Viet Nam

1. CONTEXT

1.1 Demographics

The estimated population of Viet Nam was 86,025,000 in 2009, 49.4% of them male. The population density is 263 persons per square kilometre, with most (70.3%) of the population living in rural areas. Over the past few years, the country has witnessed a gradual change in its population structure. In 2009, 25% of the population was aged 0-14 years, a decrease of 8.1% in comparison with 1999. However, the proportion aged over 65 years also increased rapidly (by 0.6%) over the same ten-year period. This shows that fertility has continued to decline over recent years while the number of elderly has been increasing gradually.

Viet Nam has 54 different ethnic groups, with the Kinh representing 87% of the total population. The rest are ethnic minorities scattered all over the country, mostly in mountainous and remote areas. Population migration is an important factor in rural-urban population growth differentials. The General Statistics Office survey on migration and family planning indicates that substantial spontaneous migration has been taking place and that migrants from rural to urban areas are numerous.

In 2009, life expectancy at birth was 70.2 for males and 75.6 for females. In the same year, the population growth rate was 1.08% per annum. The total fertility rate decreased from 2.33 in 1999 to 2.03 in 2009, reaching replacement-level fertility. In 2009, the crude birth rate was 17.6 per 1000 population and the crude death rate was 6.8 per 1000 population.

The maternal mortality ratio (MMR) was 130/100,000 live births in 1990. By 2009 the ratio had fallen to 69.0/100,000 live births. However, throughout the 2006-2009 period, the MMR remained unchanged. Thus to achieve the goal of reducing maternal mortality to 58.3/100,000 live births by 2015, Viet Nam needs to put even more effort into implementing its policies and programmes.

The under-five mortality rate was 55.4% in 1990 and had fallen by more than half to 24.1% by 2009. In order to achieve the MDG of 18.4% by 2015, however, progress must be accelerated.

1.2 Political situation

Viet Nam is a socialist republic and one-party state governed by the Communist Party of Viet Nam. The National Assembly is designated the highest representative body of the people and is the only organ with constitutional and legislative powers.

Beyond central government, the People’s Committees at different levels are responsible for daily administration at the local level. Mass organizations, such as the Women’s Union, Farmers’ Union and Youth Union, exist to serve the interests of the people and to act as a link between the people and the Party.

Although the political system is stable, the country’s senior leaders have raised concerns on a number of occasions about the lack of transparency, administrative inefficiency and corruption. Steps have been taken to strengthen open public debate and effective rule of law from the central to local level.

1.3 Socioeconomic situation

Vietnamese authorities have moved to implement a free-market economy with socialist orientation, to modernize the economy and to produce more competitive, export-driven industries. This has led to a strong rate of growth in gross domestic product (GDP). Major economic achievements in the period 2001-2005 included, among others, a high level of economic growth, averaging 7.2% per year; comprehensive development; the solution of many social problems, especially hunger eradication and poverty reduction; and the improvement of people’s living standards. In 2000, the GDP per capita was only about US$ 400. By 2009, however, it stood at US$ 1064, representing an increase of 166%.
In the last two decades, the poverty rate has been in constant decline, from 58.1% in 1993 to 28.9% in 2002 and 14.5% in 2008. On average, the number taken out of poverty is 1.8 million each year, from more than 40 million people living in poverty in 1993 down to 12.5 million in 2008. At the same time, the proportion of undernourished people, measured by the food poverty line, also decreased, from 24.9% in 1993 to 10.9% in 2002 and 6.9% in 2008. Viet Nam has now far exceeded the MDG of halving the proportion of people whose income is less than one dollar a day between 1990 and 2015, the proportion declining from 39.9% in 1993 to 4.1% in 2008.

During the period from 2001 to 2005, the economy created jobs for about 7.5 million workers. The proportion of unemployed working-age people declined from 6.4% in 2001 to 2.9% in 2009, at which time 47.7 million people, about 55.5% of the population, were employed.

