Success Factors for Women’s and Children’s Health

VIET NAM
Ministry of Health, Viet Nam
“Success factors for women’s and children’s health: Viet Nam” is a document of the Ministry of Health, Viet Nam. This report is the result of a collaboration between the Ministry of Health and multiple stakeholders in Viet Nam, supported by the Partnership for Maternal, Newborn and Child Health (PMNCH), the World Health Organization, other H4+ and health and development partners who provided input and review.

Success Factors for Women’s and Children’s Health is a three-year multidisciplinary, multi-country series of studies coordinated by PMNCH, WHO, World Bank and the Alliance for Health Policy and Systems Research, working closely with Ministries of Health, academic institutions and other partners. The objective is to understand how some countries accelerated progress to reduce preventable maternal and child deaths. The Success Factors studies include: statistical and econometric analyses of data from 144 low- and middle-income countries (LMICs) over 20 years; Boolean, qualitative comparative analysis (QCA); a literature review; and country-specific reviews in 10 fast-track countries for MDGs 4 and 5a.2 For more details see the Success Factors for Women’s and Children’s Health website: available at http://www.who.int/pmnch/successfactors/en/

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I. Executive Summary

**Progress:**
Viet Nam has made significant progress in reducing infant (under 1 year), child (under 5 years), and maternal mortality and is on track to achieve Millennium Development Goal (MDG) 4 to reduce child mortality and MDG 5a to reduce maternal mortality. Viet Nam has reduced under 5 mortality by 60%, from 58/1000 to 23.2/1000 live births between 1990 and 2012. Viet Nam has reduced maternal mortality by 70%, from 233/100 000 to 69/100 000 live births from 1990 to 2009 and has made good progress towards achieving 5b (universal access to reproductive health) although meeting unmet need for family planning especially among unmarried young people remains a challenge. Several health sector, multisector and cross-cutting strategies have played a key role in driving this progress.

**Health sector:**
Per capita government spending on health has increased almost five-fold since 1995, and Viet Nam has also expanded the network of health care facilities and workers. The overarching reproductive health strategy has been a key mechanism for prioritizing essential maternal health interventions including family planning services, tetanus vaccination of pregnant women and children, skilled birth attendance, emergency obstetric and newborn care services. The increased coverage of the Expanded Programme on Immunization, child survival and nutrition interventions contributed to the reduction in child mortality. Universal coverage is a stated objective of Viet Nam’s health systems and investment policies, and both legal and financial provisions are in place. These include social health insurance, which specifically targets the poorest and most vulnerable.
Multisector:
Viet Nam has made significant progress in increasing access to improved drinking-water and sanitation; changes have been helped by key government policies and programmes targeted at marginalized, poor and ethnic minority households. Laws on universal education have supported improvements in school enrolment and literacy rates, while the implementation of several nutrition programmes and policies have created a positive enabling environment for significant reductions in underweight and stunting, severe malnutrition and micronutrients deficiencies. Economic development has markedly advanced.

Cross-cutting:
Viet Nam has focused on and made considerable progress in poverty alleviation, reducing poverty levels from 58% in 1993 to 14.5% in 2008. Through good governance and leadership, the Doi Møi reforms allowed a managed devolution and decentralization that stimulated production and growth in farmers and firms. The devolution also impacted provincial and lower levels of government, administration and service delivery, the media, and civil society - promoting capacity and progress. Gender equality in education was strongly advanced. Viet Nam is also in the phase of demographic bonus when the number of children is decreasing, the adult active population is increasing, and the proportion of dependent old population is not yet large but growing.

Challenges:
Despite the progress in improving health outcomes in all groups, inequity between groups is increasing due to geographical, ethnic and financial barriers. Despite the poorest being covered by social health insurance, co-payments and other costs result in high out-of-pocket expenditure disadvantaging the poor and near poor. Addressing the equity gap is a challenge that Viet Nam needs to address to ensure further progress towards the MDGs. Viet Nam is now classified as a lower-middle-income country and is facing reduced support from international donors. Government commitment to adequate financing of health, particularly maternal, newborn and child health will be crucial to maintain the considerable gains to date. Other areas of priority include improving the quality and coverage of maternal, neonatal (first month of life), and child care interventions; reducing the prevalence of stunting; focusing on improved health care and access for disadvantaged groups such as ethnic minorities; and improving youth awareness, attitudes and behaviour about reproductive health issues, particularly in marginalized groups, and rural and mountainous areas where access to information and services is still limited.
2. Introduction

Viet Nam is one of 10 high-performing countries which include: Bangladesh, Cambodia, China, Egypt, Ethiopia, Lao People’s Democratic Republic (PDR), Nepal, Peru and Rwanda that are on track in 2013 to achieve MDGs 4 (to reduce child mortality by two thirds) and 5a (to reduce maternal mortality by three quarters). As the overall Success Factors studies show, improvements in gross domestic product per capita together with progress across health and other sectors, have contributed to improvements in health and development. While growth has an overall bearing on the progress of MDGs, improved policies and institutions are vital for the health-related MDGs such as MDG 4 and 5. Progress in improving the health of women and children can also be accelerated by a range of health sector, multisector and cross-cutting strategies including education, and water and sanitation.

The primary objective of the review was to identify factors both within and outside the health sector that have contributed to reductions in maternal and child mortality in Viet Nam – focusing on how improvements were made, and emphasizing policy and programme management best practices. Plausibility criteria for defining success factors were developed based on an impact model that linked policy and programme inputs with potential mortality reductions (Annex 1).

It was recognized that it can be difficult to establish causal links between policy and programme inputs and health impact. Research is needed to better quantify how policies and programmes contribute to improved health outcomes. More data in this area would enable the analysis to be further refined. The review included both quantitative and qualitative methods. The first draft was developed by local and international experts. Interviews and group meetings with stakeholders were conducted in May 2014 to further review, revise and get consensus on findings. A final draft was developed and approved by the MoH in June 2014.

Methods used for the Success Factor Study in Viet Nam

A literature review based on peer reviewed and grey literature, policy documents, programme evaluations and sector strategies and plans.

A review of quantitative data from population-based surveys, routine data systems, international databases and other sources.

A review of the draft document by stakeholders and local experts to finalize findings.

