HOW EXTERNAL SUPPORT FOR HEALTH AND HIV WILL EVOLVE AS VIET NAM BECOMES A MIDDLE-INCOME COUNTRY

Report commissioned by the UN Country Team – Viet Nam

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The statements in this publication are the views of the author and do not necessarily reflect the policies or the views of the United Nations in Viet Nam.

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ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AusAID	Australian Agency for International Development
CHC	Commune Health Center
CoC	Code of Conduct
DOH	Department of Health (provincial level)
DPF	Department of Planning and Finance (MoH)
EC	European Commission
EPI	Expanded Programme on Immunisation
FSW	Female sex worker
GBS	General budget support
GDP	Gross domestic product
GoV	Government of Viet Nam
HCS	Hanoi Core Statement
HPG	Health Partnership Group
HRD	Human resource development
HRM	Human resource management
IDA	International Development Association
IMR	Infant mortality rate
IDU	Injecting drug user
ITN	Insecticide treated net
JAHR	Joint Annual Health Review
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOH	Ministry of Health
MoHA	Ministry of Home Affairs
MPI	Ministry of Planning and Investment
MTEF	Medium Term Expenditure Framework
NGO	Non-governmental organisation
NTP	National Target Programme
ODA	Official development assistance
PGAE	Partnership Group on Aid Effectiveness
PMU	Project Management Unit
PRSC	Poverty Reduction Support Credit
SBS	Sector Budget Support
SEDP	Socio-economic development plan
Sida	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
TA	Technical assistance
TB	Tuberculosis
TC	Technical Cooperation
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAAC	Viet Nam Administration of HIV Control (MOH)
WB	World Bank
VHI	Viet Nam Health Insurance
WHO	World Health Organization
VND	Vietnamese Dong

Section 1 - Summary of key findings and recommendations

This section summarises the main report and the conclusions and recommendations made in each of the chapters.

Viet Nam will attain Middle Income Country (MIC) status around 2010 assuming that the economic situation at global and national levels so permits. As a result, some development partners have begun to plan their exit strategies and Viet Nam's access to concessional lending from the International Development Association (IDA) will be reduced.

This study aims to: explore the implications of the transition to MIC for external support to health and HIV; to present scenarios for how funding patterns may change in future; and to make recommendations on ensuring the sustainability of key public health programmes.

The effectiveness of health aid needs to be substantially improved

This study has identified significant issues in relation to the effectiveness of health aid as currently delivered to the Vietnamese health sector. External health funding represented just 2.3% of total health spending in Viet Nam as per the 2007 National Health Accounts. In terms of percentage of the government health budget health ODA represents between 5.3% and 10.2%, depending on the methodology used to estimate government health spending.[1] Despite this, it is reported that external funding has contributed - and can continue to do so - to innovation and focus on health systems development, both much needed as Viet Nam makes its transition to MIC status. While the findings in terms of health aid effectiveness are not new they need to be more proactively addressed by both the Ministry of Health (MOH) and its health partners.

It is difficult to assess the effectiveness and impact of health aid in the Vietnamese health system. This is due to a combination of factors: including poor and inconsistent reporting and monitoring on health aid flows; fragmentation and poor predictability of health aid; high reliance on project aid, much of which is largely donor driven and results in high transaction costs; and lack of a shared health sector policy framework against which the effectiveness of health aid can be measured and improved.

The health sector lags behind other sectors such as education in terms of progress against the principles defined in the Hanoi Core Statement, the Vietnamese adaptation of the Paris Declaration on Harmonisation and Alignment of Development Assistance.

On the other hand the MOH and its health partners have already agreed to move towards a programme approach, and they have also increased the level of dialogue and engagement through the Health Partners Group and the Joint Annual Health Review (JAHR). These initiatives, if properly strengthened and nurtured, have the potential to change the status quo. What remains to be done is for the MOH and its health partners to prepare a common programme of work that highlights the main health sector priorities and challenges that will need to be met as Viet Nam approaches MIC status.

Three recommendations are made for improving the effectiveness of health aid (These reflect recommendations made in 2007 by the independent reviewers of progress towards the Hanoi Core Statement):

- Building stronger sectoral capacity in sector analysis and sector monitoring through the development of a programme-based approach;

[1] *For details on methodology please refer to the main report, section 2.4.*

- Improving country leadership in the use of health aid and in definition of capacity-building needs and support modalities; and

- Phasing out parallel project management units (PMUs) and perverse financial incentives linked to existing aid delivery modalities while placing renewed focus on stronger MOH units and departments, with greater capacity for sector policy monitoring and implementation.

In sum, the first step to reduce the potential impact that a reduction of health aid might cause once Viet Nam reaches MIC status is to increase the effectiveness of current health aid.

Help Viet Nam develop a progressive, equitable and efficient model for health financing and sector regulation

Viet Nam has achieved remarkable improvements in its health, education, social and economic indicators in comparison with those achieved in other countries with similar or even higher economic status. To sustain those achievements and make further improvements Viet Nam will need to sharpen its focus on ensuring that the national health system delivers health care under the principles of equity, solidarity and efficiency.

At the moment the approach to health financing is not realising those principles to the extent needed and, left unattended, the system might become even more inequitable and less efficient given the fast pace of health care decentralisation that is taking place. As pressure increases for provinces to generate revenue to cover their health care costs there is a risk that certain essential services might become privatised or their cost become unaffordable to the most vulnerable part of the population.

A decentralised health care model needs to be properly regulated and managed if it is to deliver equitable and efficient health care with solidarity. Indications are that the MoH is making progress but needs to strengthen these functions. It is also apparent that provincial health authorities need stronger capabilities in combining needs-based health planning and monitoring of service outputs with the increasing emphasis on revenue generation that might leave poor and middle income Vietnamese more vulnerable to the consequences of catastrophic illness.

The response that health partners are providing in relation to health financing and social protection is in the right direction but needs more emphasis on both scope and scale. This is, firstly, because there is not yet a long term plan on how to address the shortcomings of the current financing model. Second, the plan would need to be supported through a programme approach involving much stronger donor coordination than is the case now, and designing such a programme of support will take time. Third, the health partners have introduced several initiatives to deal with essentially the same issues (pilots in the provinces), which has reduced both the visibility of the health financing problem and the potential leverage to be gained by the health partners.