According to the survey on household living standards conducted in 2008, 89% of the population had access to clean water (if sources such as taps, wells and rain were to be considered sanitary and those from ponds, lakes and rivers to be non-sanitary). In the same year, approximately 67% of rural households had sanitary toilets, and about 80% of schools, 82% of clinics and 72% of ward centres had sanitary water systems and toilets. Regions with difficult water source conditions, such as mountainous areas and high-saline plains, have been given priority in investments. The goal for 2010 was for 95% of the population in urban areas to have access to safe drinking water.

Spending in the environment sector has improved. Since 2007, the Government’s environmental expenditure has accounted for 1% of the total national budget, and environmental observation, disaster warnings and rescue systems have all been strengthened. Policies on diversifying investments in environmental protection and improvement have achieved initial success, while policies to support enterprises in environmental protection have gradually taken effect. Many enterprises have invested in new technologies and developed wastewater processing systems to help improve the environment.

1.4 Risks, vulnerabilities and hazards

Viet Nam is one of the most disasters-prone countries in the world. It extends over 11 latitudes, with a 3200 kilometre coastline, and is located in an area ranging from a humid tropical to a sub-tropical climate, with complex topography and a dense river network.

Every year, the country suffers from many natural disasters, such as typhoons, tropical storms, floods, drought, seawater intrusion, landslides, forest fires and, occasionally, earthquakes. Disasters triggered by typhoons and floods are by far the most frequent and severe. In recent years, disasters have occurred continually all over the country, causing vast losses in human lives, property and socioeconomic and cultural infrastructure, as well as environmental degradation. During the period from 1980 to 2009, natural disasters, including typhoons, floods and droughts, caused significant losses, including 15 917 deaths, 69 700 028 affected people and damage equivalent to US$ 7 356 350 000. Natural disasters are becoming increasingly severe in terms of magnitude, frequency and volatility, due to climate change.

The most important natural hazards are water-related, particularly typhoons and floods and, increasingly in recent years, flash floods, landslides and droughts. Typhoons occur between May and December and are often accompanied by storm surges that inundate huge areas of the delta regions with saline water. Half of all the typhoons to hit Viet Nam in the last 30 years have caused surges of at least one metre and 11% have caused surges of over 2.5 metres. These typhoons and storm surges have often overtopped—and frequently destroyed—sea dykes, causing damage and seawater flooding in addition to wind damage and flooding from the storm itself.

Besides natural disasters, man-made and technological hazards are becoming an increasing threat to communities. Such hazards include urban fires, transportation accidents, chemical or industrial accidents and epidemics, among others.

There is a risk of many diseases breaking out or being imported from overseas, especially emerging diseases like severe acute respiratory syndrome (SARS), highly pathogenic influenza A(H5N1) and encephalitis due to arbovirus, which creates many difficult challenges as regards prediction, prevention and control. At the same time, the increasingly polluted environment, unusual weather patterns, natural disasters, rapid urbanization, lack of clean water in many residential areas and increasing contact between travellers from different localities and countries
creates favourable conditions for the development and spread of diseases. These same factors may also complicate the disease situation and make it hard to control.

2. HEALTH SITUATION AND TREND

2.1 Communicable and noncommunicable diseases, health risk factors and transition

Diarrhoea is one of the leading causes of morbidity in the country. Cholera, typhoid fever and dysentery still exist in some areas where water supply and sanitary facilities remain inadequate. In 2010, the country recorded 317 cases of cholera (no deaths), of which 301 cases were Vietnamese and 16 were Cambodian.

Dengue and dengue hemorrhagic fever are also big public health problems. According to the Ministry of Health’s Department of Preventive Medicine, the incidence of dengue fever is increasing, especially in the southern area of the country. There were 128 831 cases and 109 deaths in 2010. The incidence rate for dengue fever increased 22% in 2010, and the mortality rate by 25.3%, compared with 2009. Vector control is the main activity for dengue control, including reducing mosquito breeding sites, applying biological measures for larvae reduction, and insecticide spraying during outbreaks. Education about self-protection and mobilization of different sectors in dengue control at the community level are being strengthened.