Defining criteria for success factors

To be included as key factors, policy and programme inputs had to meet four plausibility criteria including:

- Potential impact (likely to have contributed to mortality reduction based on an impact framework and available data)
- Temporal association (had been implemented long enough to have influenced mortality)
- Scale (had reached a large enough target population to influence mortality); and stakeholders within and outside the health sector
- Consensus (broad agreement between key stakeholders within and outside the health sector)
3. Country Context

Overview

Viet Nam is the easternmost country on the Indochina peninsula in South-East Asia. The northern and central parts of the country consist of highlands and the Red River Delta, while the southern part is composed mainly of coastal lowlands, forests and the Mekong River Delta. Viet or Kinh is the dominant ethnic group, constituting 86% of the population, with ethnic minority groups of Hmong, Tay, Dao, Khmer and Nung making up the remainder of the population. Approximately 30% of the population lives in urban areas, and the urban population is growing at a much faster rate than the rural population. Viet Nam is currently divided into six regions; under the regional level are 63 provinces; under the provincial level are 690 districts further divided into 11,066 rural communes (comprising several villages) or urban wards. The urban proportion of the population has increased from 19.2% in 1991 to 31.9% in 2012 (28.4 million urban residents among 89 million people in the national population). Viet Nam is also in the phase of demographic bonus when the number of children is decreasing, the adult active population is increasing, and the proportion of dependent old population is not yet large but growing.

North Viet Nam implemented a multi-level health care delivery system in the 1950s that included national hospitals through to an extensive network of primary health facilities at commune level. After reunification in 1975, the government began improving health infrastructure in the south. Preventive health care programmes were also initiated in the early 1980s to control malaria and diarrhoeal diseases and immunize against diseases. Political and economic reforms in 1986 known as Doi Moi, transformed the economy from a highly centralized, planned economy to a socialist-oriented market economy. Since then there has been significant progress in economic development, poverty reduction and improvement in health outcomes over a relatively short period of time.

As part of the reforms, in 1988 land was decollectivized and under the 1993 Land Law, certificates of use were issued to all households. This stimulated intensification and diversification in agricultural production that in turn produced poverty-reducing growth.

Viet Nam already had a relatively high adult literacy rate of more than 70% that was further boosted during the 1990s with education being considered a national priority for both social and economic development. By 2009, the literacy rate was 95.8% for males and 91.4% for female. There was a narrowing of the gender disparity in literacy rates compared to 1989 with younger cohorts having a much lower gender differential. There remain urban, rural, socioeconomic, and ethnic disparities for literacy, especially for females, with rural females and Hmong having the lowest levels. Primary school enrolment improved especially among the poor with a very high level of primary school education achieved by 1998 (98%). Although there was some downward fluctuation in the early 2000s, Viet Nam achieved universal primary enrolment by 2000 according to national standards, with gender equity.

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a. According to Viet Nam’s national standards, communes, wards and towns can be recognized as achieving universal primary education if more than 80% of 14-year-old children have completed the primary curriculum. For mountainous and difficult areas, the standard is over 70%. Districts and provinces must have more than 90% of local facilities and institutions recognized as reaching the standards of universal primary education. For mountainous and difficult areas, the standard is over 80%.
Also during the 1980s and 1990s there was great importance placed on health care availability, access and ensuring adequate health personnel were trained to serve the population. Viet Nam had a lower infant mortality compared to countries of a similar or higher per capita GNP in the 1990s. Many doctors were trained with an annual increase of 5% from 1986-1993; conversely, fewer nurses and midwives were trained resulting in lower numbers of those cadres by 1993. In addition Viet Nam has built an extensive network of village health workers supported by commune health station staff, who contributed to the delivery of preventive services. However, public health services began to suffer when public sector health staff wages declined in real terms and the legalizing of private medical practice in 1989 attracted many public staff to private practice. Public health facilities (apart from commune health centres) were also allowed to charge fees from 1989 leading to higher out-of-pocket expenditure which resulted in reduced access to health services for the very poor. In 2009 the Law on Examination and Treatment provided a unified legal framework for both public and private health sectors.

Contraceptive and abortion services were available upon request and free of charge as part of public health services from the early 1980s. In 1981 the government recommended a limit of two children per family with a birth interval of three to five years, and a recommended minimum age of 19 for having a first child. In 1988 this recommendation became official policy through a government decree. Total fertility rate decreased markedly from five in 1980 to two in 1999 and has remained just below two since that time.

During the 1990s, the government introduced a number of special programmes called National Targeted Programmes to reduce poverty and improve the health and well-being of the population, and to assist the country to meet the Millennium Development Goals. These programmes have continued and in 2011 the health-related National Targeted Programmes included: immunization; reproductive health care and child nutrition improvement; HIV/AIDS prevention and control; school health; blood transfusion safety; population and family planning; food hygiene and safety. Other National Targeted Programmes included: poverty reduction (from 1998 the National Programme for Hunger Eradication and Poverty Reduction was implemented along with Programme 135, specifically targeted at ethnic minorities); rural water and environmental sanitation; and education and training. Persistently high malnutrition rates were thought to be due to inappropriate infant and young child feeding practices and poor infrastructure for food transportation, storage and distribution rather than insufficient food supply.

In 2010, Viet Nam graduated from being classified as a low-income country to a lower-middle-income country. Its gross domestic product per capita in 2014 (purchasing power parity (PPP), current 2011 International $) was $4998, a significant increase from $972 in 1990 (see Table 1: Key country indicators) with a growth averaging 6.1% between 1993 and 2008. Although Viet Nam was historically an agrarian society with growth in the agricultural sector playing an important part to Viet Nam’s development, this has shifted with agriculture contributing only 20% of the country’s gross domestic product in 2010. Other industry (48%) and services (42%) now contribute larger shares.
Table 1: Key country indicators – health and development

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>1990-1999</th>
<th>2000-2009</th>
<th>2010-PRESENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Financing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Economic Development</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Workforce</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSICIANS (per 1000 population)</td>
<td>0.4 (1990)</td>
<td>0.5 (2001)</td>
<td>1.3 (2012)</td>
</tr>
<tr>
<td>NURSES AND MIDWIVES (per 1000 population)</td>
<td>N/A</td>
<td>0.8 (2002)</td>
<td>1 (2010)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL PRIMARY SCHOOL NET ENROLLMENT (% of primary school age children)</td>
<td>87% (1990)</td>
<td>95% (2005)</td>
<td>97% (2009)</td>
</tr>
<tr>
<td>ADULT LITERACY RATE (% of males (M) and % females (F) aged 15 and above)</td>
<td>94(M) 87(F)(1999)</td>
<td>94(M) 87(F)(2000)</td>
<td>95(M) 91(F)(2011)</td>
</tr>
<tr>
<td><strong>Environmental Management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACCESS TO CLEAN WATER (% of population with access to improved source)</td>
<td>58 (1990)</td>
<td>77 (2000)</td>
<td>95 (2012)</td>
</tr>
<tr>
<td><strong>Urban Planning/Rural Infrastructure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Human Development Index</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VALUE (reported along a scale of 0 to 1; values nearer to 1 correspond to higher human development)</td>
<td>.44 (1990)</td>
<td>.53 (2000)</td>
<td>.62 (2012)</td>
</tr>
<tr>
<td>COUNTRY RANK (2012)</td>
<td></td>
<td></td>
<td>127</td>
</tr>
<tr>
<td><strong>Good Governance</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTROL OF CORRUPTION (extent that public power is used for private gain)</td>
<td>-0.43 (1996)</td>
<td>-0.60 (2000)</td>
<td>-0.56 (2012)</td>
</tr>
</tbody>
</table>

