



**WHO COUNTRY
COOPERATION STRATEGY
2003 - 2006**

VIET NAM

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World Health Organization Viet Nam Country Office

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LIST OF ABBREVIATIONS

ADB	Asian Development Bank
ARI	Acute Respiratory Infections
CDF	Children Development Fund
EDL	Essential Drug List
GDP	Gross Domestic Product
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IDUs	Injecting Drug Users
IMCI	Integrated Management of Childhood Illness
IMF	International Monetary Fund
ISG	International Support Group
MOET	Ministry of Education and Training
MOH	Ministry of Health
MPI	Ministry of Planning & Investment
NCD	Non-Communicable Disease
NEPI	National Expanded Programme on Immunization
NGO	Non-Governmental Organisation
ODA	Official Development Assistance
PHC	Primary Health Care
SIDA	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
TB	Tuberculosis
UN	United Nations
UNDAF	United Nations Development Assistance Funds
UNICEF	United Nations Children's Funds
VHI	Vietnam Health Insurance
VSI	Vietnam Social Insurance
WB	World Bank
WHO	World Health Organization

WPRO Western Pacific Regional Office (WHO)

WR WHO's Country Representative

“Standing still is the fastest way of moving backwards in a rapidly changing world”

1. INTRODUCTION

This WHO Country Cooperation Strategy (CCS) outlines the strategic framework for the WHO's work in Viet Nam for the period 2002 – 2006.

The CCS is an attempt to articulate a coherent vision and selective priorities for collaboration between WHO and Viet Nam. It is based on a systematic assessment of recent national achievements in health care, the current and emerging health needs and development challenges; the policies and expectations of the Government; and the activities of other development partners.

While a clear aim is to ensure greater responsiveness to country needs, the CCS also reflects WHO's own values, principles and corporate and regional strategies. Important elements include WHO's intention to be more selective in its range of activities and to foster strategic thinking and putting greater emphasis on its role as policy and technical adviser. WHO globally intends to broaden its partnerships at country level and work with other development partners in a complementary manner.

Since 1986 with the launch of *doi moi* (renovation), Viet Nam is undergoing profound and rapid social and economic transformations. These changes have important implications on the well being of the population and on the performance of the health system. The Government of the Socialist Republic of Viet Nam is committed to improving the health status of its people and ensuring equity in access to health care. Development agencies and donors in the health and social development are also engaged in rethinking their country strategies. And there is a widely acknowledged need to work more collaboratively to avoid duplications and increase efficiency in a field that at times appears to be increasingly “overcrowded”. Above all, there is a need for a carefully formulated reform package for the health sector that enables Viet Nam to maintain and build upon past successes of its public health system as it encounters new economic realities and public health challenges.

It is thus a particularly opportune moment for WHO to review its own country cooperation strategy in Viet Nam.

2. GOVERNMENT AND PEOPLE: HEALTH AND DEVELOPMENT CHALLENGE

The turmoil of the “*Doi Moi*”

In little more than a decade, Viet Nam has undergone dramatic economic and social transformation. The “Doi Moi” reform process marked the shift from a centrally planned to a “socialist oriented market economy under State management”, the development of the rule of law and the implementation of an open door policy with all countries. Main reforms included return to household-based farming in agriculture, removal of restrictions on private sector activities in commerce and industry, and the rationalization of the state-owned enterprises. It is generally accepted that this process, launched in 1986, has achieved considerable progress in improving the overall well-being of the vast majority of Vietnamese people. The real GDP per capita growth averaged more than 6% annually over the decade and Vietnam has graduated from being a rice importer to the world’s second largest rice exporter. Most notably, poverty has been reduced from an estimated 70% in the mid-1980s to 37% in 2001, as measured using the World Bank’s internationally comparable poverty line. Nevertheless, Viet Nam remains one of the poorest countries in the world, with a average GDP per capita of US\$ 400 in 2000. As many as 28 million people continue to lack the minimum income necessary to provide a decent standard of living. 48% of the population still lacks access to safe water, this figure amounts to 56% in the rural areas and 33.1% of children under 5 are underweight in 1999. The disparity between urban and rural welfare is widening and ethnic minorities in mountainous and remote areas have only benefited marginally from the development process. Inequalities are raising quickly, the difference in income distribution between the poorest and the richest quintiles went from 4.9 in 1992 to 8.9 in 1999.

The challenges in the years to come remain daunting. As stated in the 10 years socio economic strategy for 2001-2010, investment and economic growth is crucial for Viet Nam’s development into the next decade, however the main challenge will be in ensuring that all regions, social strata of the population and ethnic groups participate in and gain from the development process and that the country achieve higher and more equitable levels of human development. Beside the appropriate macro economic reforms, the socio economic strategy includes the pursuit of the public administration reform (the most pressing issue is civil service pay; salaries remain too low compared to average monthly households expenditure, poor performance and “survival” corruption are therefore almost inevitable), the strengthening of the rule of law, the support and improvement of the social sectors and the enhancement of the civil society. There are however considerable uncertainties and differences of opinions on the strategies to achieve these goals within the government and the international community, and the recently finalized Poverty Reduction and Growth Strategy Paper (PRGSP) does not provide a very detailed road map for the future.

Health situation

Although the country is among the poorest in the world, its vital health indicators are comparable to those of middle-income countries. Life expectancy for instance is 10 years longer for Vietnamese women than would be expected given the country’s level of development. Infant mortality (36.7 per 1000 live births) is at the same level than countries such as Brazil, Algeria, Turkey. Viet Nam has been highly successful long before Alma Ata (1978) in providing preventive health services, in controlling the spread of communicable diseases and in achieving good health for its population. This was achieved partly thanks to its extensive health care delivery network with a very strong

Primary Health Care component (9806 commune health centres and more than 600 district hospitals), its large supply of health workers and its very well organized national public health programmes, such as the Expanded Programme on Immunization (EPI).