The response requires better coordination among partners, including for technical assistance, through a model that puts the MOH (not the health partners) in control of the responses that it wishes to pilot or implement. At the same time the MOH also needs to better define its capacity building needs and the areas where it wishes to be supported.
It makes sense for health financing to be at the centre of a better coordinated response by health partners as health financing is closely interrelated with other critical areas such as human resources management (HRM) and development (HRD), and service delivery. This means that a policy matrix focusing on health financing can be used to deal with other important policy areas, including incentives, performance, results orientation, sector regulation and stewardship, among others, and thus become the basis for the programme approach that the MOH and health partners are aiming for.

A policy matrix with strong health financing and sector regulation components would also provide direction to the Health Partners Group (HPG) and lead to a more focussed and results-oriented JAHR. The link between the JAHR and an agreed programme of work is essential for the JAHR to maintain momentum and focus more on sector monitoring – processes, policies and service outputs.

Some health partners may argue either that health financing cannot be the main or sole basis for policy dialogue or that this cannot substitute for a fully fledged health sector plan and resource envelope. However, it is important that the process adopted is appropriate to the Vietnamese context. The time needed to develop SWAp-like processes in many countries would not be possible to replicate in the case of Viet Nam. This study concurs with the recommendations made by the reviewers of the Hanoi Core Statement when they argue that *"complex new initiatives like sector-wide approaches, which take some years to become effective, are not feasible in the time available"*. A more focused, simplified (not simplistic) approach is likely to work better.

Impact of MIC status on health systems strengthening efforts and on the Vietnamese health system

The attainment of MIC status will not have significant, immediate impact in terms of presence of donors and health aid budgets, since much health aid is guaranteed until at least 2012. Beyond 2013, though, health aid budgets are likely to decline significantly. Whether or not this will affect the Vietnamese health system depends on how health partners position themselves in important areas of health policy and on whether the external aid to the health sector becomes better coordinated and more effective.

Once Viet Nam reaches MIC status, some health partners will leave and health aid will be reduced. However, it is likely that if and when health partners and the Government decide to target health aid to specific areas of health systems strengthening they will be able to find the needed sources of funding and other technical resources, but only if they work more effectively together.

This situation will present the UN agencies with considerable opportunities to continue to support the GoV and Vietnamese institutions in a number of technical areas. It is therefore important for these agencies to position themselves appropriately in relation to the health policy areas that are critical to Viet Nam.

Given these issues, current government and donor efforts to achieve common ground through the HPG and the JAHR acquire additional importance. The HPG, JAHR and the underlying "SWAP philosophy" represents an opportunity for increased engagement and dialogue between government and its health partners at a time of change. Efforts to support these processes should be continued, accelerated and strengthened.

Impact of MIC status on control of HIV and other communicable diseases

Viet Nam has achieved remarkable improvements in disease control as evidenced by consistently decreasing prevalence rates in tuberculosis (TB), malaria, avian influenza and all vaccine preventable diseases, among many others. Such success is due to a combination of factors including: (a) a remarkable economic performance combined with the principles of solidarity and social responsibility; and (b) the focus of the Vietnamese government on cost-effective health interventions effectively implemented through a hierarchical government health system.

Development partners must also be credited for their contribution through financial support and sharing the costs of important commodities. Technical assistance, training and support to programme implementation and innovation in specific areas and provinces also played a role, albeit highly donor driven and limited by poor coordination. At the moment the presence of donors remains significant in at least four diseases that are important to Viet Nam: avian influenza TB, malaria and HIV. These will be briefly reviewed next.

- **Avian influenza:** many donors have closely supported the avian influenza epidemic and there is every indication that they will continue to do so (mainly through technical as sistance and support to public health laboratories) in an area where there is strong government leadership.

- **Tuberculosis:** much progress has been achieved in tuberculosis control. The two main external financing sources are the GFATM and bilateral aid from the Netherlands. A Round 9 application to the GFATM is under consideration. While funding needs are covered until 2011 the results of the latest household survey suggest that the number of TB infected people may be 1.5 times greater than estimated previously in Viet Nam, which might require a stronger response and more resources. Most TB drugs are financed and provided by and through the government and technical support is being provided from WHO, so the medium term scenario is one of small reliance on donor funding. However, it remains to be seen whether case detection incentives hither to funded by donors will remain after their financing ceases. Such incentives are considered an important contribution to Viet Nam´s high TB case detection rates.

- **Malaria:** This is another disease where Viet Nam has achieved remarkable success nual malaria-related mortality is around 50 deaths, a very small number for such a large country that only two decades ago suffered from one of the worst malaria-related mortality in Asia. While the government funds human resources, drugs and programme costs there is high dependency on donors like the GFATM for commodities such as ITNs. Such dependency was highlighted by the GFATM itself in the Round 3 Performance Evaluation when it stated that "…there is concern that the Global Fund is the only international donor providing 60% of the national malaria budget, and this reliance is expected to increase in 2007/2008". In sum, both tuberculosis and malaria control programmes will rely on GFATM funding, although less heavily in the case of TB.

- **HIV:** In contrast with the other disease control programmes where external funding is comparatively small (although strategically significant) the field of HIV and AIDS had at least 25 major donors in 2006 implementing an estimated 121 projects countrywide and representing between 80-90% of total HIV funding. Although significant efforts have been made, there is still much to be done to halt the HIV epidemic and provide appropriate care and treatment, including: increased government expenditure; increased and better focused harm reduction efforts targeted at groups at high risk, many of whom continue to be left out by harm reduction interventions thus spreading the disease to sexual partners and other injecting drug users (IDUs); and improved donor harmonisation and alignment with government.

Harmonisation and alignment in HIV. Consideration of the implications of current support and its modalities to HIV is needed in the medium to longer term. This is advisable not because of Viet Nam reaching MIC status but because the nature of the epidemic and its likely future costs make it a priority for the Vietnamese government and its partners. The following issues emerge as significant:

- Viet Nam is not yet in a position to estimate future costs of managing the HIV epidemic. Nevertheless, the costs of managing the epidemic within the next decade are likely to be

very substantial, and will increase in the years to come even if HIV incidence goes down, which is not yet the case.