* See Table 2 for data on coverage of key RMNCH indicators.
+ Sources: World Development Indicators,18 UNDP,15 World Bank (Worldwide Governance Indicators);19 General Statistics Office of Viet Nam Database;20 UNICEF/WHO Joint Monitoring Program Water and Sanitation Vietnam Data;21 Viet Nam Joint Annual Health Report, 2013,22 Viet Nam National Institute of Nutrition Database.23
### Table 2: Key RMNCAH indicators

<table>
<thead>
<tr>
<th>Continuum of Care Stage</th>
<th>Indicator</th>
<th>Most Recent Available</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepregnancy</td>
<td>DEMAND FOR FAMILY PLANNING SATISFIED (% of women age 15-49 with met need for family planning)</td>
<td>78 (2011)</td>
<td>MICS, 2011</td>
</tr>
<tr>
<td></td>
<td>ANTENATAL CARE (% of women attended at least four times during pregnancy by any provider)</td>
<td>60 (2011) 89.4 (2012)</td>
<td>MICS, 2011 MoH, 2013 (at least three ANC visits during three trimesters)</td>
</tr>
<tr>
<td></td>
<td>TRAINED HEALTH PERSONNEL AT BIRTH (as % of total births)</td>
<td>97.9 (2012)</td>
<td>MoH, 2013</td>
</tr>
<tr>
<td></td>
<td>POSTNATAL CARE FOR MOTHERS (% of mothers who received care within two days of childbirth)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Pregnancy to postnatal</td>
<td>INFANT FEEDING (Exclusive breastfeeding for first six months)</td>
<td>19.6 (2010)</td>
<td>NIN, 2011</td>
</tr>
<tr>
<td></td>
<td>IMMUNIZATION (Children ages 12-23 months receiving DTP3)</td>
<td>95 (2011)</td>
<td>WHO and UNICEF, 2012</td>
</tr>
<tr>
<td></td>
<td>PNEUMONIA (Antibiotic treatment for pneumonia)</td>
<td>68 (2011)</td>
<td>MICS, 2011</td>
</tr>
<tr>
<td></td>
<td>STUNTING PREVALENCE (% of children under 5 who have low height for age)</td>
<td>25.9 (2013)</td>
<td>NIN, 2013</td>
</tr>
</tbody>
</table>

Sources: MICS: Multiple Indicator Cluster Survey;²⁴ MoH: Ministry of Health;²² NIN: National Institute of Nutrition;²⁵, ²⁶ VAAC;²⁷ WHO and UNICEF.²⁸

### Figure 1: Relationship of multisectoral & health policies and maternal health outcomes
4. Key Trends, Timelines and Challenges

The Millennium Development Goals have become a guiding framework for action in many low and lower-middle income countries including Viet Nam. Five of the MDGs are closely related to health (MDG 1, 4, 5, 6 and 7) and a number of health policies, strategies and National Targeted Programmes (NTPs) have been developed to steer the national response for achieving the related MDGs. Viet Nam has achieved or is on track to meet the targets for MDG 1: to eradicate extreme poverty and hunger; MDG 4: to reduce child mortality; MDG 5: to improve maternal health; and parts of MDG 7: to ensure environmental sustainability, notably achieving goal 7c to halve the proportion of the population without sustainable access to safe drinking water and basic sanitation. Other MDGs are critical determinants of health, specifically MDG 2: to achieve universal primary school education, and MDG 3: to promote gender equality and empower women. Viet Nam has made considerable progress, achieving both these MDG targets ahead of 2015.

**MDG 4 and 5 trends and challenges**

Viet Nam has achieved sustained reductions in infant (under 1 year) and child (under 5 years) mortality, and is on track to meet its MDG 4 target having reduced child mortality by 60%, from 58/1000 to 23.2/1000 live births between 1990 and 2012 based on national data. The UN Inter-agency Group for Child Mortality Estimations supports this result reporting a reduction of 55% from 51 to 23/1000 live births over the same period. Considerable progress has also been made in reducing maternal mortality with Viet Nam on track to meet its target for MDG 5a having reduced maternal mortality by 70%, from 233/100 000 to 69/100 000 live births from 1990 to 2009 based on national data. Updated global estimates from 1990 to 2013 are reporting a reduction of 65 percent from 140 to 49/100 000 live births.

**Figure 2: MDG 4 progress - under 5 and infant mortality rates**

Viet Nam's fertility rate (total births per woman) declined rapidly from the 1970s when it was estimated to be six, down to four by the early 1990s and two by 2000. It has been relatively stable since 2000. Good progress has been made to expand access to quality reproductive health, including family planning and increased use of modern contraception, with the contraceptive prevalence rate (CPR) increasing from 74% in 2001 to 80% in 2008 for the age group 15–49 years.

However, progress in meeting both MDG 4 and 5 has been inequitable and there are disparities in health outcomes between population groups. Key challenges to progress towards the MDG targets have included.

Geographical barriers and inequity: Viet Nam is home to rural populations in remote areas, posing geographical and cultural challenges in access to health care. The highland regions in Northwest and Central Viet Nam are more difficult to service than the Mekong and Red River Deltas. Interventions requiring significant support from the health system or multiple service points, such as multiple antenatal care visits, are the most inequitably distributed. There is also evidence of disparities by poverty level, educational level of mothers, and ethnicity.

Figure 3: MDG 5 progress - maternal mortality ratio and fertility rate

High out-of-pocket health expenditure: The Doi Moi reforms resulted in a significant proportional reduction in health spending by the state with public health facilities being permitted to charge user fees (except for commune health centres), and private health services legalized since 1989.\textsuperscript{41} Health services have been increasingly financed by out-of-pocket payments, which reached a peak of 68% of expenditure on health in 2005. Out-of-pocket payments have since reduced, but remain high at around 50% in 2012.\textsuperscript{22} Due to the rapid reduction in poverty, increases in personal income were able to supplement lower state spending by way of out-of-pocket expenditure.\textsuperscript{42} However, the poor and near poor have been disproportionately disadvantaged and gaps in health access and outcomes have developed. The Social Health Insurance (SHI) scheme, operating since the mid 1990s has become an important source of funding for the health care system with 67% of the population able to access this scheme by 2011.\textsuperscript{22} All poor people, children under 6 years, ethnic minorities living in remote areas and other vulnerable or meritorious groups are fully covered by the SHI scheme.\textsuperscript{43} To date the SHI scheme covers mainly curative treatment at health facilities so some preventive services are not covered, for example those required for good quality antenatal care such as syphilis screening and iron-folate supplementation.