The national malaria control programme has continued its efforts to halt and reverse the incidence of malaria, and plans to have malaria eradicated by 2015. Over the past 15 years, the number of malaria patients in the country has decreased by 83% (from 1.1 million cases to less than 100 000), and many provinces have reported no case of malaria in recent years. The number of confirmed malaria cases dropped from 19 497 in 2005 to 17 515 in 2010. However, mortality increased from 18 malaria deaths in 2005 to 21 deaths in 2010. In general, malaria has been prevented and reduced in the whole country, with a reduction in morbidity and mortality and no occurrence of a malaria epidemic. Malaria is controlled in endemic areas. Every year since 2000, 10 to 12 million people in malaria-plagued areas have been protected by free anti-mosquito insecticides, 1.2 to 2 million with chemical spraying and 9.5 to 10 million with insecticide-treated mosquito nets. The challenges for malaria control include the uncontrolled movement in and out malaria areas by forest-goers and people staying overnight in rice fields and coffee plantations; people crossing international borders; and remote and hard-to-reach areas where minority groups with a low level of education are living.

In 2009, pneumonia was among the leading causes of morbidity. According to 2009 hospital statistics, there were 353 623 new pneumonia cases and 1146 related deaths.

Viet Nam essentially managed to keep the growth rate in HIV infections to under 0.3% in the period from 2004 to 2010. The current HIV prevalence rate is estimated to be 0.28% (all ages), with nationwide prevalence of 187 per 100 000 people. There were 15 713 new HIV infections, 5785 new cases of AIDS and 3928 reported deaths due to HIV/AIDS in 2009, with an estimated 293 000 people living with HIV/AIDS. The HIV prevalence rate in adults (from 15 to 49 years old) was 0.44% in 2010. The HIV epidemic remains largely concentrated among key populations at higher risk; there is a high level of HIV prevalence among injecting drug users (28.6%), female sex workers (4.4%) and their partners, and men having sex with men (9.4% and 5.3% in Hanoi and HCMC, respectively), while HIV prevalence among pregnant women remains low (0.37%). According to the Ministry of Health, HIV-infected people aged 20-39 years account for more than 80% of all reported cases, that rate having hardly changed in five years. Moreover, the percentage of people aged 30-39 in the total number of reported HIV infections is increasing. HIV prevention, care and treatment services are being expanded rapidly. It is estimated by the Ministry of Health that the number of people living with HIV in need of antiretroviral treatment increased from 42 480 in 2006 to 72 970 in 2010. The National Action Plan states that 70% of adults and all children infected with HIV will be eligible to receive ARV by the year 2010.

In 2009, there was a slight increase in the number of recent tuberculosis (TB) cases, with 95 970 being reported in 2005 and 95 036 in 2009, of which 51 291 were new pulmonary AFB-positive cases, 18 612 cases of pulmonary tuberculosis with negative AFB, and 18 333 cases of non-pulmonary tuberculosis. The number of tuberculosis-related deaths has decreased, although not significantly: 1936 TB deaths were reported in 2005 compared with 1689 in 2009. Most TB patients receive treatment under the directly observed treatment, short-course (DOTS) strategy. With a detection rate of 54.0% and a high success rate (92.0%), Viet Nam has reached WHO’s target for
TB control. However, the tuberculosis control programme is facing new challenges, including drug-resistant bacillus (it is estimated that about 30% of new cases are resistant to one drug and 2.3% to more than one) and tuberculosis among HIV/AIDS patients.

The mortality and morbidity rates for leprosy are not high. The number of new leprosy cases decreased from 588 new cases in 2007 to 359 new cases reported in 2010. Viet Nam has reached WHO’s leprosy elimination target on the national scale (the incidence rate is less than 1/10,000 people).

Noncommunicable diseases (NCD) have shown a tendency to increase in the last two decades, with total morbidity rising from 39.0% in 1986 to 66.3% in 2009, and mortality from 41.1% to 63.3%. Economic growth, the ageing population and lifestyle changes are the leading causes of the increasing NCD burden. Some NCD are common among children, such as nutritional disorders, asthma, vision disorders, dental caries, congenital malformations, and disability due to accident or illness. These diseases are also found among adults. Diseases commonly found among the elderly include cardiovascular disease, diabetes and cancer.