Many of the *doi moi* reforms touched the health sector. With the advent of *doi moi* the commune health centres which used to depend for their financing from the agricultural work brigades, including for the salaries of the health workers had to rely on the People's committees. Funding was insufficient and the PHC system was close to collapse. In addition, the lack of resources had a negative impact on the hospitals. Faced with this situation and in view of the limited resources, the government introduced important health sector reforms, including user fees for health services, legalization of private medical practice and the deregulation of the pharmaceutical market. The number of private providers increased rapidly, however the government was not well prepared to regulate and monitor the quality of services. This combined with an under funded public sector had serious negative consequences in term of access to care for a large part of the population and quality of care. To overcome these problems, the government took over the payment of the health workers at commune level and create a social insurance in 1992 which covers 12 percent of the population. At the same time, the improvements in the well being of the population prevented any deterioration in the health status of the population. However, many of the problems faced by the health sector during the last 10 years have still not been solved.

Health problems

The health situation can be characterized as follows: (i) Still a high prevalence of chronic malnutrition among the under five population and of low birth weight; (ii) Relatively high maternal mortality and neonatal mortality, mainly in ethnic minorities and in remote areas and high rate of induced abortion; (iii) An unfinished agenda in infectious, vector-borne and communicable diseases although they represent now less than 25% of the causes of mortality (e.g. ARI and parasitic diseases in children, Hepatitis B, food borne related problems); (iv) a steady increase in non communicable diseases such as cardiovascular diseases, cancers, diabetes; (v) New or re-emerging diseases such as tuberculosis, HIV/AIDS, dengue fever and Japanese encephalitis are increasing. The number of officially reported cases of HIV in 2002 is around 40 000. Cases have been reported in all the provinces. However reported figures significantly understate the scale of the problem, it is estimated that at least 120 000 people are infected by HIV; (vi) Increasing importance of life-style related diseases (tobacco, alcohol and drug abuse, injuries-road accidents, violence, suicide, mental health); accidents are set to overtake infectious diseases as the most common causes of mortality – accounting for more than 20% of total mortality. Drug abuse is a growing concern, the vast majority of the 97000 registered drug users are under the age of 30; (vii) Emergence of high drug resistance to common antibiotics.

Considerable disparities in health status exist between different geographical regions and between population groups. In general, health indicators in the Mekong River Delta, the Central Highlands and the Northern Uplands are considerably worse than in the rest of the country. Maternal and infant mortality rates among ethnic groups are much higher than the national averages. Social inequalities increased although at a slow pace and infant mortality in the 20% poorest part of the population is increasing.

Health sector problems

Government budget for health is low: 3\$ per capita in 2000, this places Viet Nam behind China and the Philippines. A large share of government health spending is on hospitals and spending on public health services is greater in better-off provinces, as provincial health spending is partly financed by provincial governments. The budget allocated from the central level does little to redress this inequality between provinces and within provinces. The introduction of user fees in health facilities and the emergence of private practitioners and drug sellers led to a very high private spending on health, (80% of total health spending), which is mainly concentrated on pharmaceuticals. The total health expenditure therefore is relatively high (between 25 and 30\$ per capita per year) and places Viet Nam among those countries in Asia that spend the most on health care. As the exemptions system does not work properly and the social health insurance covers only a small portion of the population, there are increased inequalities between rich and poor in term of access to services. The poor utilize public health facilities less and spend less on health care in absolute term; however expenditure on health is a main cause of poverty. The low quality of care and the lack of patient oriented and user friendly approaches also prevent the health services to function to their full potential, even within the existing limited resources. This situation is partly due to the low salaries of the health staff. Preventive health programmes continue however to be successfully delivered through vertical approaches. Finally the lack of a strong legal framework for the private sector and of enforcement capacity leads to a very irrational use of resources, this is particularly true in the pharmaceutical sector with large expenditure on unnecessary and sometimes useless drugs.

Viet Nam to day is therefore faced with serious problems. The main challenge is to protect the achievements gained (in term of health outcomes and health services) and to ensure that the health system contribute fully to the improvement of the health of the population and the reduction of health inequalities. The Millennium development goals will be attained only if this happens.

Government response

The government has formulated in the Ten year Socio-Economic development strategy, in the CPRGS and in the strategy for people's health care for the years 2001–2010 ambitious goals and targets including substantially improving the human development index of the country, providing prevention and treatment to all people and increasing life expectancy to 70-75 years.

The new health strategy recognized the important role of health and the need to invest in health for an accelerated socio-economic development and for improving the quality of life of every individual. The strategy is based on four principles: (i) equity and efficiency of the health sector; (ii) fight against the broad social determinants of bad health; (iii) integration of traditional and modern medicine and (iv) appropriate public-private mix with the government in a position to protect the public interest.

The strategy outlines the main policies and proposals of the government for improving the overall level of health and the distribution of health among all the population (ethnic minority groups, women, children, poor and the elderly). These include:

Using more effectively the government budget and moving to prepayment schemes in the medium term for financing health.

Reviewing and strengthening the organization of the health sector, and consolidating and developing PHC/community based services.

Strengthening preventive care and health promotion, and improving curative care and putting in place an effective referral system.

Developing the human resources according to the need of each level and improving their training.

Developing traditional medicine and implementing the national drug policy in order to promote the rational and effective use of modern and traditional drugs.

Developing new technologies to catch up with other countries in the region.

Improving the capacity of planning and management in all areas within the health sector.

As it stands to day the strategy provides a broad basis for further planning and can be seen as an orientation document for the development of the health sector. However, it does not provide specific solutions on how: (i) to ensure an equal access to health care; (ii) to improve the performance of the health system and the quality of care; (iii) to rationalize the use of and the expenditure on drugs. (iv) to respond to the new public health problems including non-communicable diseases.

3. DEVELOPMENT ASSISTANCE AND COORDINATION

Overall trends in Aid

Prior to 1994 Viet Nam has received very limited support; the former Soviet Union and China were the most important donors till 1970. In the period immediately following the dissolution of the Soviet Union, support came mainly from the United Nations and a few major bilateral donors, including those long term donors such as Australia, Finland and Sweden, who had continuously provided assistance to Viet Nam since the 1970s. The impressive track record of the *doi moi* process, during the 1989-1993 period occurred when external assistance was quite modest. In that period, ideas were more important than money. One key role of the external agencies was to help the Vietnamese to be informed of relevant regional and international experience in relation to economic policies.