Table 3: Factors associated with mortality declines, 1990-2012

<table>
<thead>
<tr>
<th>Factors influencing child mortality declines</th>
<th>Factors affecting maternal mortality declines</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved coverage of essential immunizations</td>
<td>Improved contraceptive prevalence and low unmet need</td>
<td>Wide variations in coverage of maternal and child health interventions and nutritional status by geographic area; reduced coverage in poor, less educated, remote rural, and ethnic minority populations.</td>
</tr>
<tr>
<td>Vitamin A supplementation</td>
<td>Decreased fertility rate</td>
<td>Quality of care for antenatal care, routine delivery, emergency obstetric and newborn care, immediate postpartum and postnatal care needs improvement</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Increased median birth interval – to 34 months</td>
<td>Inequities in income, infrastructure and availability of education continue; remote rural and less educated populations are more difficult to reach</td>
</tr>
<tr>
<td>Birth spacing</td>
<td>High proportion of deliveries with trained health personnel, facility deliveries</td>
<td>Greater focus needed to reduce neonatal deaths which are now estimated to account for over 60% of all infant deaths in Viet Nam\textsuperscript{12}</td>
</tr>
<tr>
<td>Sufficient skilled health workforce from 1980s onwards</td>
<td>Sufficient skilled health workforce from 1980s onwards</td>
<td></td>
</tr>
<tr>
<td>Integrated Management of Childhood Illness and prior ARI/CDD programmes</td>
<td>Access to safe abortion</td>
<td></td>
</tr>
<tr>
<td>Management of malnutrition</td>
<td>Access to emergency obstetric care</td>
<td></td>
</tr>
</tbody>
</table>

Economic, environmental, and educational improvements

- Proportion of the population that is below the poverty line (58% in 1993 to 14.5% in 2008)\textsuperscript{10,45}
- Per capita income ($972 in 1990 to $4998 in 2012)
- Female literacy (70% in 1990s to 91.4% in 2011)
- High net enrolment in primary education (98% in 1998)
- Access to improved drinking-water (58% in 1990 to 96% in 2011)
- Access to improved sanitation (37% in 1990 to 75% in 2011)
- Poorest and youngest people covered by health insurance for curative treatment
5. Health Sector Initiatives and Investments

Health sector factors

Health sector investments

Since 1990, government health expenditure per capita has increased in Viet Nam as in all 10 high-performing countries. Viet Nam's progress against its MDG 4 and 5 targets has in part been attributed to the country’s ability to link maternal, neonatal and child health interventions to broader health system investment.\(^{46}\)

The total health expenditure per capita in Viet Nam (public and private expenditure, purchasing power parity, PPP, Int$), has increased almost five-fold from $49 in 1995 to $233 in 2012.\(^{47, 48}\) This increase has coincided with a reduction in the proportion of out-of-pocket health expenditure from 63% to 49% over the same period. Improvements in the provision of RMNCH services, through improved facilities, hospitals, clinics and training of medical staff, have also led to improvements in health outcomes.

Reproductive health services are provided by a service delivery network ranging from central to commune-level provision. Every province in Viet Nam has reproductive health centres and most district health centres also provide reproductive health services. At the local level, 99% of communes have health centres, 93% of communes have midwives and 66% have doctors; 84% of hamlets and villages have health care workers. All hamlets and residential blocks have volunteer family planning collaborators.\(^{14}\)

Viet Nam is one of several high-performing countries to have increased its physician workforce since the 1990s, and has established a professional midwives' association that is affiliated to the International Confederation of Midwives (ICM). The capacity of the health workforce has been boosted by the targeted use of village health workers. Village Health Workers have recently been recognized with increased remuneration for their services from the government. In addition, the MoH with support from UNFPA developed innovative solutions to improve maternal health in remote, ethnic areas where the maternal mortality ratio is three to four times higher than the national ratio. Since 2000, one major hospital in Ho Chi Minh began training young ethnic minority women to become village midwives. This programme has been expanded to remote areas where local women are trained as village ethnic midwives for six to 18 months in provincial hospitals. The main roles of the village midwives are: health promotion, recognition of high-risk pregnancies, and providing support and encouragement to women to access health care and deliver at health facilities, or assist home deliveries where referral is not possible. Village midwives have also recently been officially recognized by the government allowing them to be remunerated. The government network of facilities is further bolstered by civil society organizations (CSOs) including nongovernmental organizations (NGOs), social organizations and other community partners.\(^{49}\) CSOs have focused on building and strengthening social capital in communities, mostly focusing on the most vulnerable groups. They have been able to implement innovative models of service delivery to reach remote ethnic minority groups.
Outcomes monitored using evidence
Viet Nam has made efforts to strengthen its vital registration system. The roles and responsibilities of the different ministries and government bodies regarding civil registration and vital statistics are established by a government decree. Although all deaths (including maternal deaths) are required to be registered within 15 days, and the level of reporting of deaths in hospitals is high, not all maternal deaths are captured through the civil registration system. At the commune level, the commune health station staff are responsible for reporting on vital events.14

The National Health Survey (NHS) also includes a monitoring and evaluation (M&E) plan. The RMNCH M&E plan includes all 11 indicators recommended by the Commission on Information and Accountability. The data are published on the website of the Ministry of Health (MoH), allowing a wider range of stakeholders to use the information and to facilitate transparency of results.

Additionally, the National Assembly is active in monitoring the implementation of critical health and related legislations, such as the National Health Insurance Law (2009), the Labour Code (1994 and updated in 2014) and the Law on Child Protection, Care and Education (2004). Central-level ministries coordinate among themselves and with provincial- and district-level leaders on monitoring missions, visits and meetings at the provincial and district levels, to actively monitor the implementation of relevant RMNCH-focused legislations. The missions’ findings are documented and reported to the MoH.14

Political prioritization of essential health interventions
The expansion of reproductive health and family planning services, particularly to underserved populations, has been a core strategy to help reduce maternal mortality across high-performing countries, including Viet Nam.

Viet Nam’s National Strategy on Reproductive Health Care for the period 2001–2010 is a policy targeted at improving reproductive health and reducing child and maternal mortality (see Health sector spotlight). The strategy aims to maintain the trend in decreasing fertility, while ensuring the rights of women and couples to have children and select quality contraceptives and reduce unsafe abortions. It aims to improve the health status of women and mothers, to deliver reproductive health care and to improve reproductive and sexual health of adolescents through education and counselling in school and out-of-school settings. Education will include increasing awareness about sexuality, safe sex, and HIV/AIDS and other sexually transmitted diseases in the general population. The Ministry of Health developed the Maternal Mortality Audit (MMA) with support from, UNICEF, WHO and the United Nations Population Fund (UNFPA) to better understand the cause of maternal deaths in Viet Nam. The government has been working on expanding the MMA to the whole country since 2000.50 As of 2012, a National MMA Committee has been established and the MMA has been implemented in all provinces.
Historically, accurate estimates for the maternal mortality ratio (MMR) in Viet Nam have been difficult to determine due to the inherent complexities in gathering maternal death data. A maternal mortality study was conducted in 2000-2001 in seven provinces representing diverse geographical areas in Viet Nam and the outcomes were extrapolated to give a national ratio. A national MMR of 130 per 100,000 live births was estimated, ranging from 45 to 411 per 100,000 live births in the different provinces. Other earlier estimates from Ministry of Health and international agency sources indicated an MMR of between 95 and 160 per 100,000 live births. The finding that the MMR had probably not substantially decreased in the previous five years triggered a response from the Ministry of Health.