- To effectively manage the epidemic Viet Nam will need to substantially increase the volume of financial and human resources devoted to it. First, because current levels of external funding are so large and aid modalities so fragmented that they are neither reliable nor sustainable in the medium to long term. Second, because current levels of government funding are too low, and it is not clear which specific areas should be managed by the government, and which should be allocated to development partners. predictable funding. The focus of donor funding remains largely determined by the donors.Third, because failure to address the epidemic at this stage could cost Viet Nam much more in terms of loss of human life and related health care costs in the future (between 5,000 and 10,000 new HIV+ cases per year will need health care). Fourthly, because reliance on out-of-pocket expenditure by health service users implies that unless financial support is scaled up the burden of AIDS will be borne disproportionately by Vietnamese families. Many of these families may see their lifelong household income and savings reduced, or they may decide or be forced to abandon treatment and preventive measures, which would have negative consequences for the HIV epidemic.

- MOH, the Viet Nam Administration of HIV Control (VAAC) and other government bodies will need support to better plan for present and future needs and for strategically planning the HIV response on the basis of realistic scenarios. HIV external partners will also need to improve the way they work together, with Government agencies and with civil society. They also need to address the perverse incentives being introduced by the additional financial emoluments provided to HIV staff. Increasingly incentives should be more homogeneous and performance based.

In spite of the large donor presence and considerable levels of external funding Viet Nam has yet to fully respond to the challenge of its HIV epidemic and meet the targets the GoV and its partners have set. The HIV epidemic may not be large in comparison to many other countries but it threatens serious consequences if prevention, treatment, care and support are not scaled up urgently.

It is in the interest of the GoV to better coordinate the response to the HIV epidemic and require development partners to better harmonise and align their own contributions. Funding for HIV relies heavily on two health partners, the GFATM and PEPFAR, whose funding is by no means assured beyond the medium term. Another important donor, DFID is unlikely to continue support to HIV post MIC, at least not on the scale it has to date. The risk of external funding dropping significantly and the small proportion of government funding means that the GoV should consider incrementally increasing its budgetary allocation, particularly in areas that it considers of strategic importance and where high dependency on donor aid may not be advisable. It should also ensure that the poor and the low-income middle classes do not incur catastrophic expenditure as a result of a relative developing AIDS, particularly in the geographical areas that are not covered by free anti-retroviral treatment provided by donors.

Section 2 - Overview of current external support to the health sector in Viet Nam

2.1 Acknowledgements

This report was commissioned to HLSP by the office of the World Health Organisation in Viet Nam. The author would like to thank Rebecca Dodd, who prepared the detailed terms of reference for the study and secured funding for it. Thanks are also due to the administration personnel of the WHO office in Viet Nam for effectively preparing and coordinating the meetings agenda of the author while in Hanoi, and to the HLSP office in London for providing valuable logistics support.

The author had the enormous advantage and privilege of working with Dr Nguyen Dinh Cuong, a Vietnamese medical doctor, consultant and researcher who prepared and delivered the questionnaires for development partners, who searched, requested and delivered many of the aid and health financing data tables, and who provided valuable support to this author during my stay in Hanoi.

The author would like to thank the Vietnamese Ministry of Health and the officers at the Viet Nam Aids Council (VAAC) for kindly and openly exchanging views and ideas. Thanks are also due to the community of development partners all of whom shared an interest in the study and found time to reply to the questionnaires and then meet the authors in person.

A complete list of people met or contacted for this study is provided as Annex 4.

2.2 Responsibility

While the World Health Organisation provided the funding for this study and HLSP Ltd delivered the consulting services the opinions and conclusions found in this report are solely those of the author and do not necessarily represent those of the World Health Organisation or HLSP Ltd.

2.3 Background

It is expected that Viet Nam will reach Middle-Income Country (MIC) status in 2009-10. As a result, some development partners are beginning to plan their exit strategies and Viet Nam's access to concessional lending will eventually be reduced.

While external assistance (aid) accounts for only a small share of total health spending (less than 5%) it is quite significant in particular areas, such as communicable disease control where, for example, external aid covers nearly 90% of Viet Nam's HIV programme, including provision of anti-retroviral drugs, condoms, syringes and needles.

This study will explore the implications of the transition to MIC for external support to health and HIV, present scenarios for how funding patterns may change in future and make recommendations for ensuring the sustainability of key public health programmes. It is hoped that this analysis will provide useful intelligence and information during the MIC transition phase.

In addition, the report will also serve as a specific input to (i) the Joint Annual Health Review, 2008, which will focus on health financing; (ii) the Viet Nam Development Report 2008, which will look at opportunities for resource mobilization over the medium-term, and (iii) the UN Country Team's working group on aid effectiveness, which will make recommendations on how to strengthen UN engagement with the aid effectiveness dialogue in Viet Nam. Finally, this report complements plans to carry out a National AIDS Spending Assessment (a review of spending to date), and to resource estimation for future implementation of the National HIV programme.

2.4 Aid flows and partner activity in health in Viet Nam

Assessing aid flows. One of the purposes of this study is to assess donor activity in the Vietnamese health sector. This has proven a difficult task for the following reasons:

- In Viet Nam health donors (also referred to as health partners) do not annually or systematically report their health activities or volumes of health aid (pledged or spent). In the absence of such reporting aid flows can only be estimated on the basis of ad hoc surveys or indirectly from information available in data sources outside of the Ministry of Health.

- One such data source on aid flows is the DAD (Donor Assistance Database) database available with the Ministry of Planning and Investment (MPI). This database is updated annually on the basis of information on pledges and expenditure officially reported by donors, and it currently shows information up to 2007. The main limitations of this database are that: (a) it captures aid officially reported to the MPI, but many real aid flows appear to be unreported (as is the case with US aid, whose flows are grossly under-represented in the database); (b) several important sources of external aid such as the global funds (including GFATM and GAVI) or large projects funded by PEPFAR are not represented; and (c) the database is for general aid, currently registering 16 different categories of health related funding, but these have varied year on year, making annual comparisons and trends difficult to analyse.[2] On the basis of the DAD the total volume of aid to the health sector in 2006 was US$140 million.