Donor support increased substantially after 1993, pledges averaged some US\$2 billion a year to reach a cumulative US\$17.5 billion between 1993 and 2000. So far, 80% of the total pledges have been translated into signed programmes. ODA funds are increasingly oriented towards major infrastructure (56% in 1999), particularly energy and transport, mainly highways. The underdeveloped rural road system receives only limited funds; the same applies for drinking water and sanitation although only half of the Vietnamese population has access to safe water and sanitation facilities. Human development is in the third position after policy and institutional support with US\$230 million, or 14% of

annual ODA in 2000, allocated to mostly education and health. Rural development is the fourth category, receiving 13% of total ODA disbursements in 2000. Other sectors include natural resource management and industrial development, and emergency and relief programmes. Main “donors” are Japan followed by ADB, the World Bank, France, Denmark and the UN-agencies. Large funds are also released by the international NGO community.

The type of ODA has also been changing during the last years. There has been a rise of capital investment programmes (62% of total ODA in 2000) followed by technical assistance (21%). The sectors of education, health, economic management and public administration continue to attract the bulk of technical assistance, mostly given on a grant basis. The changing composition of ODA is reflected in the structure of ODA with an increased share of loans: from 10% in 1993 to 72% in 2000.

An increased share of ODA is spent at provincial level (66%). Over the last five years all the regions have benefited from ODA, although not at the same extent. ODA per capita remains low in the Mekong Delta, North Central Coast, South Central Coast and in the Central Highlands, regions where a large proportion of the poor live.

Looking ahead, the Government projects that the financing required for the next 5 years socio-economic plan will be around US\$56-57 billion. These tentative plans imply that the ODA share of total investments is envisaged to remain largely the same as in the previous period, i.e. around 17% of the total investment. Viet Nam has been able to maintain firm control over its own development agenda and has not succumbed to aid dependence; however it is now faced with a difficult agenda of continuing policy reform and institutional change, along with the challenge of managing a large aid programme funded by a diverse range of donors. The increased share of loans also calls for proper attention given to investments in order to avoid the debt trap and aid dependency.

ODA to the health sector

Data on ODA to the health sector are often inconsistent and there are several estimates of the total amount, one of the reasons of this situation is that ODA to the health sector is channeled through different partners (central and local). However the health sector is a major beneficiary of the estimated \$2 billion ODA per year, it receives between \$50m and \$80m per year, most of it in the form of technical cooperation on a grant basis. According to MOH there are around 180 on going assisted projects in the health sector. Vertical disease control programmes, primary health care, reproductive health and family planning represent all together more than 60% of the total commitment. The remaining is divided between hospitals and sector policy and planning. New public health problems such as HIV/Aids, traffic injuries, occupational accidents, tobacco, NCD receive only limited support.

Major donors in health are at the end of 2000 the World Bank, the ADB, Japan, the UN agencies, Sweden, Australia, Germany and the European Community. The annual flow of resources going to the health sector has more than doubled between 1991 and 1999. However the government own resources as well as other sources of revenue such as user fees and health insurance have increased at a faster rate, so that the share of ODA in total public health spending has actually declined between 1991 and 1999. ODA accounts to

day for less than 10% of public spending on health.

ODA to the health sector is concentrated among few provinces: 15 provinces have received over the period 1991-1998 more than 80% of the total ODA to the health sector, although they account for only 31% of the country's population. Analysis shows that ODA is not targeted on the basis of a province's income level but more on the basis of donor priorities.

Mechanisms for coordination

One of the main issues in ODA in Viet Nam is the relatively low rate of disbursement; this is due to a rapidly growing number of donors with a vast array of different procedures and the lack of experience and capacity of the government to deal with important flow of ODA. In addition, donors often try to influence the pace or direction of reform, this has led to donor driven projects and lack of national ownership. Schemes such as CDF and UNDAF do not seem to have a major impact on aid coordination and management. The Socio-economic development strategy 2001-2010, the CPRGS and the sectoral strategies and plans should provide a framework for a more coordinated ODA.

Some progress has however been made in donor-government relations: roles and responsibilities have been defined more clearly, capacity has been strengthened and there is a large number of partnership groups between donors and the government, which provide a forum for increased policy dialogue. However from analysis of the past, three clear principles emerge: (i) the success of the aid programme over the long term will require that policies, institutions and spending reinforce each other; (ii) priorities must be set nationally and leadership in the partnership should be provided by the Vietnamese authorities; (iii) aid coordination is the responsibility of the government, but substantial support to enhance its aid coordination capacity should come from the international community.

The scale of donor assistance has overwhelmed the Ministry of Health and often overstretched its limited capacities. This has resulted in (i) donor-assisted projects not always reflecting government priorities; (ii) overlap and duplication among different donors and government programmes; (iii) lack of participation of the ministry in projects identification and design, and (iv) lack of ownership by local partners of donor-financed projects. However, over the last three years, the discussion on ODA implementation issues between the government and the international community has intensified. The MOH has established a new department, which has been successful in improving coordination and in organizing an International Support Group, which meets regularly and provides a forum for exchange of information and discussions on health sector issues. WHO is supporting the MOH and leading a number of working groups, including an informal partnership: "the health sector working group" aiming at improving the coherence of the international community support to the health sector. The next step should be the elaboration of an operational ODA framework for the health sector, which can serve as base for joint discussions and planning of new projects; this should be based on the CPRGS and on the Viet Nam Development Targets (VDTs). Sector wide approaches to health are also under discussion. The MOH is interested in such approaches and it is expected the ISG will take a prominent role in developing a step by step process towards the setting up of joint mechanisms for policy and strategy

formulation, the improvement of accountability in the management of public finance at all levels, as well a stronger involvement of the civil society.

4. WHO: CURRENT COUNTRY PROGRAMME

WHO in Viet Nam

Since 1968, WHO has established a wide range of collaborative programmes with the Government of Viet Nam and played an important role in national health development. The central goal of the collaboration has been the improvement of the health of the population. In the 70s and 80s when very few donors were present in the country, capacity strengthening through exposure to international experience and support to development of key institutions such as the Institute of Public Health were preeminent features of WHO strategies. Over the years, as issues in the health sector became more diverse, the scope of WHO collaborative activities expanded to cover a large number of projects, many of them funding routine activities. However, in 2000-2001 and 2002-2003, an effort was done to focus on a more limited number of priority projects and to group them in meaningful areas with the aim to increase effectiveness and efficiency, to strengthen coordinated and synergic approaches and to facilitate team work.