The 1994 International Conference on Population and Development in Cairo urged countries to broaden their approach to reproductive health to include reproductive health rights, gender equity and empowerment and education. The Global Safe Motherhood Initiative was launched in 1987 and 10 years later, Ministry of Health representatives from Viet Nam attended a technical consultation to review progress and agree on essential actions to improve maternal health over the next decade. At the same time, the commitment to meeting MDGs was a strong political factor that was shaping the agenda for skilled birth attendance.

It was into this context that the Viet Nam National Reproductive Health Strategy 2001-2010 was developed. The results from the maternal mortality study further led the development of the National Safe Motherhood Plan 2003-2010 to address the continuing high rates of maternal mortality, as well as a National Master Plan of Action (2006–2010) and Vision (to 2020) for Adolescents and Youth to address the issue of adolescent reproductive health. Significantly, the Government of Viet Nam prioritized reducing maternal mortality (MDG 5) through the Strategy for Protection and Care of the People’s Health 2001–2010, Five-Year Socio-Economic Development Plan 2006-2010 as well as the Reproductive Health Strategy 2001-2010. Funding for implementation of the National Safe Motherhood Plan and National Master Plan of Action came from central government sources as well as development partners.
**Antenatal care and birth attendance by trained health workers:** Enhanced antenatal care has been identified as an important factor contributing to safer deliveries and a reduction in obstetric complications, maternal mortality and neonatal deaths. Viet Nam’s MoH recommends at least three antenatal care visits\(^5\) and the number of women receiving at least three checks increased from 42% in 1997 to 89% in 2012. The WHO-recommended four antenatal check-ups increased from 15% in 1997 to 60% in 2011 (see Table 2: Key RMNCH coverage indicators). The overall coverage of births attended by trained health workers has also increased from 77% in 1997 to 98% of births in 2012.\(^2\), \(^3\) However, geographic, economic and ethnic disparities exist for both antenatal care and skilled birth attendance with a far lower proportion of births occurring in health facilities or with a trained health worker in rural and remote areas.

**Tetanus vaccination for pregnant women:** In line with the World Health Organization (WHO) recommendations on maternal and neonatal tetanus elimination, Viet Nam has prioritized tetanus immunization during pregnancy as an essential intervention. In 2008, the national average percentage of pregnant women receiving at least two doses of tetanus vaccination stood at 94.8%; all the regions have upwards of 90% coverage for this indicator (with the exception of the Northwest).\(^1\)

**Increasing the use of contraceptives and family planning services:** The use of contraceptives among women aged 15 to 49 years increased from 74% in 2001 to 80% in 2008. The CPR for those aged 35–44 was close to 90% in 2008, compared to around 85% in 2001. The usage rates have been mostly constant across provinces. The use of modern contraceptive methods has also increased. These achievements stem largely from the expansion of the reproductive health care service network from central to provincial level.\(^4\) The met need in Viet Nam for contraception is 78% (see Table 2: Key RMNCH coverage indicators). However, unmet contraceptive need for young single sexually active women is high and abortions are common. Reproductive and sexual health education and access to youth friendly services for adolescents is a great need. Access to the Internet for reproductive and sexual health information is used extensively by urban young people; however, other approaches may be needed for youth in rural areas.

**Improving child health:** Viet Nam has implemented targeted interventions to improve child health including the earlier Acute Respiratory Infection and Control of Diarrhoea Programmes, and in 1996 the Integrated Management of Childhood Illness (IMCI) programme. Most medical schools and about one third of nursing schools incorporate IMCI into the preservice training curricula. The Expanded Programme for Immunization was introduced in 1981 to Viet Nam. Since that time the programme has demonstrated major public health impact in reducing morbidity and mortality of vaccine preventable diseases. Current immunization coverage rates are over 90%. In 2008 the Plan of Action to Accelerate the Reduction of Stunting was launched and then incorporated in the National Nutrition Strategy 2011-2020, and the National Action Plan for Child Survival (2012-2015) is being implemented. The Viet Nam UNICEF Child Survival and Development Programme adopted a multisectoral approach to tackling the issue of mortality among children under the age of 5 years. The programme explicitly focused on targeting the disadvantaged population groups such as ethnic minorities and the poor in urban and rural areas. It addressed financial, supply and demand barriers to accessing maternal, newborn and child health care, along with nutrition and water and sanitation.
Legal and financial entitlements, especially for underserved populations

Viet Nam’s focused effort to target rural and marginalized populations has been a key factor in its progress towards its MDG 4 and 5 targets.\(^{46}\) Universal coverage is a stated objective of the government’s health systems and investment policies. The State’s commitment to subsidized premium payments and developments in the health care, financing and payments systems are key to achieving this goal.\(^{43}\) Viet Nam doubled its social security health expenditure as a percentage of general government health costs from 20% in 2002 to just short of 40% in 2011. The proportion of health expenditure funded by out-of-pocket expenditure has fallen over this time: Viet Nam is one of six high-performing countries, alongside Cambodia, China, Ethiopia, Nepal and Rwanda, to have effected such a reduction.\(^{48}\)

Various forms of health insurance schemes have been implemented across high-performing countries including Viet Nam, to provide financial protection against catastrophic health care costs and help achieve universal coverage. The Health Care Fund for the Poor (HCFP) was created in 2003 in order to increase access to health services for the poor and marginalized. In 2009, the National Health Insurance Law was established, outlining an implementation plan for the national health insurance policy and its aim to achieve universal health coverage by the year 2014 (see Health care financing spotlight). Participants are eligible for a health insurance card, which enables them to access health care from government health facilities. The National Health Insurance Law (2008) identifies the most vulnerable groups – the poorest, and children under the age of 6 years – and looks to address their health care needs.\(^{53}\) In 2013, the coverage rate of the social health insurance system was 67%.\(^{22}\)
The HCFP was created in 2003 in order to increase access to health services for the poor and marginalized sections of the population. It was designed in accordance with the following broad principles:

- Funded primarily by the central government, with some contribution from the provincial governments;
- Sets out clear eligibility criteria in terms of the target population;
- Covers all levels of health care service delivery, from the commune level and upwards;
- Establishes clear guidelines for implementation.

The HCFP was administered by provincial health offices, and the programme aimed to provide free health care to poor households and ethnic minorities in the mountainous regions of Viet Nam. Additionally, the programme also identified children under the age of 6 years as target beneficiaries. The beneficiaries were issued with a free health care card for availing services. After the introduction of a new National Health Insurance Law in 2009, the HCFP was converted into the Compulsory Social Health Insurance (SHI) scheme, which entitled beneficiaries with health insurance to health care fully subsidized from government revenues.