Rates of protein energy malnutrition and micronutrient deficiencies among the under-fives have fallen significantly, although the under-five malnutrition rate varies greatly among income groups. A 2008 study by the General Statistics Office revealed that improvements to the under-five malnutrition rate are harder to make among the lower income group. In particular, the gap between the poorest and richest groups has widened from two times higher in 1992/1993 (40.2% compared with 20.1%) to over 3.5 times in 2006 (28.6% compared with 6.8%). Nevertheless, a new trend towards overweight and obesity in children in cities and more economically developed areas has developed and needs to be controlled in order to prevent the negative consequences that may result, such as diabetes and cardiovascular diseases.

The cancer incidence rate has been increasing, with about 106,421 new cases per year. The case fatality rate is very high.

Lifestyle-related health problems are becoming increasingly important, particularly those related to tobacco use, alcohol and drug abuse; injuries due to road accidents or violence; suicide; and mental disorders. However, non-users of tobacco, alcohol and drugs, particularly women and children, may also suffer from external effects like passive or second-hand smoking, domestic violence, traffic accidents and exposure to HIV/AIDS. In 2002, the adult male smoking prevalence rate was 56.0% (compared with 50.0% in 1998). Males aged 15 years and over consume an average of 12.5 cigarettes per day and a female of the same age 8.1 cigarettes per day. The Vietnam National Health Survey 2001-2002 showed that 45.7% of males and 19.9% of females aged 15 and over drink, and each drinks 100 ml of spirits/wine or one can/bottle of beer or more each time.

Injuries and accidents are causing serious concern. In the period from 2002 to 2009, morbidity due to accidents, injuries and poisonings increased from 9.2% of all hospital admissions to 10.8%, and hospital deaths related to accidents increased from 18.8% of all deaths in hospitals to 22.6%. Transport accident is the sixth leading cause of mortality.

2.2 Outbreaks of communicable diseases

In the period from 2006 to 2010, Viet Nam also had to face challenges related to newly emerging diseases. Dangerous and new diseases, including those caused through animal-to-human transmission, have threatened to break out into pandemics. The first reported case of highly pathogenic influenza A (H5N1) in December 2003. Nationally, 37 provinces/cities have now reported infections, with 112 infected cases and 57 deaths. According to a report of the Preventive Medicine Department in the Ministry of Health, 1104 positive cases of infection with the pandemic influenza A (H1N1) 2009 virus had been recorded by the end of December 2009, with 53 deaths. The number of infections increased gradually from October 2010 to January 2011, but most cases are mild and clusters of cases have not yet been recorded.

Having been under control for many years, acute diarrhoeal disease broke out once again in 2007, with an infection rate of 2.24/100,000 people, and new cases of infection continue to be recorded. In 2009 alone, 239 cases nationally tested positive for *Vibrio cholerae*.

In 2004, dengue fever was widespread in the Mekong delta, accounting for 84.0% of cases, with 9.0% in the south central coast, 5.0% in the central highlands, and only 2.0% in the north. Treatment currently consists of analgesic and antipyretic drugs, such as acetaminophen. The prevention methods being applied include activities to reduce
vectors in the community and to monitor when there is an outbreak. The health sector has made great efforts to reduce the incidence of dengue fever, and only 88 deaths due to dengue were detected in 2008. The sustainability of these achievements and the potential reduction of morbidity and mortality are still in question.

An outbreak of hand, foot and mouth disease in 2010 led to 11,709 cases being recorded, including six deaths. Hand, foot and mouth epidemic risk increases, particularly in preschools and kindergartens, after local flooding, in crowded areas, and in areas where sanitation conditions are poor.

2.3 Leading causes of mortality and morbidity

In the past, most of the leading causes of morbidity were communicable diseases. However, in 2009, noncommunicable diseases were also among the leading causes (reported by public hospitals), with the incidence rate for hypertension being particularly high.

Currently the vital registration system in Viet Nam does not operate effectively and cannot provide accurate data on numbers of deaths, causes of death, or age, sex and socioeconomic status of those who die. Therefore, it is still necessary to rely on mortality data collected in public hospitals for assessment of mortality patterns and trends. According to 2009 data from hospitals, injuries, AIDS-related conditions, pneumonia, accidents and some NCD are the leading causes of mortality.

