mobilize 'One WHO' and 'One UN' support for Viet Nam's health sector development:

- Provide adequate human and financial resources to support the WHO Country Office.
- Strengthen coordination and communication among all three levels of the Organization.
- Strengthen coordination and communication among UN agencies resident in Viet Nam.

### **Cross-cutting issues**

For practical reasons, key directions and strategic interventions have been grouped into six clusters. However, it is important to recognize that a number of issues are cross-cutting. The WHO Country Office team has identified some key areas in this regard:

- Thematic cross-cutting issues: gender, human rights, equity, quality. The aim with these issues is that they be ‘mainstreamed’ into all programme areas (to the degree that is relevant for any given programme), although this does not exclude distinct work being undertaken on each in terms of policies, tools, capacity-building, etc., where needed.
- Cross-cutting programmatic areas/issues requiring or relating to technical cooperation. These are areas where some coordination and information-sharing is needed, and where it may be possible for more than one technical area/team to jointly develop products and activities. These areas include: human resources, health promotion, health information, essential drugs, health legislation, health financing, and monitoring and evaluation. Different approaches will be used by the country team to facilitate cross-cutting work and/or information-sharing for priority areas.

### **Functions of WHO in Viet Nam**

WHO has identified five generic functions that describe a spectrum of different support approaches provided by WHO at country level. These functions can be used to identify the type(s) of support considered most relevant to fulfil each cluster of key directions and strategic interventions. The five functions are:

#### Function 1

Providing critical technical support to routine, essential implementation of a limited number of health programmes.

#### Function 2

Promoting and supporting research and the development of guidelines, evaluating programme effectiveness, and stimulating innovative activities that will bring about catalytic changes in the health sector.

### Function 3

Assisting in the adoption of international norms and standards, articulating ethical and evidence-based policy options, and catalyzing the adoption of technical strategies and innovation through seed funding.

### Function 4

Building sustainable institutional capacity, providing high-level policy and strategy development advice, engaging in partnerships and network-building in areas where joint action is needed, and exercising influence on policies related to government spending on health and investment by development partners in the sector.

### Function 5

Monitoring the health situation, assessing and projecting health trends, and sharing knowledge, information, policy options, advocacy positions and guidelines.

The emphasis on different functions may change over time, depending on support provided by other partners and donors. Several development partners already provide large amounts of supplies and equipment, fellowships/study tour assistance and support for printing materials and meetings. WHO's role in these areas has now become relatively minor. Increasingly, WHO is expecting to be able to shift away from routine implementation towards those functions that stimulate new research and innovative strategies, facilitate the adoption of appropriate norms and standards and evidence-based policy, build institutional capacity and networks, and more effectively share knowledge and information. WHO, with its significant number of technical staff and consultants, already plays an influential role in many of these areas with both the Ministry of Health and development partners. However, the need for this type of technical support is likely to increase further, particularly towards the end of the period covered by this Strategy, as middle-income status draws near and donors prepare to reduce their financial support to Viet Nam.

Table 5 presents the views of the WHO country team on the relative importance of the functions within each cluster during the period from 2007 to 2011. Overall, WHO will pay more attention to advocacy, policy development, monitoring and information sharing. Support for routine implementation will be curtailed substantially. However, higher priority should also be given to catalyzing the adoption of new approaches and techniques, and adoption of norms, standards and guidelines.

Table 5: Relative importance of WHO functions within each cluster

<b>Functions</b>  <b>Principle Clusters</b>	<u>Function 1</u> Technical support to routine implementation	<u>Function 2</u> Research and development	<u>Function 3</u> Adoption of norms and standards and catalyzing adoption of technical strategies	<u>Function 4</u> Institutional capacity-building, policy advice and network-building	<u>Function 5</u> Information and knowledge sharing, monitoring and evaluation
1. Health policy, legislation and system development	-	+++	+++++	+++++	+++
2. Communicable disease surveillance, prevention and control	+	++	+++	+++++	+++++
3. Promoting a healthy environment and healthy lifestyles, and noncommunicable diseases	++	+	+++++	++	+++
4. Women and children	-	++	+++++	+++	++
5. HIV/AIDS and tuberculosis	++	+	+++	+++++	++
6. Partnerships and coordination	++	+	++	+++++	+++

(-) denotes no role in the function while the number of (+) indicates the relative importance of that function

## **Section 7: Implementing the strategic agenda**

The CCS will become the framework of cooperation between WHO and Viet Nam. It articulates the commitment of WHO/Viet Nam to health sector development, and defines the priorities for WHO's work with the Government of Viet Nam from 2007 to 2011. WHO is in a favourable position to take a lead in the health sector using the CCS as a starting point to develop a broader joint United Nations health sector support strategy. The CCS also represents WHO's intention to translate the 'One WHO' principle into practice in Viet Nam. WHO will therefore take all steps necessary to ensure the successful implementation of the strategies outlined in this document and to mobilize the resources required to achieve the intended results. All three levels of the Organization — the Viet Nam Country Office, the Western Pacific Regional Office and WHO Headquarters — will each take their share of responsibility in implementing this CCS.

### **The WHO Country Office**

#### Provision of technical assistance

As a specialized United Nations technical agency, WHO's key asset and strength lie in its technical resources and its ability to mobilize technical support from others. As such the Organization's resources are best used for providing technical expertise to support critical and new areas in the health sector.

One of the roles of WHO technical staff is to support the development of Viet Nam's health institutions to meet international standards, and to build capacity in the health workforce to manage the health systems in an equitable, fair and sustainable manner. The availability of technical staff to provide expertise, guidance and know-how to WHO-supported programmes, not only helps facilitate their implementation, but also helps to mobilize resources. This is reflected in the large amount of extra-budgetary resources mobilized by WHO staff in the past two biennia which, in the Programme Budget 2006-2007, exceeded the regular budgetary allocation by more than three times.