An impact evaluation found the programme to be well-targeted at the poor, with more than half of the programme beneficiaries in 2004 being in the poorest 20% of the country’s population (2004).

The evaluation also concluded that the programme has been successful in increasing the utilization of services and has reduced the risk of catastrophic out-of-pocket spending. The initial impact of the programme, however, was more pronounced for inpatient care than for outpatient care. By 2007, it was estimated that 18% of the country’s population (around 15 million people) was covered by the HCFP.
6. Initiatives and Investments Outside the Health Sector

**Education**

Viet Nam is one of several high-performing countries to have prioritized improvements in education for several decades, highlighting it as a key tool for country development.

The Viet Nam Government signed the World Declaration on Education for All in 1990; the following decade saw the introduction of the Law on Universalization of Primary Education (1991) and the Law on Education (1998). The introduction of legislation and national programmes to introduce universal and free education is a common theme across high-performing countries. By 2009, Viet Nam had a net enrolment rate in primary school of 95.5%; primary school completion rate of 88.2%; and literacy rate of 97.1% for those aged 15-24 years. Viet Nam has made good progress in promoting gender equality, increasing girls’ participation in education and towards its MDG 3 target of eliminating gender disparity in education. Importantly for maternal and child health, Viet Nam has made striking improvements in secondary school enrolment with a more than doubling from 30 to 62% between 1993 and 1998, and to 79% by 2006.

Its MDG 3.1 target (ratio of girls to boys in primary, secondary and tertiary education) has already been met.

Significant progress has been made across many high-performing countries towards achieving universal primary education: Viet Nam has made good progress to meet targets for net enrolment ratio in primary education, completion of primary education, and on improving the literacy rate of 15–24 year-olds. In 2010, the adult literacy rates for males and females aged 15 years and above were 95% and 91% respectively (see Table 1: Key country indicators).
Nutrition

Viet Nam has made good progress on reducing the prevalence of underweight children under 5 years of age: the prevalence of stunting in Viet Nam declined significantly from 57% in 1990 to 36.5% in 2000 and to 25.9% in 2013, while that of underweight children declined from 51.5% to 33.8% to 15.3% in the same period.\textsuperscript{25, 26, 58}

The government has introduced a number of laws and policies to tackle nutrition issues, with support from multilateral agencies, such as WHO and the United Nations Children’s Fund (UNICEF). In Viet Nam, recent developments have included the introduction of the ten-year National Nutrition Strategy (2011–2020), National Action Plan for Nutrition (2012-2015), and National Action Plan for Infant and Young Child Feeding (2012–2015) (see Multisector spotlight).

The integration of nutrition programmes and alignment of policies, stakeholders and donors across sectors to improve nutrition has been effective in Viet Nam. The Viet Nam Government has worked with multilateral agencies on a variety of interventions: e.g. developing behaviour change communication campaigns; promoting breastfeeding; regulating the trading and use of breast milk substitutes; extending maternity leave from four to six months; and improving the nutrition surveillance system.

Infrastructure, water supply and sanitation

High-performing countries such as Viet Nam have introduced community-based programmes for water, sanitation and infrastructure, which have been identified as key contributors to improvements.

Viet Nam’s national programme for Hunger Eradication and Poverty Reduction (HEPR) and Programme 135, launched in 1998 and aimed at marginalized and poor households and ethnic minorities, prioritized development of basic infrastructure incomes in all communes. Communes were provided with the resource allocation to invest in identified local projects of their choosing, including roads, health centres, schools and irrigation and water supply systems.\textsuperscript{45}

Viet Nam has made good progress towards increasing the proportion of the population using an improved drinking-water source and improved sanitation facility respectively. The Rural Water Supply and Sanitation national target programme under the Ministry of Agriculture and Rural Development and the Ministry of Health began its first phase in 1998, and is now into its third phase (2011-2015). The percentage of the population with access to improved sanitation facilities increased significantly from 37% in 1990 to 75% in 2012.\textsuperscript{21} Over the same period, the percentage of the population with access to improved water sources increased from 58% in 1990 to 95% in 2012.\textsuperscript{21} Progress has been equitable, narrowing the gap between rural and urban populations with access to improved water sources. In 1990, 49% of rural and 88% of urban populations were using an improved drinking-water source; by 2010, 93% of rural and 99% of urban populations had access.\textsuperscript{32}

More recently, drinking-water quality is being focused on with a Government Decree on the Regulation on Water Safety and a circular outlining guidelines on water safety. The Ministry of Health under the Department of Health and Environmental Management Administration with support from WHO is developing systems for water quality monitoring and surveillance for urban and rural areas.
Progress in sanitation has lagged behind improved water sources but is now receiving greater attention from the government and partners. In 2008, the Ministry of Agriculture and Rural Development initiated a more coordinated approach between various development partners and the government for the improvement of drinking water and sanitation.

Reductions in stunting have been shown to be closely linked to improved sanitation, particularly the decrease in open defecation and access to improved water supply (see Figure 5).

**Figure 5: Stunting and hygiene**

![Stunting and hygiene graph](image)

**Innovation and research**

Trends in increasing mobile phone usage have been identified across high-performing countries. In Viet Nam, mobile and electronic technologies have been used to improve reporting, data collection, access to data, data storage, referrals and communication between patients and health care providers. Viet Nam has developed e-health capabilities by putting in place an overarching information, communication and technology (ICT) strategy for all sectors, and the MoH has also developed its own ICT strategy. All hospitals at the provincial level and 75% of hospitals at the district level have Internet connectivity. E-health services and applications are developing, although data collection, management and analysis for health care monitoring are still in early stages.
Spotlight of a sector outside of health

NUTRITION

Improving nutrition has been a key priority for the Government of Viet Nam. The National Institute of Nutrition was established in 1980 by the government under the Ministry of Health in order to provide technical assistance and support to the government to improve the poor nutritional status of the population following the war. The Prime Minister, indicating the high national priority of nutrition, ratified the first National Plan of Action for Nutrition 1995-2000, and all subsequent National Nutrition Strategies (2001-2010 and 2011-2020). These multisectoral strategies focused on improving knowledge of nutrition; reducing maternal and child undernutrition; reducing micronutrient deficiencies; and improving food security at a household level. The 2001-2010 strategy linked with the Hunger Eradication and Poverty Alleviation Strategy and safe water and environmental sanitation as key aspects of improving the nutritional status of the population. The integration of nutrition programmes and alignment of policies, stakeholders and donors across sectors to improve nutrition has been effective in Viet Nam. The Viet Nam Government has worked with multilateral agencies on a variety of interventions: e.g. developing behaviour change communication campaigns; promoting breastfeeding; regulating the trading and use of breast milk substitutes; extending maternity leave from four to six months; and improving the nutrition surveillance system. Recent developments have included the Action Plan for Infant and Young Child Feeding (2012–2015).