In 2002, the WHO team consists of around 30 people, including 14 internationally and three nationally recruited professional staff. However this number is very unstable, all the posts except two (the Representative and the Programme Management Officer) and few general support staff are funded from extra budgetary resources for specific activities and for defined period of time. In 2002-2003 the country budget is around US\$ 8 million, including an estimated US\$ 3.5 million in extra budgetary funds. This component has been increasing recently due to successful mobilization of resources at country level.

The Ministry of Health is the primary working partner. Nevertheless, recently, the work of WHO in Viet Nam has begun to assume a more inclusive definition of the nature of the health sector leading to greater collaboration with other government institutions, mass organizations, UN agencies, NGOs and with the international donor community.

Key Programme Areas

Since the 2000-2001 biennium, WHO has grouped the various projects for which it provides technical and financial inputs in three programmatic areas: combating communicable diseases, building healthy communities and populations, and developing a stronger and more equitable health sector. Key programmes under each area include:

Combating Communicable Diseases

Immunizations, where support is given jointly with UNICEF to the National Expanded Programme on Immunizations, to strengthen the routine operations of the programme, to introduce Hepatitis B immunization and injection safety and to strengthen quality assurance in vaccine production. The eradication of poliomyelitis was certified in 2000.

Malaria and parasitic diseases, where WHO is supporting the development of models for sustainable disease prevention and control, operational research in the use of new

technologies and drugs and improvement of data on burden of diseases such as *cysticercosis and echinococcosis*.

Prevention and control of *sexually transmitted infections including HIV/AIDS*. In addition to supporting surveillance activities, the office strengthens the capacity of the MOH and the national Aids programme to carry out harm reduction interventions such as 100% condom use in high risk behaviours, and to introduce care and support for people living with HIV and Aids.

The office is also collaborating with various research and training institutions and departments of the MOH on efforts to improve *surveillance systems* in disadvantaged areas as well as strengthening the national programmes for *tuberculosis control*, leprosy elimination, dengue and plague.

Building healthy communities and populations

Environmental health where WHO is promoting healthy settings, helping the government to monitor water quality and food safety and contributing to strengthen the capacity of occupational health services through the support to demonstration projects on Health Promotion in the Workplace and the development of national guidelines on occupational health.

Maternal and child health through support to interventions such as safe motherhood, and assistance to MOH and other partners in the adaptation and implementation of the IMCI approach and an integrated policy on child health.

Prevention and control of *non-communicable diseases and life-style problems*. WHO supports MOH to develop integrated approach for the prevention of NCD, to expand community-based services for NCD, mental health services and care for the elderly. The fights against tobacco and injuries are important priorities of the office.

Developing a stronger and more equitable health sector

WHO works to strengthen the capacity of the *national health administration* to better manage existing health services, e.g. re-organisation of the service delivery infrastructure, improvement of the health information system, management of primary health care, development of a more robust system for health and pharmaceutical inspection. As part of this work, the office also supports the Health Insurance agency and the implementation of *community health insurance* models.

Human resources for health, where support is mainly given to MOH on issues such as health workforce planning and labour norms; and on nursing, including community nursing.

Essential drugs, blood safety, traditional medicine, where WHO provides support to the government mainly through consultants.

The office is also actively involved in *emergency preparedness* activities and in relief work particularly for mitigating the effects of the floods and natural disasters that periodically affect certain areas of the country.

In these three programmatic areas, support is provided through extensive technical inputs for instance when new programmes and/or guidelines need to be developed, tested and expanded (e.g. IMCI, HIV/Aids, community social insurance); through policy support, dissemination of information on key policy issues and alternative strategies, and testing of models (e.g. health sector policy and reform); and through advocacy, policy and technical advice for emerging priorities in health.

In addition WHO is involved in a variety of *coordinating mechanisms*, sub committees and working groups. Members of the team have actively contributed to Common Country Assessment (CCA), UNDAF, the Comprehensive Reduction and Growth Strategy (CPRGS), the activities related to the Millennium Development Goals (MDGs) and to the Consultative group meetings. WHO is also assisting policy formulation and promoting coordination in the health sector. This involves exercising influence on the definition of strategies on health and development issues that impinge on health. This is done through interactions with Government agencies and the donor community and the management of partnership and technical groups (e.g. Health Sector Working Group, Reproductive Health Group, UN HIV/Aids Theme Group).

Current Comparative Advantages and Constraints

The Viet Nam country office has demonstrable comparative advantages:

The recognition of WHO as the primary agency in health not only by the Government, but also by the donor community, the United Nations Agencies, the World Bank and IMF, and the Non Governmental Organisations being national or international. To day in Viet Nam the WHO country office is considered as an indispensable partner for all issues related to health from the purely technical ones to the ones related to health and poverty, health and macro economic reforms, health and ethnic minorities, the MDGs, etc. It is also seen as the “moral leader”, advocating for the poor, fighting against the increasing social inequalities, and proposing technical interventions to address these issues.

The recognition of WHO by most partners as the obvious organisation to assist the MOH and eventually other Ministries in the Government in donor coordination.

The recognition of WHO by the Ministry of Health, the specialized Institutes of the MOH, most of the international partners as providing sound, objective and neutral policy and technical advice. This recognition is based on a number of factors: the reputation of WHO globally and the soundness of most of the interventions and strategies developed at central level; the reputation of the country office and the quality of its technical staff; and the very good consultants selected by the regional Office.

A rather large technical staff of high quality working on a day to day basis with national counterparts in MOH but also with other partners at central, provincial and PHC levels. This provides easy access to decision-makers at the different levels of the health sector.

The very professional backup from WPRO, providing expert advice and the best technical practices, even at short notice; and mobilizing financial resources for the country office.

A good relationship with most of the international NGOs working in the health sector. This relation is based on trust, share of common values and support from the WHO

country office, mainly in relation to technical issues and scaling up of the sound and relevant interventions developed by the INGOs at community level.

A good relationship with ministries outside health like Ministry of Education, Ministry of Fisheries, Ministry of Planning and Investment (MPI), and with the Social Commission of the Central Committee of the Communist Party.

At the same time WHO faces some constraints:

The difficulty to make the Government and major partners such as the IMF and the WB committed to health as part of the development process and to influence the macro economic policies; the main objective of the country being economic growth and industrialization.