2.4 Maternal, child and infant diseases

The maternal mortality ratio (MMR) and the infant mortality rate (IMR) are lower than other Asian countries with the same level of economic development. More than 93.7% of pregnant women were cared for by skilled health personnel in 2009, and 94.4% during delivery. The MMR fell from 200 per 100,000 live births in the 1980s to 69.0 per 100,000 in 2009. However, there are huge differences in MMR across regions, with the highest in the northern mountainous area and the central highlands.

The IMR has also fallen rapidly in the past two decades: from 55.0 per 1000 live births in 1983 it declined to 16.0 in 2009. In the nine years leading up to 2009, the rate fell from 31.2 per 1000 live births to 16.0, a decline of more than one half, with an average reduction of 1.8% per year.

The under-five mortality rate fell from 42.0 in 1999 to 24.1 per 1000 live births in 2009, with an average decline of 1.8% per year. A recent study indicated that deaths among children under five years of age are concentrated in the perinatal period and are mainly due to premature birth, asphyxia at birth or multiple birth defects. For children beyond the perinatal period, mortality is mainly due to drowning, respiratory infection or encephalitis.

Child malnutrition is measured using two basic indicators: the proportion of children born with low birth weights and the proportion of children under five years of age who are malnourished. The proportion of babies born with low birth weights (under 2500g) declined from 7.3% in 2000 to 5.3% in 2008; the under-five malnutrition rate fell from 33.8% to 18.9% over the same period. Of increasing concern recently has been the overweight and obesity rate for those under five years of age. The current rate is 6.2 times higher than it was in 2000 and has increased in both rural and urban areas. Indeed, despite having emerged quite recently, child overweight and obesity is increasing even faster in rural areas than in urban areas.

2.5 Burden of disease

No available information, with the exception of a few specific diseases.

3. HEALTH SYSTEM

3.1 Ministry of Health’s mission, vision and objectives

The Ministry of Health is the government agency exercising state management in the field of people’s health care, including preventive medicine; consultation and treatment; rehabilitation; traditional medicine; pharmaceuticals, including vaccine production; hazardous effects of cosmetics on human health; food hygiene and safety; medical equipment; health facilities; population and family planning; and health system development and management.
3.2 Organization of health services and delivery systems

The health system is a mixed public-private provider system, in which the public system plays a key role in health care, especially in policy, prevention, research and training. The private sector has grown steadily since the ‘reform’ of the health sector in 1989, but is mainly active in outpatient care; inpatient care is provided essentially through the public sector.

The health care network is organized under state administrative units: central, provincial, district, commune and village levels, with the Ministry of Health at the central level. In the public sector, there are 783 general hospitals, 144 specialized hospitals and 11,636 primary health centres. The establishment of the grassroots health care network (including commune and district levels) as the foundation for health care has yielded many achievements, especially that of contributing towards attainment of national health care goals for the entire population. The health stations in communes provide primary health care services, including consultation, outbreak prevention and surveillance, treatment of common diseases, maternal and child health care, family planning, and hygiene and health promotion. The total number of private facilities rose from 56,000 facilities in 2001 to 65,000 in 2004. In 2009, there were 102 private hospitals, accounting for 8.9% of the total number of hospitals nationwide, with 5,822 beds, accounting for 3.2% of the total number of hospital beds.

Health care is further strengthened by implementation of national health programmes to deal with diseases and health issues that are of important public health concern. For example, the tuberculosis control programme has made every effort to maintain, over many years, a high implementation rate, with DOTS now covering 100% of the affected population. WHO has highly commended the programme and has ranked it as being on par with those countries reaching the highest achievements in the world.

In the period 2001-2010, the immunization rate for infants remained high, at over 90%. As a result, Viet Nam has succeeded in sustaining the eradication of poliomyelitis (since 2000) and the elimination of neonatal tetanus, as well as significantly reducing the rate of children contracting dangerous infectious diseases through the Expanded Child Immunization Programme.