In addition, reductions in stunting are closely associated with improved sanitation, particularly the decrease in open defecation. Viet Nam has made considerable progress towards increasing the proportion of the population using an improved drinking-water source and improved sanitation facilities contributing to healthier families and a decline in child stunting. Although the reduction of underweight children continues to advance, from the mid-2000s stunting reduction had stalled (see Annex 2). In 2008, the National Institute of Nutrition together with support from partners, developed the Plan of Action to Accelerate the Reduction of Child Stunting. This was subsequently incorporated into the National Nutrition Strategy 2011-2020.
7. Key Actors and Political Economy

In the 1980s, good access to health care and corresponding good health outcomes relative to other countries with a similar GDP was the legacy of the central planning era with its strong political commitment to equity and universal coverage. Viet Nam has continued to make remarkable progress since the Doi Moi reforms that saw the country transition from a centrally controlled to a market economy. However, due to the reform policies that included the introduction of user fees and private practice, gaps in access to social services and in other human development outcomes have emerged between poor and rich, rural and urban areas, and between ethnic minority groups and the majority Kinh people. The overarching National Target Programme for Hunger Eradication and Poverty Reduction began in 1998 together with Programme 135. The latter was especially targeted at improving the lives of ethnic minorities and had priorities to reduce the proportion of poor households to below 10% and eliminate chronic hunger through: provision of jobs; reducing unemployment; and improving basic infrastructure in poor communes (access to electricity, improving roads for transportation, small scale irrigation, improving schools and improving health facilities). These programmes have contributed greatly to the overall development of Viet Nam.60

8. Governance and Leadership

Viet Nam is one of a few high-performing countries to have made open commitments to enable civic participation and improve government accountability and transparency to the public. The National Assembly has constituted a parliamentary committee on social affairs, which is also responsible for health issues, and organizes forums and monitoring missions of members of parliament on RMNCH. The government has a high degree of coordination with civil society organizations (CSOs); such collaborations have helped to create evidence on best practices and influence policy through advocacy. NGOs have also contributed particularly to health promotion and service delivery in remote areas.

The Vietnamese media play an active role in disseminating information about RMNCH issues, and are supported by a number of national bodies towards this end.50 Viet Nam appears committed to facilitating improvements in the public's access to information.
9. Lessons Learned and Future Priorities

The convergence of greatly improved determinants for maternal and child health including economic development, education, water and sanitation, adequate health personnel, and accessible and affordable health services have resulted in Viet Nam’s achievement towards meeting MDG 4 and 5. However, despite the significant progress, key challenges need to be addressed to ensure that the gains made so far are maintained and that further progress is accelerated.

**Equitable access:** Inequalities in infant and under 5 mortality between the poor and better off have continued to widen in Viet Nam. Geographic inequalities are also widening: Viet Nam’s richer south and Red River Delta have reduced infant mortality faster than the poorer central and northern regions of the country. Ethnic inequities are also present for maternal health care utilization. As in the majority of high-performing countries, reducing inequity is key to improving maternal and child health outcomes. In Viet Nam, critical actions needed to improve equitable access include: addressing financial barriers to access; investing in health systems in marginalized areas; and strengthening communication and transportation networks. The MoH-led, joint UN-supported review of equity- and health-related MDGs is a positive step, and the resolution from the Prime Minister to all provinces issued in January 2014 is a political reaffirmation of the significance of health-related MDGs to the socioeconomic development agenda and goals, and could help advocate for resource allocation to address equity issues.

**Health service quality:** Viet Nam has achieved remarkable coverage of health facilities and health workforce allowing access and availability of health services down to commune level. However, improving the quality of care is urgently needed to build on gains in maternal and child health.

**Neonatal intervention quality and coverage:** Despite significant progress in reducing child mortality, a greater focus on newborn health is needed in Viet Nam. Neonatal mortality in Viet Nam is estimated to account for over 60% of all deaths in infants under 1 year of age and over 50% of all deaths in children under the age of 5 years. Viet Nam is placed relatively low on the global ranking for neonatal deaths within the first 28 days of life (84 of 187 countries) and for infant mortality rate ranked 92 of 188 countries. To ensure that child mortality is further reduced, investment is required to: improve antenatal care; update clinical protocols for routine newborn care, and care and referral of high risk newborns; ensure better coverage of birth registrations; bolster the service quality and delivery infrastructure in the remote and mountainous regions of the country; and promote sound practices to encourage women to travel and stay at facilities around the time of delivery for safe birth.
**Maternal health intervention quality:** Although great progress has been achieved in reducing maternal mortality in Viet Nam, provision of resources to district facilities is still required. These include resources to undertake comprehensive emergency obstetric care including safe caesarean sections; blood transfusions; early referrals for high-risk pregnancies; and addressing unmet need for contraception including postpartum and post-abortion family planning. In addition, scaling up training of ethnic village midwives is needed for very remote villages to offer routine care; detection and referral of high-risk pregnancies; and basic emergency obstetric and newborn care where referral is not possible.

**Malnutrition and stunting:** Childhood malnutrition remains a key challenge for Viet Nam. Despite the progress made, there are opportunities for better coordination between various sectors and ministries on addressing malnutrition (such as safe water, sanitation, hygiene and nutrition). Increased budget allocations to health care and for better routine data collection are required to address the issue of stunting.

**Youth awareness about reproductive health issues:** The limited awareness and access to youth friendly services in Viet Nam among youth about reproductive health issues can lead to unsafe sexual practices. A 2010 survey of youths highlighted that teenagers lacked adequate knowledge about sex. The unmet need for contraception among young people (age groups 15–19 and 20–24 years), especially for those unmarried, is also high, leading to a number of unwanted pregnancies and unsafe abortions, even though abortions are legal in Viet Nam. Interventions targeted specifically at youths and their particular needs are required.

**Scaling up sanitation and hygiene:** At present diarrhoea and pneumonia are estimated to contribute 10% and 12% of under 5 mortality respectively in Viet Nam. Related morbidity and mortality can be reduced with improved sanitation and critical hygiene behaviours. Although the proportion of households with hand-washing facilities with soap is very high (86.6%), only 25.5% of caregivers use soap for hand-washing after faecal contact and only 6.3% use soap for hand-washing before feeding a child. Only 75% of the population has access to improved sanitary facilities although access to improved water sources are high (95%). An improved policy, institutional and funding environment will be required, in order to internalize the latest approaches to community mobilization, pro-poor sanitation marketing, and hand-washing promotion.

High-performing countries such as Viet Nam have made significant progress in improving maternal and child health and have either met or are on track to achieve MDGs to reduce maternal and child mortality. This summary does not attempt to draw causal inferences linking improvements in RMNCH to the implementation of particular policies and programmes. Instead, the progressive policies and programmes discussed illustrate leading strategies in health, multisector and cross-cutting areas that have helped Viet Nam make progress on MDGs 4 and 5.