The difficulty to secure support for implementing approaches in line with WHO objectives in the field of health sector reform and mainly health financing. The lack of a consensus among the leaders in the country on the road toward an efficient equity-oriented health sector and the weakness of MOH lead to decisions taken outside MOH and which can be detrimental to the health of the population, mainly the poor.

The general difficulty of implementing changes in a centralized bureaucratic system quite reluctant to introduce systemic changes and intersectoral initiatives.

The fact that the main partner of WHO remains the MOH and that the Regular Budget and even Extra Budgetary resources are considered by the government of Viet Nam as their budget. To day it is not feasible for the country office to use the budget to support NGOs or academic institutions, except if it is cleared by MOH and MPI. This clearance is nearly never obtained.

The competition among UN agencies and INGOs for financial resources and leadership, mainly in areas where WHO mandate is not very clear-cut such as HIV/Aids (e.g. harm reduction for IDUs) and Reproductive Health.

The lack of WHO presence outside Hanoi, in a system which is in the same time highly centralized with the preponderant role of Hanoi as political capital and highly decentralized in term of technical implementation. Many of WHO initiatives have been limited to the Northern areas. Much more needs to be done in the Central highlands and the south in order to tackle poverty and address the unfinished agenda of infectious diseases as well as the problems brought about by rapid urbanization.

The lack of good coordination between the country office and certain technical programmes in headquarters which work directly with institutions in Viet Nam involving the country office only to solve problems. In many instances, these projects create confusion, are not used properly for decision-making and are often of poor quality, because of the lack of supervision.

The fact that the reorganization of the various projects in coherent groupings has not yet fully translated into an integrated approach to assess the problems, make priorities and develop solutions and interventions. In addition the money does not still necessarily follow priorities or needs.

The relatively low level of delegation of authority to the WR, the absence of funds which can be used discretionarily by the WR and the bureaucratic nature of WHO which

prevent flexibility and seizing opportunities.

The fact that most of the staff depend on extra budgetary resources, leading to the absence of a sustainable core team as funds are often secured only for few months and to a mix of staff which is donor driven and not country needs driven. In addition the absence of national professional staff, the appropriate balance between international staff and consultants are unsolved issues.

5. WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO Corporate Policy Framework

A WHO Country Cooperation Strategy needs to reflect the Organisation's corporate policy framework and regional strategies, alongside the health needs of the country and the activities of other development partners.

WHO's mission, as set out in its constitution, remains the attainment, for all people, of the highest possible level of health. A number of challenges have emerged from the significant changes in international health in the last decade, including a new understanding of the causes and consequences of ill-health; the greater complexity of health systems; increasing prominence for 'safeguarding health' as a component of humanitarian action; and a world increasingly looking to the UN system for leadership. WHO has developed a corporate policy framework to guide its response to this changing global environment and to enable WHO to make the greatest possible contribution to world health.

The policy framework continues to reflect the value and principles articulated in the global Health For All policy, which was re-affirmed by the World Health Assembly in 1998 with new emphases on:

- Adopting a broader approach to health within the context of human development, humanitarian action and human right, focusing particularly on the links between health and poverty reduction,

- Playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise,

- Triggering more effective action to improve health and to decrease inequities in health outcomes by carefully negotiating partnerships and catalyzing action on the part of others,

- Creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking, and innovation.

WHO's Goals and Priorities

WHO's goals are to build healthy populations and communities and to combat ill health.

To attain these goals, the following four interrelated strategic directions have been set:

- Reducing excess mortality, morbidity and disability, especially in poor and marginalised populations.
- Promoting healthy lifestyles and reducing factors of risks to human health that arise from environmental, economic, social and behavioural causes.
- Developing health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair.
- Developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

In addition to these strategic directions, WHO has also defined limited specific priorities, based on criteria which include the potential for a significant reduction in the burden of disease using existing cost-effective technologies (particularly where the health of the poor will demonstrably benefit), and the urgent need for new information, technical strategies, or products to reduce a high burden of disease. The specific priorities are: Malaria, TB, Mental Health, Tobacco, Non-Communicable Diseases, Making pregnancy safer and children's health, HIV/AIDS, Health and Environment, Food Safety, Blood Safety, Health Systems.

Regional Emphasis

Within the WHO corporate strategy and in the light of emerging health challenges in the Region, the WHO Regional Office for the Western Pacific has tailored its own supporting framework for action around four outcome-oriented themes: combating communicable diseases, building healthy communities and populations, developing a stronger health sector, and reaching out (which encompasses information technology, external relations and public information). The 1999 Regional Committee Meeting made TB a special regional project, in recognition of the fact that one quarter of all TB victims (some 2 million people) live in the region. Three quarters of them are in the prime of their productive and reproductive lives, and the majority bears a double burden of disease and poverty.

6. WHO STRATEGIC AGENDA FOR VIET NAM: THE NEXT FIVE YEARS

WHO's Mission in Viet Nam

WHO's mission in Viet Nam is to collaborate with the Government and other relevant parties in improving the health of the peoples of Viet Nam and in reducing health inequalities, within the framework of the Millennium Development Goals (MDGs) and

the Viet Nam Development Targets. This will be achieved by focused action in selected key areas and by monitoring policy action and health outcomes.

Justification of the WHO Strategic Agenda

The new WHO Strategic Agenda is based on an analysis of the present national situation, on the current role of WHO, and on the comparative advantages and constraints of the Organization in Viet Nam and globally, as reflected in the previous sections of the document. This shared assessment provides the justification for the shifts in principles, functions, content and mode of operation of WHO outlined in this section and the next one.

WHO Principles

The WHO strategic agenda for Vietnam will be based on the following principles:

- Being more selective in deciding what part of the national health programme WHO will support, while at the same time being more proactive and flexible;
- Leaving room for responding to requests and legitimate expectations of government and its partners, within clearly defined boundaries;
- Emphasizing WHO's role of policy and technical adviser and acting as a resource facilitation and support team for the government and the international community, while supporting evidence based approaches and rapid scale up of what works;
- Taking into account strategies and activities of other partners and looking for opportunities to increase and strengthen partnerships within the national plans and frameworks
- Monitoring better the WHO's work and performance.