The HIV/AIDS control programme was a priority health programme for the period from 2001 to 2005. Through its implementation, more than 90% of state officials, members of popular organizations, servicemen and students, more than 80% of the urban population, and 70% of the rural and mountain-dwelling population gained good knowledge about HIV/AIDS and participated actively in HIV/AIDS intervention activities.

3.3 Health policy, planning and regulatory framework

The Government set ambitious goals and targets in the Ten-Year Socio-Economic Development Strategy, the Comprehensive Poverty Reduction and Growth Strategy and the National Strategy for People’s Health Care 2001–2010. These included substantially improving the human development index of the country and providing prevention and treatment services to the whole population.

The Minister of Health then promulgated a five-year plan for the health sector, setting the following new targets for 2010:

- to increase average life expectancy to 71 years;
- to reduce the maternal mortality ratio to below 70 per 100,000 live births;
- to reduce the infant mortality rate to below 25 per 1000 live births;
- to reduce the under-five mortality rate to below 32 per 1000 live births;
- to reduce the percentage of low-birth-weight infants to below 6%;
- to reduce the percentage of malnourished under-five children to below 20%;
- to increase the average height of young people to at least 160 cm;
- to increase the ratio of medical doctors per population to 4.5/10,000 people;
- to increase the ratio of college-trained pharmacists to 1/10,000 people.

The National Strategy recognized the important role of health and the need to invest in health for accelerated socioeconomic development and to improve the quality of life of each individual. The strategy was based on four principles:
• equity and efficiency of the health sector;
• the fight against the broad social determinants of bad health;
• the integration of traditional and modern medicines; and
• an appropriate public-private mix, with the Government in a position to protect the public interest.

The strategy outlined the Government’s main policies and proposals for improving the overall level and distribution of health among the entire population (ethnic minority groups, women, children, the poor and the elderly). These included:

• using the government budget more effectively and moving to prepayment schemes in the medium term to finance health;
• reviewing and strengthening the organization of the health sector, and consolidating and developing primary health care/community-based services;
• strengthening preventive care and health promotion, improving curative care, and putting in place an effective referral system;
• developing human resources according to the needs of each level, and improving training;
• developing traditional medicines and implementing the national drug policy in order to promote rational and effective use of modern and traditional drugs;
• developing new technologies to catch up with other countries in the Region; and
• increasing planning and management capacity in all areas within the health sector.

The National Strategy provided a broad basis for further planning and can be seen as an orientation document for the development of the health sector. However, it did not provide specific solutions on how to: (1) ensure equal access to health care; (2) improve the performance of the health system and the quality of care; (3) rationalize the prescription and use of drugs and expenditure on medicines; and (4) respond to new public health problems, including noncommunicable diseases.

Some more recent policies have attempted to address these issues. In October 2002, the Prime Minister signed Decree 139 to establish the Health Care Fund for the Poor, which aims to provide free health Insurance for 14.6 million people. As of December 2008, 15.8 million people had received health care through this financing mechanism.

### 3.4 Health care financing

Since 2000, the State has continued building and adjusting health financing policies with greater concern for equity, efficiency and development than in the past. The broad orientation of health financing was decided upon in the 1990s through development of a health insurance scheme, the partial-user-fee policy and the Government resolution on “social mobilization” in the areas of education, health and culture. These orientations have created a health financing system that combines partially subsidized state health services with health services that collect user fees from patients. Nevertheless, the partial user fees created some contradictions and have led to inequalities. Therefore, the Government had to pay attention to financial assistance for certain social groups, especially for the poor. Health financing underwent further major changes in the 1990s as the State began to strongly promote decentralization of public finance, which had major implications for the health sector.

Total health expenditure in 2008 was 7.3% of GDP, with government expenditure accounting for only 38.5%. Most health finance is used for curative and preventive care (93%-98%): curative care accounts for 75.2% and preventive care for 23.6%, and there is some expenditure on scientific research and training (less than 2%). By 2008, within the sphere of the government system, the number of enrolees in public health insurance was over 37.7 million, accounting for 43.76% of the population, including compulsory insurance, voluntary insurance and insurance for the poor.