- A second source of information is the OECD DAC, but this source is based on data provided by bilateral and multilateral agencies at headquarters level (i.e. not the country offices) so it tends to under-represent the real figures, as many bilateral aid decisions are made at country level on the basis of unspent aid resources. The DAC database does incorporate GFATM pledges but also seems to under-represent the volume of US aid. According to the OECD DAC, total health aid to Viet Nam in 2006 (the last year for which information is available) amounted to US$ 208 million distributed among 63 different projects.

- A third source of information is provided in a spreadsheet depicting the activities of 28 health donors in Viet Nam.[3] This database was found to be the best in terms of depicting donor activity in health (by project, by technical area and by province), but it was less useful for estimating aid flows as information is incomplete and has not been disaggregated by year. On the basis of this database the total number of health projects receiving donor funding was around 64 projects, which coincides with the numbers shown in the DAC database.

The authors of this report attempted to gather information on aid flows to health directly from health partners using a simple questionnaire (see Annex 2 – Methodology). The questionnaire focussed on health partners' plans post Viet Nam becoming a MIC, but it also included a section on current and planned aid flows. Unfortunately, the section on aid flows was not always filled in or it provided bulk figures (per project) rather than yearly figures. It was therefore too incomplete to be used for aid quantification purposes, but it proved extremely useful to describe health partners' plans post 2010, as discussed later.

[2] By this we mean that the database does not always use the same criteria to attribute aid to one particular sub-sector or another from one year to the next.
[3] This spreadsheet is known as the "28 Donors Active in Health", and its origin seem to be in a JICA funded Technical Mission from 2007 that provided a compendium of on-going projects in the health sector. The author though could not have access to the original report.

Aid flows as a proportion of health expenditure. It is estimated that external official development assistance (ODA) for health in Viet Nam represented 2.2% of total health spending (as per the 2007 National Health Accounts). As a percentage of government health spending health ODA represented between 5.3% and 10.2% depending on the methodology used.[4] However, even these figures are sometimes disputed for, in addition to the problems of quantifying health ODA, there are methodological issues linked to how government health spending is calculated by the MPI in Viet Nam. For example, all user charges contributed by patients are included as government health expenditure, which is quite unusual and distorts the denominator for calculating the proportion of external ODA in health.

External aid to health represents a moderate amount compared to many low income countries and explains why health aid is perceived as a minor contributor to health spending in Viet Nam. However, despite this health aid has played important roles in the development of the Vietnamese health sector, as is discussed next.

2.5 What health donors fund in Viet Nam, and how they fund it

By combining and tallying information from two of the databases (DAC and the "28 donors") with that provided by donors in the study questionnaires the authors were able to assess the main focus of donor activity over recent years. The resulting table has been attached as Annex 2, and although volumes of funding are still missing for some projects the areas and modalities of donor investment stand out quite clearly. The information provided by health donors who replied to our questionnaire has been compiled in a separate document not included in this report that can be obtained from WHO Office in Viet Nam, on request.

The main areas where health partners are active in Viet Nam and the main aid modalities show the following characteristics:

- Except for its modest volume donor health support in Viet Nam is not very different from that found in other countries in the region. However, the volume of aid targeted at the hospital sector suggests a profile more typical of a middle income country than of a low income country.

- The type of areas favoured by health donor support represented were, according to OECD DAC: 35% investment projects; 25% technical cooperation; 1.9% a combination of the former two; and 0.8% sector programme support.

- The hospital sector (infrastructure, equipment and capacity building) was found to be a favoured area for support among donors such as Finland, France, Spain, Italy and JICA, some of whom also contribute to disease control interventions through support to national laboratories, blood banks, for example.

- Large donors like the World Bank, the ADB and the EC, together with their co-financing partners (such as AusAID) support health sector strengthening activities, although the World Bank is also an important funder in areas like HIV (with DFID co-financing) and in strengthening regional health systems (North Uplands project). Germany and Sweden on the other hand have been long term supporters of health systems strengthening at provincial level.

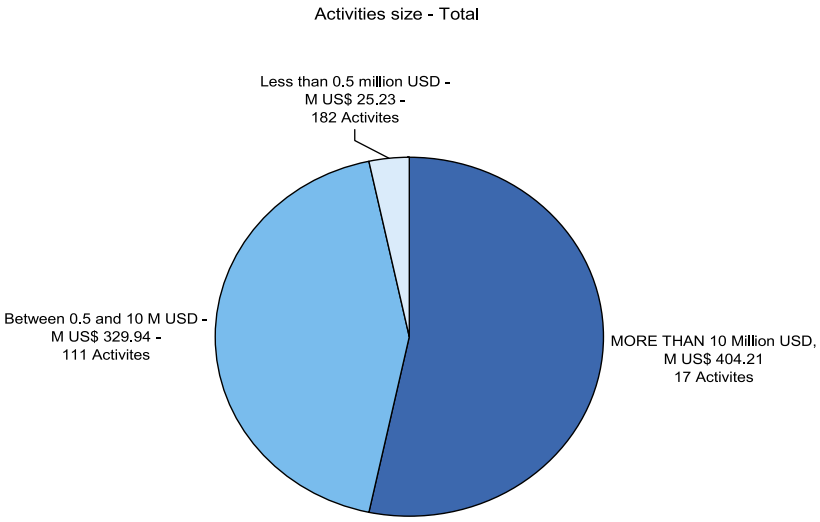
[4] Using the estimate of ODA as a proportion of total health expenditure from the NHA 2007 at 2.3% and working from NHA 1998-2003 (the last available confirmed data series) the ODA calculation for 2006 would be: 5.3% of government health budget when health sources include –as is the practice by the GoV- "user fees, loans, grants, health insurance, and others". When "Net Health Sources" from government budget are used, which includes health insurance but not user fees, loans or grants then the percentage would be 8.4%. Finally, if health insurance is excluded as a source of government budget (as is the practice in most countries) health ODA will represent 10.2% of the government health budget. Source: Peter Annear, Health Economist. Personal communication.

- The majority of donor funding in Viet Nam in terms of volume and in terms of numbers of partners is in the area of communicable disease control and in support to national target programmes (disease interventions). This is the area where partners such as the UN specialised agencies (UNICEF, UNFPA, WHO, UNAIDS), bilateral donors, such as the Netherlands and Luxembourg, and global initiatives like GFATM and the GAVI Alliance are more active. As will be discussed in section 4 of this report support to HIV takes the lion's share of donor support in health, reflecting large increases in PEPFAR and GFATM funding in recent years.