WHO Strategic Functions

WHO has defined five sets of functions in its work at country level:

- Function 1 - supporting routine long-term implementation
- Function 2 - catalyzing adoption of technical strategies and innovations; country-specific adaptation of guidelines; seeding large-scale implementation
- Function 3 - supporting research and development; policy experimentation; development of guidelines; stimulating the monitoring of health and health sector performance; trends assessment and anticipation
- Function 4 - providing information and advocacy, sharing knowledge (global, regional, inter-country) for appropriate policy options and positions; (including case studies of good practice, generic guidelines and standards, and study tours
- Function 5 - providing specific high level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spending of government and development partners.

In general WHO will move progressively towards more attention to research and development, policy experimentation, knowledge-sharing and advocacy and policy development and advice.

WHO Strategic Agenda: WHO Areas

The areas of work covered under this strategic agenda have not changed significantly from the current WHO programme, as the work on a coherent grouping of the various activities and projects was initiated by the WHO office in Viet Nam before the beginning of the CCS and was partly reflected in the Programme budget 2002-2003. What this document does propose however, is to rearrange the areas under four broad components in order to clarify more the domains of intervention of WHO.

Area 1: Health policy: advocacy, analysis, institutional development and partnerships

This area is new, most of the activities it includes have been carried out in the past, although to a limited extent. It was never clearly highlighted as a core area of WHO at country level. It is a functional area more than a management one and very important in achieving WHO mission and assisting the country to attain the MDGs. It is typically within the WHO comparative advantage of exercising influence on policy and action of government and development partners; and serving as broker and arbiter. WHO will need to mobilize additional resources from the donor community for this area as the budget available is very limited.

Advocacy for health

WHO will increase its advocacy role in relation to MOH, other ministries, the Communist Party, the National Assembly, mass organizations, multi and bilateral agencies in favour of health. It will (i) strengthen its advocacy in relation to the broad determinants of health which are outside the health services, (ii) put health more at the centre of the development agenda, and (iii) influence as much as feasible the macro-economic policies and promote policies aiming at reducing social and health inequalities. It will support the MOH in being more involved in the work of the government when related to health, such as the CPRGS and the Public Expenditure Review.

How:

- Dissemination of information and policy and technical advice, including to the civil society and international and national NGOs;
- Operational research and health impact assessments of implications of different socio-economic policy options on the health status of the population;
- Organization of conferences, workshops, etc. to engage policy makers on issues related to the main determinants of health, which have an important influence on the health status of the population (e.g. the social determinants);
- Active participation to working groups on health sector issues, poverty, gender, equity, and other related matters,
- Regular contacts with the other UN agencies, the Bretton-Woods institutions and major donors active at the macro level.

MOH stewardship and governance

WHO will support the MOH in (i) developing new roles and functions under a decentralized system for the different levels (including the technical institutes), (ii)

strengthening policy analysis, performance assessment, quality assurance monitoring and evaluation, (iii) improving institutional effectiveness and efficiency, including financial monitoring, accounting and auditing, (iv) improving the quality and use of information to better manage the health sector and set priorities, and (v) developing systems, rules and procedures within the decentralization process to ensure that provinces act in accordance with national goals, strategies and standards and that regional disparities are minimized.

How:

- Provision of policy and technical support and sharing of information on the various options for addressing institutional issues in close collaboration with other partners;
- Provision of technical expertise to the national vertical programmes and technical institutes in changing their role (more leading and less implementing) and improving their capacity to support effectively a more integrated peripheral health system;
- Provision of expertise, support to new models/operational research in areas of policy analysis, performance assessment, information systems;
- Provision of expertise in areas of public management (including financial management)

Operationalization of policies

Many “sub sectoral” health policies and strategies have been developed during the last few years: national tobacco control policy, reproductive health strategy, national nutrition policy, national policy on injuries prevention, etc., however most of these policies are yet to be put in action. In addition many pilot projects, even the ones properly evaluated, are not scaled up. WHO will support the MOH and other partners in (i) operationalizing the policies, and (ii) scaling up evidence based pilot projects. The objective will be to prioritize interventions with strong public health impact and providing more benefits for the poor.

How:

- Provision of technical support and dissemination of new ideas and models in order to operationalize policies at lower levels, this may mean in certain cases working more at provincial and district levels;
- Provision of technical support and methodologies to evaluate and document pilot projects,
- Organization of forums, debates and other approaches to disseminate lessons learnt in specific pilot projects and to facilitate country-wide application of these lessons.

Partnerships and coordination

WHO will (i) promote effective comprehensive policies and seek to ensure that those adopted are reflected in the donor’s portfolio and in the government budget, (ii) promote greater coherence among the donor community in the implementation of sub-sectoral health policies and/or strategies (e.g. safe motherhood plan, HIV/Aids, etc.), (iii) promote active involvement of the civil society, the national and international NGOs in the health policy development and implementation, (iv) support the harmonization of ODA

procedures, including a phased implementation of SWAp, (v) increase government ownership of the coordination function, and (vi) mobilize resources for the government and for WHO.

How:

- Advocacy of evidence-based national and international policy positions;
- Organization of working groups and policy debates;
- Support to partnerships between government and other national and external entities, including patients' groups;
- Support MOH to strengthen the International Support Group.

Area 2: Health System Development

It is important to use the comparative advantage of WHO for moving the health agenda forward by influencing policies, strategies and interventions. A large amount of resources is invested in this area by the World Bank, the Asian Development Bank and other partners. The role of WHO will therefore be limited to supporting policy experimentation, advocating for scaling up well evaluated interventions, and supporting country specific adaptation of management innovations and standards. The support will be more focused and strategic than in past biennia.

Delivery of quality health care

WHO will focus on management and quality assurance of health services. In an increased decentralized context where greater flexibility should be given to peripheral levels in the identification of local problems and solutions, there is a new role (planning and budget autonomy) for the provincial and district health management teams in improving the PHC network capacity and the quality of prevention and care at district, communal and community levels.

Key challenges will be: (i) to bring together the different technical programmes which usually have their own budget and develop at national level their own frameworks, tools and training separately and (ii) to improve the responsiveness of the services to the needs of the population at all levels of care.