### 3.5 Human resources for health

Currently, the number of health workers per bed in general for the whole country is 1.4 (including contract workers). The number of medical doctors on average for the whole country is about 2.6 per 10 beds, while the number of nurses is about 3.0 per 10 beds. The number of doctors per 1000 population is 0.66, the number of nurses is 0.88, and the number of pharmacists is 0.12 (not including the private sector).
According to data from the Ministry of Health, of all health workers at the provincial level in the whole country, 81.8% are working in curative care and 13.0% in preventive medicine, while those in management account for 4.0%.

The number of health staff in public facilities increased from 241,498 in 2003 to 301,980 in 2009. Total staff at the central, provincial, district and communal levels include: 56,661 medical doctors (including PhD and Masters degrees), 10,524 pharmacists (in 2008), 75,891 nurses and 24,998 midwives.

3.6 Partnerships

The external relations line of the Party and the State is one of multilateralism, diversification and expansion of health cooperation with international NGOs and foreign partners to gain financial, technical and technological support. In implementation of this, international cooperation in health has created positive changes in terms of both quantity and quality. Since the 1990s, the number of donors/partners in health has increased considerably. However, aid for health still accounts for just 3% of total health expenditure and between 8% and 10% of government spending. As Viet Nam reaches middle-income-country status, the number of health partners is expected to decline; indeed, some partners with a global mandate to focus on the poorest countries have already announced their intention to leave the country. Nevertheless, aid to the health sector has been significant in certain areas, particularly HIV/AIDS and communicable disease control. Funds received through official development assistance (ODA) have come in diverse forms and have included grant aid from governments, international organizations, intergovernmental organizations and NGOs, and soft loans from international monetary institutions. While Viet Nam has a substantial general budget-support programme, coordinated by the World Bank, there are no examples of budget or programmatic support in the health sector, where assistance remains heavily project-based (98% of health projects funded by a single donor).

3.7 Challenges to health system strengthening

Despite the important achievements recorded in health care, the country is still beset by many problems. The Party Politburo’s Resolution No. 46 - NQ/TW on Health Care, Protection and Improvement for People in the New Situation points out irrationalities in the health sector as follows:

- The health system is slow to renew and has not adapted itself to the development of a socialist-oriented market economy and changes in disease patterns.
- The quality of health services has not met the increasingly diversified needs of the people.
- The health care conditions for the poor and those in remote areas and areas inhabited by ethnic groups remain very difficult.
- Pharmaceutical production and supply capacity remains weak; the price of pharmaceuticals remains high in comparison with people’s incomes.
- The organization and operation of preventive medicine remain insufficient. A portion of the population lacks awareness about self-protection, self-care and health promotion. Environmental health and food safety have not been put under tight control.

Therefore, Viet Nam still faces a number of key challenges, such as:

- achieving adequate recognition that improved health outcomes are central to poverty reduction and economic growth and that health improvements require an intersectoral approach to address broad health determinants;
- developing a clear consensus among policy-makers on the road to developing an efficient equity-oriented health sector;
- achieving better coordination among ministries and across departments in the Ministry of Health and among partners;
- strengthening pro-poor health policies to meet the needs of the disadvantaged and ethnic minorities, particularly addressing the problems of financial access and the lack of responsiveness of health services to the needs of the poor;
- strengthening the public health agenda to address the incomplete agenda of infectious diseases and the problems brought about by urbanization, changing lifestyles and an ageing population;
- strengthening capacities at district and provincial levels to prioritize and implement successful interventions within an increasingly decentralized health system; and
improving the enforcement of regulations and speeding up the implementation of public administration reform.

4. **LISTING OF MAJOR INFORMATION SOURCES AND DATABASES**

   **Title 1**  
   Web address: http://www.gso.gov.vn

   **Title 2**  

   **Title 3**  

   **Title 4**  

   **Title 5**  
   Web address: http://www.moh.gov.vn/tinbyt/

   **Title 6**  
   Operator: Ministry of planning & Investment

5. **ADDRESSES**

   **MINISTRY OF HEALTH**
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