Even though the health areas are similar to other countries Viet Nam presents a number of distinct features in terms of the aid modalities favoured by health donors:

Fragmentation of health aid. Health aid to Viet Nam is extremely fragmented in terms of small amounts of aid supporting many different projects, This fact combined with the small size of annual aid allocations by individual donors has raised concerns about the overall effectiveness of health aid to Viet Nam. Fragmentation is apparent in various ways. One is that, for example, 58% of health aid provided to Viet Nam between 2002 and 2006 was in the form of small projects of less than $500,000. An additional 35% was funding projects of between $0.5 million and $10 million. Only 5% of the health projects were for amounts equal or above $10 million (Figure 1).

Figure 1: Size of Donor Supported activities – Cumulative total 2002-2006. Source OECD DAC



A recent report by OECD DAC in 2008 sheds further light into the extent of health aid fragmentation by showing that 11 out of 24 health donors in Viet Nam represent less than 10% of total health funding. [5]

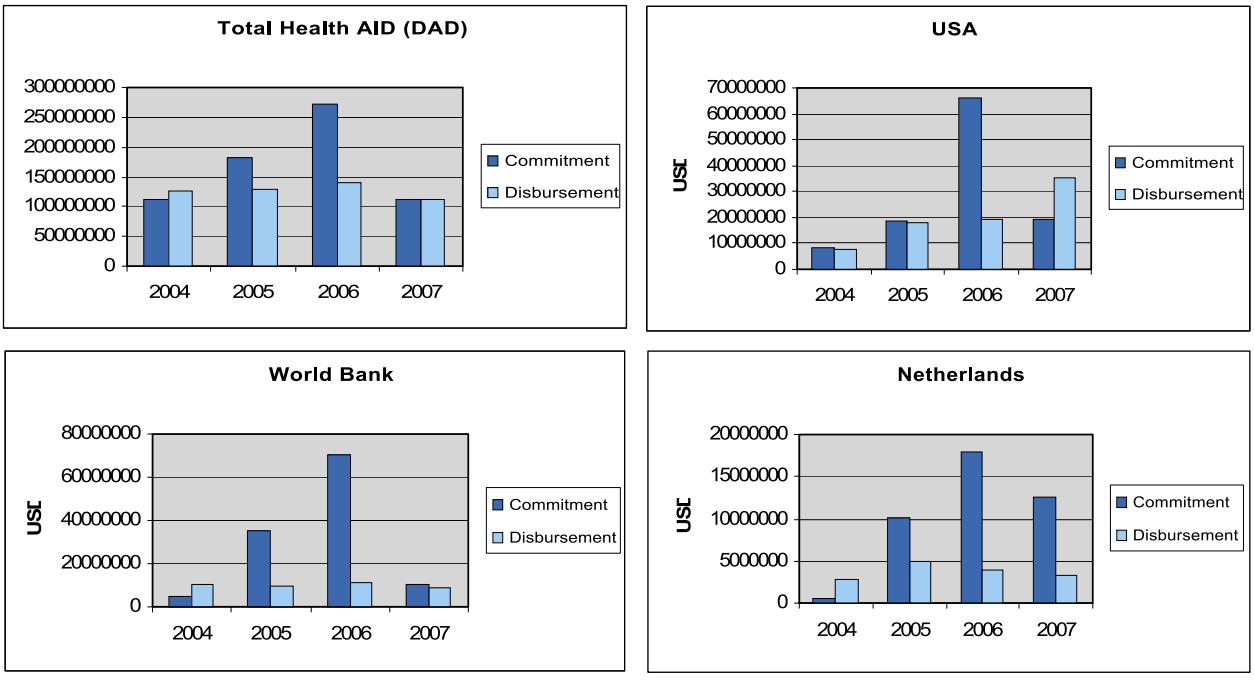
Over-reliance on project aid. The large majority of health aid to Viet Nam is provided in project form. In 2007, once PEPFAR and GFATM grants are factored in the number of externally funded health projects reached 75 (see Annex 2). Project aid is almost the sole form of health aid in Viet Nam as sector budget support, pool funding, basket funding or any other forms of joint programme financing are not in place. Thus, while health partners and government are increasingly interested in programme based funding, there is little actual experience with its use in the Vietnamese health sector.

[5] *Scaling up: Aid fragmentation, aid allocation and aid predictability – Report of the 2008 survey of aid allocation policies and indicative forward spending plans. OECD Development Assistance Committee. May 2008.*

Small projects funded by a single donor. Most health projects (98% of them) were found to be funded by a single health donor. Multi-donor health funded programmes are rare. Until recently multi-funded projects were either absent or very few in number. They consisted mainly of projects led by UN agencies, like UNICEF and WHO incorporating funding from large international NGOs (like Save the Children Fund). More recently, some bilateral and multilateral development agencies have begun to co-finance larger programmes. Such is the case of DFID or the EC co-financing World Bank programmes or Australian aid contributing to the new ADB health project. Even though the number and volume of co-financed projects is likely to increase in the coming years this is unlikely to reduce significantly the total number of projects, except in the case of donors planning to phase out their health sector funding in the coming years. One way to reduce the effects of fragmentation and reduce transaction costs would be for health donors to concentrate more of their aid at sector level by co-financing programmes. Where funding is delivered jointly with the MoH, project management units (PMUs) are often set up to manage the resources. This is another characteristic of aid to Viet Nam: a recent evaluation study found about 111 PMUs to be in operation, a fairly large number by any standard. [6]

Predictability of health aid. Development aid is generally reported to be quite unpredictable. Recent studies monitoring the implementation of the Paris Declaration on Harmonisation and Alignment (known in Viet Nam as the "Hanoi Core Statement") also mention that a large proportion of aid budgets remain unspent.[7] Unspent budgets and unpredictable budgets are usually two sides of the same problem. Limited predictability of health aid is evidenced by the significant differences between committed and disbursed funds among many health partners. The charts below taken from the MPI DAD database illustrate the extent of unpredictability of health aid in the period 2004 to 2007. They are also consistent with OECD DAC data. [8]

Figure 2: Health Commitments and Actual Disbursements by health donors in Viet Nam 2007. Source: DAD, MPI, Government of Viet Nam