How:

- Support to the development of transition strategies for the provision of prevention and care at communal and district levels, taking advantage and incorporating the resources and structures of the vertical programmes and of Global or Regional initiatives aimed to eradicate or eliminate communicable diseases (Neonatal Tetanus, Measles, Leprosy, Lymphatic Filariasis, Trachoma);
- Support to selected provinces for testing new management and technical approaches at provincial and district levels including supportive supervision systems, client-centered health information systems, holistic care models and comprehensive action plans on priority areas such as health promotion;

- Support to on-going and new projects promoting a multifunctional Village Health Workers able to address local health priority needs within the District/Communal framework of the basic health service;
- Support to the implementation of tested and relevant models for improving quality of care and family health practices at district and commune levels and the scaling up of effective approaches developed in projects supported by bilateral donors or/and NGOs;
- Support to research on sustainable provision of quality health services in poor and remote areas and on mechanisms to promote users' rights;
- Dissemination of lessons learned from country specific experiences in PHC and advocacy for the establishment of a PHC information exchange network;
- Technical support to the development of standards in a number of key areas such as clinical laboratories, injection safety and medical equipment.

In addition to this general support to the improvement of the health services, WHO will focus on a specific aspect of the health services, which is providing Comprehensive Essential Obstetric and New-born care, including improving quality, equitable access and use of maternal and new-born care services.

How:

- Advocacy for political commitment and acceptance from government and other stakeholders, including donors, to provide the necessary support to implement the initiative "Make Pregnancy Safer" and to improve access to and quality of care for the new-born through the four levels of the health system, but with priority to actions to be undertaken at the District and Commune levels of care;
- Support to the formulation of an appropriate strategy, priority setting and action plan for comprehensive obstetric care and essential newborn care, with special focus at the District and Commune levels of care;
- Support to the adaptation and nationwide implementation of standards and guidelines for reproductive and newborn health services;
- Promotion of sustainable methodologies for improving and monitoring the quality of care of services.

Human resources

WHO will work with the Ministry of Health at central and provincial level, and with the Ministry of Education and Training and other educational establishments in charge of the development of health personnel to ensure that the country has the human resources needed for coping with the epidemiological and demographic transition and that they are appropriately trained. WHO will not involve itself extensively in human resources training, only if it is a very important area and there is no other donor willing to support.

Key challenges will be staff motivation and accountability (incentives) in the public sector and the compliance to ethical standards in both the public and the private sectors.

How:

- Information sharing, advocacy and provision of expertise on various aspects of staff development, such as the review of systems and plans, staff norms and performance indicators, staff motivation and accountability for key categories of health workers, including nurses and midwives, nutritionists, community psychiatry staff (social workers, psychologists, therapists), health inspectors, laboratory technicians, pharmacists, health education officers, etc;
- Targeted support to research and adaptation of new training methodologies to improve prevention and care activities, effectiveness and teamwork in the workplace particularly at district and provincial level;
- Provision of expertise for the development of new curricula in very specific fields (e.g. community nurses) and update of existing ones to reflect national strategies (e.g. IMCI);
- Technical support to the development of guidelines and basic training materials for pre-service and on-the-job training in specific fields;
- Promotion of technical cooperation with academic and research institutions affiliated to or supported by WHO, particularly in the Western Pacific region;
- Changes in the overseas fellowships programme towards more selected master's degrees and crucial areas where there are obvious gaps.

Financing

WHO will support the efforts of the MOH and other partners in: (i) improving the national health expenditure frameworks, (ii) developing a comprehensive master plan for equitable health financing strategies and (iii) strengthening social health insurance, including community health insurance.

Key challenges will be to coordinate the activities of the various donors in health financing and to define a road map for the next twenty years in order to achieve universal coverage with social insurance.

How:

- Technical and limited financial support to the development of national health accounts and public expenditure reviews in close coordination with other UN agencies and the WB;
- Provision of information and advocacy for an increased level of budgetary funding for the health sector;
- Information sharing for the formulation of appropriate health financing options;
- Support to the development and wider extension of community based insurance systems, mainly for the rural population;
- Technical support to the VHI and the VSI for extending the coverage of the social compulsory and voluntary health insurance to other sectors of the population and for developing and implementing a health insurance master plan.

Rules, regulations and compliance

WHO will support the MOH and other institutions in (i) developing adequate regulatory policies and tools, in particular in the financing and provision of private health services, pharmaceuticals and food safety, and (ii) building the capacity of the staff, including the ones dealing with inspection.

How:

- Limited technical support in developing and updating laws and regulations;
- Providing advice on defining norms and rules for instance in food safety and food quality;
- Provision of guidelines and training materials, models from other countries;
- Training of staff on regulatory matters and inspection;
- Exposure to international experience through attendances to international conferences such as the ones related to Codex Alimentarius.

Essential drugs, blood and blood products

WHO will support the MOH in its efforts to improve the use of pharmaceuticals and blood. Its support will be complementary to the support provided by other international partners: SIDA for the pharmaceuticals and the World Bank for blood safety and conditional to the commitment of the government and the availability of additional financial resources.

How:

- Advocacy and policy advice at central level;
- Technical advice and training on specific technical and managerial issues in relation to rational use of drugs, and quality assurance of the transfusion services;
- Technical support to the development of materials for the health personnel (EDLs, standard treatment guidelines, safe use of blood, etc.) and for the personnel of the blood banks;
- Technical support to the establishment of a system of non-remunerated voluntary blood donors.

Area 3: Healthy environment and lifestyles

This area was not well developed in the past mainly by lack of technical staff in the country office and unclear strategies at regional and headquarters levels. In view of the epidemiologic and demographic transition in Viet Nam, this area has now a particular importance, it is also an area which is not well covered by donors and in which there is not always agreement on the interventions to implement. It is an area where there is a clear role for WHO in Viet Nam, if technical and financial resources are secured. It is unfortunately not an area very popular with donors.

Health and Environment

WHO will work with the MOH and other government and non-government agencies in building support to healthy environments and life styles. The emphasis will be on healthy schools, healthy workplaces, food safety and safe water and sanitation.

How:

- Policy advice and advocacy at highest level on the role of broad health determinants;
- Promotion of public information and education to support community mobilization on environmental health matters and promote selective approaches to environmental health risk management;
- Support to integrated health promotion in schools and workplaces in close coordination with MOH, MOET and UNICEF (e.g. health promoting schools);
- Support to operational research and innovative schemes on issues related to school health, occupational health, urban health, etc. and to the dissemination of the lessons learnt for policy formulation and scaling up;
- Support to the development of guidelines, policies and training packages to promote healthy behaviour and lifestyles in the community (e.g. schools, workplace, small enterprises and market places) and to mitigate the health effects of industrial development;
- Support the establishment of mechanisms for multi-sectoral approaches between disease control institutes, departments of MOH and other ministries.