The CCS will adopt an evidence-based approach to determine the national and international technical staff requirements of a programme. These requirements will be linked to a number of indicators mutually agreed by WHO and the Ministry of Health, relating to each programme's past performance, the burden of the disease in question, international commitments, the added value of technical assistance, and so on.

#### Mobilization of locally available resources

Many of the embassies and development partners present in Viet Nam have a large degree of autonomy, and the discretion to make resource allocation decisions in-country. An important role of the WHO Country Office is to mobilize such resources in support of health; a substantial amount of WHO's own funds for Viet Nam are raised locally.

#### Managing WHO collaborative programmes and WHO resources

The WHO Country Office is responsible for managing the resources and the programmes implemented by WHO in Viet Nam. It has to ensure that all WHO collaborative

programmes are properly planned, implemented, monitored and evaluated. It is accountable for the delivery of the products planned under each of its supported programmes, as well as the costs of delivering them. It must ensure that the resources allocated for Viet Nam are properly utilized and accounted for.

Over the past few bienniums, around 30%-39% of the WHO budget allocated for Viet Nam has been used for technical assistance and support for international standard setting, while a large part of WHO's resources have been used for non-essential supplies and equipment, study tours, translation and printing of documents, routine training and some contractual work, which should either be part of the routine responsibilities of the Ministry of Health or could be financed through other non-technical donor agencies. Moreover, large parts of the biennial budgets have been used to support small and vertical projects.

It is therefore necessary to change the way resources are used and managed in supporting WHO's technical programmes. WHO will focus its resources on provision of technical expertise in areas where they are judged to be of importance to WHO and Viet Nam. Priority must be given to essential areas for the attainment of the country's health sector goals. Programmes that have become self-sustaining (no longer require support from WHO) will be phased out, allowing the Organization to support new programme areas and deal with emerging health issues. Considerably fewer resources should be allocated to supplies and equipment, printing, study tours and routine tasks that are non-essential.

#### Information management and disease surveillance

A core function of the WHO Country Office is to gather accurate and timely information on the country's health situation, and of relevance to the international community. This information is usually gathered through both official and unofficial means, such as government publications, research studies and documents, routine information collection systems and disease surveillance reports.

### **The WHO Regional Office for the Western Pacific**

The WHO Regional Office for the Western Pacific provides technical and administrative backup to the WHO Country Office, as well as the experience of Member States in the Region. Through its wide regional networks, the WHO Regional Office can assist Viet Nam in institution-building and in helping national institutions to achieve international standards and become WHO collaborating centres. A major role played by the Regional Office is resource mobilization for Viet Nam in priority areas.

### **WHO Headquarters**

WHO Headquarters can play three major roles in supporting CCS implementation in Viet Nam:

#### Technical support and piloting of new initiatives

WHO Headquarters can provide technical support in areas where there is inadequate expertise in the Regional Office. These are usually programme areas where the health issues/diseases concerned are either newly emerging or are not very common in the Region. WHO Headquarters may also pilot certain new initiatives in Viet Nam so as to provide new insights into certain health issues/disease control programmes. Similarly, new approaches/methods initiated by Viet Nam may be shared with other countries through the assistance of WHO Headquarters.

#### Standards, guidelines, and tools

Providing evidence-based standards, guidelines and tools developed according to global experience has been a major function of WHO Headquarters. These resources can be drawn on by both the WHO country office and the Government as means to improve the health sector as a whole and as yardsticks to measure the performance of certain aspects.

#### Resource mobilization

Like the Regional Office, WHO Headquarters is an additional arena for effective mobilization of donor resources to support the country.

### **The CCS application process**

The CCS will be effective for five years. As such, it will cover the period of three biennial programme budgets. It is therefore necessary to adopt a common process for applying the CCS in the development of the two upcoming biennial programmes.

#### Dissemination of the CCS document

This document will be disseminated to all concerned parties in order to raise awareness about the CCS at the managerial and project levels within government and with development partners. Government and WHO staff should ensure that the CCS is applied in all future WHO/Government of Viet Nam collaborative planning processes.

#### Making available proper WHO planning tools

To ensure that all parties follow the same process in planning a collaborative programme according to the CCS, proper WHO planning tools should be provided to all the parties concerned. This can be achieved by holding in-country programme planning and management training workshops.

#### Re-orienting Ministry of Health staff on WHO-Government of Viet Nam collaborative programme development and implementation

This involves three steps: (1) educating Ministry of Health staff and counterparts about partners' roles and responsibilities in applying the WHO results-based management and implementation approach; (2) changing behaviour in project implementation and use of WHO resources; and (3) learning to account for resource utilization and results based on prescribed technical criteria and cost norms.

#### Development and delivery of outputs/products

The products planned need to be consistent with the strategic objectives of the CCS. The rationale for developing the activities to deliver a product needs to be properly justified. There should be appropriate indicators and tools to measure the quality and delivery status of the products according to certain time-frames.

Review and renewal process

The CCS is a dynamic document and should be renewed and revised from time to time. Its strategies should be assessed regularly to ensure that the intended results can indeed be delivered through their application. The timing for renewal can be decided mutually by both WHO and the Government.

**Annex I: WHO Core Functions**

1. Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.
2. Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.
3. Setting norms and standards, and promoting and monitoring their implementation.
4. Articulating ethical and evidence-based policy options.
5. Providing technical support, catalyzing change and building sustainable institutional capacity.
6. Monitoring the health situation and assessing health trends.