[6] *Marcus Cox, Sam Wangwe, Hisaaki Mitsui, Tran Thi Hanh. Independent Monitoring Report on the Hanoi Core Statement. Final report November 2007*

[7] *Cox et al. op cit.*

[8] *Analysts may argue that a longer (3 year) look at commitments versus disbursements would offer a much more even picture of predictability than the annual one. However, from the viewpoint of the country receiving aid current differences are still significant on an annual basis and show higher variations than those found in countries with lower levels of development like Mozambique, Uganda, Zambia or Bangladesh.*

While unpredictability is high, the impact that unpredictable aid has on the planning and performance of the national health system is hard to establish because of the over-reliance on parallel, project-type aid and because there is not a broader health sector performance framework against which the performance of project aid can be evaluated. In the cases where project aid is delivered jointly by health partners and MoH departments through PMUs, the impact of unpredictability on the health sector is likely to be larger, as the Government may allocate counterpart government resources to those initiatives, which would have greater implications if donor pledges were not actually made, but this was not assessed in any depth during our study.

2.6 Effectiveness of aid to the health sector in Viet Nam

While this study has not enabled a deep analysis of health aid effectiveness in Viet Nam it is clear from the previous section that there are a number of factors that considerably limit the effectiveness of aid to the health sector. These include: (a) poor, inconsistent reporting and monitoring of health aid flows; (b) high levels of fragmentation and poor predictability of health aid; (c) high reliance on project aid, much of which is single-donor funded, largely donor driven and high in transaction costs; and (d) much of the effectiveness of project aid in terms of health system development remains unknown.

Although the situation depicted is not unique to health, the health sector in Viet Nam features among the less developed sectors in terms of its adherence to the principles of the Paris Declaration or, in Vietnamese terminology, the Hanoi Core Statement on aid effectiveness.

For example:

- Most donors have aligned their country programmes to the Socio Economic Development Plan (SEDP), but alignment at this level has not been a very onerous commitment and has not involved any significant reorientation in donor programmes. Alignment at sectoral level represents a more difficult challenge, as this depends on the state of sector planning and budgeting processes, as well as the quality of engagement by donors, both of which have been reported to be weak in the Vietnamese health sector.

- In the most advanced sectors, such as education, line ministries have begun to plan their activities against a common resource envelope, which includes both national resources and ODA. This has taken several years of harmonisation and alignment efforts to achieve. In health, programme based funding and the move towards a SWAp are being discussed, but progress seems slow and a clear roadmap to move in that direction is not yet in place.

- Since the HCS was adopted, new aid modalities, principally targeted budget support, have been trialled in education, small infrastructure and rural water and sanitation, but not yet in health. Essentially, the incentives for moving in that direction do not seem to be clear in the case of health, a sector with low aid dependency where donors have a limited ability to influence policy or to engage with the MOH in medium-term sector planning. On going initiatives for moving towards a programme approach in health are, at best, incipient, even in sub-sectors like HIV where the presence of donors and volumes of aid would make such an approach more relevant. In study interviews with health partners, the ADB was keen to develop a policy matrix as the basis for stronger focus on priorities and for more robust policy dialogue. While this is a very promising initiative, it is yet unclear (and critical) whether other important health partners will follow suit.

- If a programme approach in health is to be developed, the MOH will also need to demonstrate greater drive and determination to move in that direction, and to become more engaged in diagnosing its own capacity-building needs, developing its capacity-

building strategies and providing donors with clear guidance on preferred support modalities. GoV and health donors should agree on a comprehensive approach to capacity building, as required under the HCS, and on practical measures to strengthen country leadership of capacity-building support.

- Parallel ODA structures can compromise sustainability and distort resource allocation. Donors need to make a clear commitment, not merely to avoid parallel structures and financial incentives to set up new projects, but also to phase them out for existing projects. This will entail some careful change management, including additional capacity-building support to assist GoV with the integration of existing projects. GoV and donors should jointly develop a road map for accomplishing this.

All the above issues have been reported in the Independent Evaluation of the HCS (see footnote 4). The reviewers also make specific reference to the importance of the social sector advancing towards the HCS with greater determination as Viet Nam approaches MIC status:

> *"A factor with a strong bearing on aid effectiveness is Viet Nam's approaching MIC status... There is as yet no clear consensus on the implications of this for the HCS. Bringing country systems up to international standards, to enable Viet Nam to access new forms of development finance, is clearly a priority".*

2.7 Conclusions and recommendations

There are significant issues to be addressed in Viet Nam in relation to the effectiveness of health aid as it is currently delivered to the health sector. External health funding may be small in terms of total or government health spending, yet it has brought and can continue to bring innovation and focus on health systems, both much needed as Viet Nam makes its transition to MIC status. While the findings in terms of health aid effectiveness are not new they need to be more proactively addressed by both the Ministry of Health (MOH) and its health partners.

For a start, the effectiveness and impact of health aid in the Vietnamese health system remain largely unknown, while issues relating to aid effectiveness and predictability are apparent. Also, the health sector lags behind other sectors such as education in terms of progress against the principles defined in the Hanoi Core Statement. Against that context the shift in direction that the MOH and its health partners have begun to make in recent years towards a programme approach through the Health Partners Group and the JAHR are very welcome and should be nurtured and accelerated. What remains to be done is for the MOH and its health partners to prepare a common programme of work that highlights the main health sector priorities and challenges that will need to be met as Viet Nam approaches MIC status.

Three recommendations are made for improving the effectiveness of health aid along the same lines as those made in 2007 by the independent reviewers of progress towards the Hanoi Core Statement:

- Building stronger sectoral capacity in sector analysis and sector monitoring through the development of programme-based approaches;

- Improving country leadership in the use of health aid and in definition of capacity-building needs and support modalities; and

- Phasing out parallel PMUs and perverse financial incentives linked to existing aid delivery modalities while renewed focus is placed on stronger MOH units and departments more competent in terms of sector policy monitoring and implementation.