Social change, life styles and health promotion

WHO will support the MOH and other partners in developing appropriate answers to emerging problems, including mental health problems, suicide, injuries, tobacco use and non-communicable diseases.

How:

- Support to operational research and the process of scaling up relevant lessons learned from research, pilot projects and other successful health promotion interventions on emerging health priorities such as accident and injury prevention, mental health, suicide and tobacco control;
- Assistance to MOH in the identification and implementation of innovative approaches and organisational changes for a successful integration of activities related to these new problems at all levels of service delivery;
- Support the implementation of a national strategy for NCD prevention and control, and advocacy for increased funding from national and international agencies;
- Provision of technical support to ensure the full participation of Vietnam to the Framework Convention for Tobacco Control and to facilitate the implementation of the national tobacco control policy
- Provision of technical support to the Government and other partners to operationalize the new policy on injury prevention

Adolescent health and development

WHO will work with the MOH, the Youth Union, the Ministry of Education, UN

agencies, INGO's, research institutions and national adolescent experts in the formulation of a comprehensive Adolescent Health and Development policy and in the preparation of implementation plans to put this policy into practice.

How:

- Advocacy for ADHD particularly through the Youth Union and MOH policy makers;
- Technical support to policy development,
- Support to operational research and situation analysis on ADHD issues including STI's/HIV;
- Capacity building and training around Youth Friendly Health Services;
- Support to partnerships and mobilization of resources.

HIV/Aids

WHO will provide selective support to MOH in dealing with the HIV/AIDS epidemic through: (i) enhancing leadership and coordination; (ii) reducing the vulnerability of injecting drug users and sex workers to HIV infection; (iii) scaling up the care and support of the AIDS patients; (iv) combating stigma and discrimination linked to HIV/AIDS; and (iv) protecting young people from epidemic and its impact.

How:

- Advocacy for policy changes in relation to HIV/Aids at the highest level;
- Technical and managerial support to pilot projects for 100% condom use in relation to high risk behaviours;
- Technical assistance to the surveillance of HIV/AIDS epidemic;
- Technical support to strengthen the capacity of the health services in providing care and support to HIV infected persons;
- Support to the constituency of self-organizations of people living with HIV/AIDS and advocacy for the involvement of such organizations in all programmatic aspects;
- Support to operational research aimed to identify appropriate institutional and community responses to socio-cultural factors influencing the spread of HIV infection.

Area 4: Communicable diseases

Although the burden of communicable diseases is decreasing, there is still an unfinished agenda. WHO has been very strong in this area in the past biennia and will continue for the next biennium. However but WHO should reassess its role, focuses on few topics and functions and eventually sunsets some activities.

Child health

WHO will support MOH in reducing infant mortality and Under Five Mortality and morbidity across the country with priority to the disadvantaged groups through: (i) the support to NEPI in relation to measles and hepatitis B, (ii) the extension of the three

components of IMCI; (ii) the improvement of neonatal care, and (iii) advocacy for the development of a child health strategy and policy and the provision of comprehensive and integrated health care services to the children. In addition, WHO will support in selected places the improvement of the nutritional status of children and women in reproductive age.

How:

- Advocacy for child health and provision of assistance for policy development on integrated care of children;
- Support to development of planning, training, monitoring and supervision tools in order to strengthen and scale up the implementation of IMCI at the District and Communal levels of care as well as at community and household levels;
- Technical support to MOH and to other partners on neonatal care;
- Promotion of and support to operational research on effective integrated child and mother care, weaning practices and nutritional habits, breast feeding, etc;
- Support the production of health educational messages for the promotion of breast feeding and appropriate weaning practices.

Emerging and neglected communicable diseases

WHO will support MOH in dealing with parasitic infections, which have a heavy impact on the health status of the population, contributing to chronic malnutrition and iron micro nutrient deficiency, as well as affecting cognitive development of school and pre-school age children.

How:

- Promotion of strong collaboration among the agricultural, education and health sectors;
- Support to the development and adoption of norms and regulations on food safety, food processing and appropriate fertilisation schemes;
- Advocacy and technical support for enhancing health promotion, scaling up environmental and selective school health interventions (regular deworming, iron supplementation, others).

Sustaining achievements and effective interventions for the prevention and control of Communicable Diseases

WHO will support MOH in consolidating the achievements of on going programmes aimed to prevent and control communicable diseases (EPI, TB, Malaria, Dengue, Leprosy), through selective actions in order to: (i) facilitate an appropriate level of integration of the vertical programmes in the health service delivery system, as a key strategy to enhance their sustainability, and (ii) ensure equitable access to preventive measures and quality care to the population, with special focus on most disadvantaged.

How:

Advocacy for Government commitment and adequate support from external donors.

- Support to the development and the dissemination of key IEC messages focusing on the promotion of community, household and individual attitudes and practices to prevent and control communicable diseases;
- Support to operational research aimed at identifying innovative strategies for efficient implementation of on-going programmes, taking into account the epidemiological situation of each communicable disease, as well as the specific challenges in the prevention and control of each disease;
- Provision of “focused” technical assistance on critical areas of on-going programmes for the prevention and control of Communicable Diseases (quality control of vaccine production, safety injection, etc.);
- Support to the formulation and implementation of transition strategies for the provision of integrated basic health services based on the local health priorities, merging also the resources and implementation capacities of the existing vertical programmes;
- Support to the simplification and the capacity of the early warning system for out-break detection and response at provincial level.

Shift in effort and functions

Functions before and after the adoption of the CCS Strategic Agenda.

Areas	F 1: Routine implementation	F2: Catalysing, adaptation of technical strategies	F3: R&D, monitoring	F4: Knowledge sharing and advocacy	F5: Policy advice
1. Health policy: advocacy, etc.	+/-	-/-	-/+++	+/>+++	++/>++++
2. Health system development	+/-	+/>++++	-/+++	+/>+++	++/>++++
3. Healthy environment and lifestyles	+/>+	+/>+++	+/>++++	+/>++++	+/>+++
4. Communicable diseases	+++/>+	++/>++	++/>++++	++/>+++	+/>+++