Viet Nam has shown significant commitment to reducing maternal and child mortality: collaboration between government, civil society and multilateral partners and a focus on community-based approaches have helped to sustain advances. However, further steps could be taken to ensure that progress is equitable across populations. In order to continue the advances made so far and further reduce the incidence of child and maternal mortality, increased efforts need to be made in reducing disparities in access by addressing geographical and financial barriers, improving neonatal (first month of life) intervention quality and coverage, addressing stunting and increasing youth awareness about reproductive health issues.
### Timeline with key policy inputs

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<thead>
<tr>
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<tr>
<td><strong>1981</strong> Government recommendation for a limit of 2 children per family with a birth interval of 3-5 years and minimum age of 19 years for having first child</td>
<td><strong>1991</strong> Law on Universalization of Primary Education</td>
<td><strong>2001-2010</strong> National Strategy for Reproductive Health Care; Strategy for Protection and Care of People’s Health; National Nutrition Strategy</td>
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<td><strong>1986</strong> <em>Doi Moi</em> (renovation) reforms</td>
<td><strong>1992</strong> Government Decree on Social Health Insurance</td>
<td><strong>2002</strong> Health Care Fund for the Poor</td>
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<td><strong>1988</strong> Government decree legalizing the 1981 recommendation to limit families to 2 children</td>
<td><strong>1993</strong> Land Law</td>
<td><strong>2003-2010</strong> National Plan on Safe Motherhood</td>
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<td><strong>1988</strong> Decollectivization of land</td>
<td><strong>1993</strong> Vitamin A deficiency control programme</td>
<td><strong>2004</strong> Law on Child Protection, Care and Education</td>
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<td><strong>1989</strong> Legalization of private medical practice; User fees allowed to be charged for public health facilities (except for commune health centres)</td>
<td><strong>1994</strong> Upgrading Commune Health Centre System</td>
<td><strong>2005</strong> Hanoi Core Statement (Paris Declaration on Aid Effectiveness)</td>
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<td><strong>1994</strong> The Labour Code</td>
<td><strong>2006-2010</strong> Five-year Socio-Economic Development Plan</td>
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<td><strong>1995-2000</strong> National Plan of Action for Nutrition</td>
<td><strong>2009</strong> Law on Examination &amp; Treatment</td>
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<td><strong>1998</strong> Promulgation of decree on health insurance to unify the provincial-level funds; Law on Education; National Programme for Hunger Eradication and Poverty Reduction and Programme 135 targeted at ethnic minorities; Child Malnutrition Control Programme</td>
<td><strong>2009-2015</strong> National Health Insurance Law; The National Action Plan for Child Survival</td>
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<td><strong>2010-2020</strong> National Strategy on HIV/AIDS Prevention and Control in Viet Nam</td>
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<td><strong>2011-2020</strong> National Nutrition Strategy</td>
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<td><strong>2012-2015</strong> National Plan of Action for Nutrition</td>
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<td><strong>2011-2020</strong> National Population and Reproductive Health Strategy</td>
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<td><strong>2011-2015</strong> Five-year Health Sector Development Plan; National Plan on Reproductive Health Care focusing on Safe Motherhood and Newborn Care</td>
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<td><strong>2012-2015</strong> Infant and Young Child Feeding Plan</td>
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10. Annex I

Conceptual framework:
Defining policy and programme success factors for women's and children's health

Political and economic context and overall governance

Health Sector Initiatives & Investments
- Leadership/Governance
- Health Financing
- Health Workforce
- Health Infrastructure/Supplies
- HIS/Research
- Health Service Delivery

Program Outputs
- Increased supply/access
- Increased demand
- Improved quality
- Improved information/knowledge

Increased Population Coverage
Of key RMNCH interventions

Improved Survival and Health

Other Initiatives & Investments
Education (of women/mothers), Nutrition, Infrastructure, Water & Sanitation
II. Annex 2

Data trends

### Child mortality trends

- **Under 5 mortality rate**
- **Infant mortality rate**

![Graph of Child mortality trends](source: GSO, GSO)

### Child mortality trends

- **Neonatal mortality rate**

![Graph of Child mortality trends](source: World Development Indicators, World Development Indicators)

### Maternal mortality & fertility trends

- **Fertility rate**
- **Maternal mortality ratio**

![Graph of Maternal mortality & fertility trends](source: Census and GSO, Census and GSO)

### Maternal mortality & fertility trends

- **Fertility rate**
- **Maternal mortality ratio**

![Graph of Maternal mortality & fertility trends](note: Dashed line indicates missing data. Source: World Development Indicators, World Development Indicators)

### Child nutritional status trends

- **Stunting**
- **Underweight**

![Graph of Child nutritional status trends](source: National Institute of Nutrition, National Institute of Nutrition)

### Child nutritional status trends

- **Stunting (height for age)**
- **Underweight (weight for age)**

![Graph of Child nutritional status trends](note: Dashed line indicates missing data. Source: World Development Indicators, World Development Indicators)
12. References


52. National clinical guidelines on reproductive health care services. Ha Noi: Ministry of Health; 2009.


13. Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<td>CDD</td>
<td>Diarrhoeal Disease Control</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>e-health</td>
<td>Electronic Health</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GSO</td>
<td>General Statistics Office</td>
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<td>HCFP</td>
<td>Health Care Fund for the Poor</td>
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<td>HEPR</td>
<td>Hunger Eradication and Poverty Reduction</td>
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<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome</td>
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<td>ICM</td>
<td>International Confederation of Midwives</td>
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<td>ICT</td>
<td>Information and Communication Technology</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<td>JAHR</td>
<td>Joint Annual Health Review</td>
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<td>LMIC</td>
<td>Low- and Middle-Income Countries</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MDA</td>
<td>Maternal Death Audit</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>MMA</td>
<td>Maternal Mortality Audit</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NGO</td>
<td>Non-governmental Organization</td>
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<td>NHS</td>
<td>National Health Survey</td>
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<td>NIN</td>
<td>National Institute of Nutrition</td>
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<td>NMR</td>
<td>Neonatal Mortality Rate</td>
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<td>NTP</td>
<td>National Targeted Programme</td>
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<td>PMNCH</td>
<td>Partnership for Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>PPP</td>
<td>Purchasing Power Parity</td>
</tr>
<tr>
<td>QCA</td>
<td>Qualitative Comparative Analysis</td>
</tr>
<tr>
<td>RMNCH</td>
<td>Reproductive, Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>SHI</td>
<td>Social Health Insurance</td>
</tr>
<tr>
<td>TFR</td>
<td>Total Fertility Rate</td>
</tr>
<tr>
<td>U5MR</td>
<td>Under 5 Mortality Rate</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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