Section 3 - Health system priorities during the transition to MIC

3.1 Brief overview of health progress in Viet Nam

Viet Nam, a socialist republic, liberalised its economy and adopted a market approach following the Doi Moi programme initiated in 1986. Since then, its economic performance and social indicators have improved steadily to the extent that Viet Nam has achieved levels of social development and basic health that are remarkably better than those in countries with similar or even higher per capita incomes. Much of this achievement has been the result of widespread practices of promoting social solidarity and a relatively egalitarian distribution of wealth and income. For example, the number of poor households decreased from 58% in 1993 to 19% in 2006 (World Bank, Country Overview 2008).

Another contributor to the relative well being of the majority of the population has been a health system with wide population coverage, which provides many modern and cost-effective disease control interventions and primary health care services delivered through an extensive grassroots health services network (World Bank, Country Overview 2008). The combined effect of all the above is that Viet Nam has either already achieved or is on the way to achieving most of its education and health related MDGs, with the exception of the HIV indicators, linked to a growing HIV epidemic.

However, Viet Nam also has one of the highest rates of childhood malnutrition in the region and, in common with other countries in epidemiological transition, it is also facing an increasing burden of non communicable diseases, of which tobacco related diseases and mortality related to road accidents represent a significant challenge (WHO profile 2008).

Finally, all health and social indicators should be looked at with care as there are important differences in poverty levels, health status and access to basic and health services among richer and poorer population groups and provinces. The gap in terms of access to health and basic services and the income gap between the richer and poorer quintiles have increased in recent years (MOH/HPG Joint Annual Health Review 2007).

In sum, Viet Nam has achieved remarkable improvements in its health, education, social and economic indicators far and above those achieved in other countries with similar or even higher economic status. However, while the country continues to make steady progress in all these areas it will need to sharpen its focus and performance in a few critical areas. These include the expanding HIV epidemic, high childhood malnutrition levels and growing differentials in health status between the better off and poorest Vietnamese. An additional challenge is to address the model for health financing.

3.2 Health financing and delivery in Viet Nam

The first responsibility of a government aiming to bring equity in access to health care, to achieve solidarity in the distribution of health care costs and to attain the best possible health outcomes for the whole population, particularly the poor, is to have a health financing model that enables and strengthens the achievement of such principles. There is increasing evidence that the health financing model in Viet Nam may not deliver successfully on one or more of these three principles of equity, solidarity and efficiency. This section looks first at health financing issues, as these will largely determine the type of health care system that will emerge as Viet Nam attains MIC status.

Box 1 - Summarises the main health financing issues.[9]

Box 1 – Health Financing in Viet Nam

Viet Nam spends about 5% of its GDP on health, 70% of its revenues being raised through out-of-pocket (OOP) payments. This reflects a relatively small share of government expenditure allocated to health (the government spends less that "expected") rather than a small share of government spending in GDP. Aware of these issues the Vietnamese government and the National Assembly have pledged to increase health spending up to 10% of total government spending by 2010, but this commitment may not be feasible given the current macro-economic situation that has hit Viet Nam badly.[10]

While Viet Nam has done and continues to do better than most other countries in terms of health services and health outcomes, its health system could do much better, particularly in terms of efficiency and protection of the poor. For example, Viet Nam has a high incidence of catastrophic household health spending since a large fraction of households make out-of-pocket (OOP) payments for health care that exceed a reasonable fraction of their income. Viet Nam is still far from the government goal of achieving universal health coverage since the country's social health insurance only covers about 43% of the population. Besides, most government spending on health is still on supply-side subsidies, with the total health insurance programme accounting for just 10% of health spending.The supply side subsidies are absorbed mostly by urban high-tech hospitals, while social health insurance enrolments and outlays are highest among the better off and the poorest quintile (covered by compulsory insurance by the government) leaving the middle three wealth quintiles without subsidised health coverage.

Viet Nam's provider payments methods are a mix of budget (dominated by bed norms) and fee-for service, with prices fixed by the government in 1995. This has led to high utilisation of hospital services, with bed occupancy rates often exceeding 100%, while many primary services remain under-used, the latter reflecting a generalised perception among the population that hospital care is better, including the poor who have an incentive to use hospital services as the price differentials with community health services are comparatively small. The current financing model is thus full of perverse incentives that result in high consumption of often unnecessary care and that commit households to levels of spending above their means or even their needs. This situation has probably been made worse by the considerable autonomy that has been granted to hospitals and by an increased recent focus on user charges.

In sum, low government health spending, high reliance on OOP payments, perverse provider payment methods and prevalence of supply-side subsidies all work against the government goal of achieving universal health coverage. These features also mitigate against protecting poor people from catastrophic illness and from spending on unnecessary health care, or on health care that could be provided at lower cost and in lower level health facilities.

The significant number of financing and service delivery constraints in Viet Nam's modern, progressive and socially conscious national health system is probably due to a succession of health-related decrees, decisions and laws that appear progressive when looked at individually but have jointly resulted in a rather regressive health financing situation. This health financing model may not be able to protect poor and low middle-income Vietnamese from the impact of catastrophic illness, especially now that the global and Vietnamese economic recession may put household economies under unbearable stress.

[9] The information in the text box is based on a recent World Bank study by S Liebermann and A Wagstaff, "Health Financing and Delivery in Viet Nam: the short- and medium-term policy agenda", a draft of which was presented by the authors on 18 June 2008 in Hanoi. While the study provides useful figures and analysis the use that has been made of them is exclusively the responsibility of the author of this report. I wish to thank and congratulate my World Bank colleagues for an excellent study.

[10] Viet Nam´s economic situation has experienced a recent downturn and is fast overheating according to many sources including UNDP, The World Bank and The Economist Intelligence Unit from where most of the following figures have been extracted. Year on year inflation is at 25% (from 6-8% in previous years) and the current account deficit represents 9.2% of GDP. The trade deficit is huge at US$ 14 billion. GDP growth scenarios are being lowered at around 7% for 2008 and the offshore trading of the Viet Nam Dong is pricing a further 30% devaluation. The government number one priority is said to be inflation. In these circumstances higher government spending in social sectors appears unlikely in the short term.

3.3 Why should health partners increase their involvement in health financing, sector regulation and stewardship?

The main reasons for health partners and the government to address the health financing situation and the linked needs for stronger sector regulation and stewardship include the following.

- The model is not achieving the principles of equity, solidarity or efficiency. Left unattended it might become more inequitable and inefficient given the fast pace of health care decentralisation that is taking place. As pressure increases for provinces to generate revenue to cover their health care costs there is a risk that certain essential services might become privatised or their cost become unaffordable to part of the population.

- For a decentralised health care model to deliver equitable and efficient health care with solidarity it needs to be properly regulated and managed. While making progress, further strengthening is needed of MOH regulatory, normative and stewardship capabilities. It is also apparent that provincial health authorities need stronger capacity in combining needs-based health planning and monitoring of service outputs with the increasing emphasis on revenue generation that might leave poor and middle income Vietnamese more vulnerable to the consequences of catastrophic disease.

- The response that health partners are providing in relation to health financing and social protection seems insufficient. Firstly, there is not yet a long term plan on how to address the shortcomings of the current financing model. Second, any such plan would need to be supported through a programme approach involving much stronger donor coordination than is the case now, and designing such a programme of support will take time. Thirdly, part of the response will require better coordinated technical assistance through a model that prevents individual donors providing different responses to essentially the same problems. In our opinion such disjointed responses have reduced the visibility of the health financing problem and the leverage that health partners have in relation to stakeholders such as the MOH and the MOF.

- It makes sense for health financing to be at the centre of a better coordinated response by health partners as health financing is closely interrelated with other critical areas such as human resources management (HRM) and development (HRD) and services delivery. This means that a policy matrix containing the main elements to be addressed in health financing could be used to deal with other important policy areas (such as incentives, performance, and results orientation), so it could become the basis for the programme approach that the MOH and health partners are aiming for.

- A policy matrix with a strong health financing component could provide direction to the Health Partners Group and lead to a more focussed and result oriented JAHR, where the emphasis is on the joint programme of work rather than “improved coordination” or progress against the indicators of the JAHR monitoring matrix (since the current matrix fails to link sector development indicators with a mutually agreed MOH-HPG plan of work). Such a link is essential to move towards a programme based approach and linked financing.

- Donors who argue either that health financing cannot be the main or sole basis for policy dialogue or that it cannot substitute for a fully fledged health sector plan and resource envelope should remember the length of time that these processes have taken in other countries, not always with the expected results. The reviewers of the Hanoi Core Statement also argue that “complex new initiatives like sector-wide approaches, which take some years to become effective, are not feasible in the time available”. A more focused and simplified approach is likely to work better.

3.4 Will there be major gaps left by departing health partners or by smaller health aid budgets?

Although modest in volume donors have over the years provided substantial support to strengthening the Vietnamese national health system by supporting, technically or financially areas such as: health policy and legislation; health services delivery, including hospital and PHC pilots; strategic planning, governance and stewardship of the sector; health financing (in many forms) and protection of the poor; sector monitoring and evaluation; and, more recently, harmonisation and alignment (H&A) of external development assistance. How will progress in these areas be affected once Viet Nam attains MIC status?

In order to answer that question we must first consider how important and effective is current donor support to the health sector in terms of its health systems development potential and its capacity to influence sector policy. Judging from the previous chapter much health development assistance is of unknown effectiveness.[11] Therefore, instead of considering health aid effectiveness, which is variable and hard to measure we propose to look at the health systems development potential of current health partner initiatives. In that light we consider that the more important and needed health partner interventions during Viet Nam´s transition to MIC are and will be those with the characteristics below.

- The government has taken an active role in design and implementation. In this category we would place the World Bank and ADB health projects and programmes and the financial contributions from donors who have chosen to co-finance those projects such as DFID, Australian Aid, Japan or the EC (to mention the main ones).

- The funding provided by donors supports essential health commodities. In this group we would place PEPFAR, GFATM, Clinton Foundation and some programmes supported by the World Bank in the area of HIV and communicable diseases.

The responses provided by health partners to our questionnaire (see Table 1 at the end of this section) suggests that funding in the above areas will be available until at least the year 2013, if not beyond, and that therefore these areas will be covered as Viet Nam attains MIC status. Of course, beyond that point the situation will change and much of that funding will no longer be available.

There is a third area where the funding of health partners brings in innovation and helps adapt certain interventions to the Vietnamese context. This is done mainly through technical cooperation projects, demonstration projects and pilots. It is not possible to predict which donor departures are likely to have an impact on which technical areas beyond the following considerations:

- In the absence of coordination structures for technical assistance and in the context of a rather insufficient policy dialogue between government and health partners the impact of technical cooperation is very much reduced. From interviews held it would appear that much technical cooperation is very donor driven, to be point of being at times just “tolerated” by the MOH rather than requested or wanted.

- Our sense is that if and when health partners and government eventually decide to target health aid to specific areas of health systems strengthening they will easily find the needed sources of funding. Therefore it is important to look at what type of health aid

[11] These issues are discussed in the evaluation of the Hanoi Core Statement by Cox et al (references earlier) but also in numerous reports, including: Feasibility of the Programme Approach in the Health Sector in Viet Nam by Leon Bijlmakers, Nguyen Thanh Hang, Nguyen Thien Huong, Dao Thanh Huyen, Martin Schmidt & Stefan Sjölander. June 2006.

and of technical cooperation will be needed in the coming years, rather than at the gaps that will be left by departing donors. In this sense the departure of donors who have for many years supported health systems development in Viet Nam (such as Sweden and the Netherlands) and the likely reductions in aid budgets forecast by other partners (see Table 1) may not leave a significant or irreparable gap if the effectiveness and coordination of health aid are promptly and substantially improved, as argued in previous sections of this report.

- Therefore, it is in the hands of the GoV and its health partners to ensure that any key gaps left by departing donors are compensated for by remaining health partners, but this would require a much better coordinated, predictable and cohesive approach to delivering health aid than the one that is in place right now.

The situation above will present the UN agencies with considerable opportunities to continue to support the GoV and Vietnamese institutions in a number of technical areas. UNICEF, UNFPA and UNAIDS have stated (see table 1) that they will stay in Viet Nam for as long as the government asks them to stay. The three agencies are assessing their position in relation to MIC status (UNICEF is actually conducting an assessment on the same) but they are likely to provide support post MIC even if some reductions in their country aid budgets are to be expected. It is therefore quite important for these agencies to position themselves well in health policy areas that are critical to Viet Nam's development.

3.5 The future for technical assistance (TA)

While a few health partners have delegated the provision of technical assistance to either specialised agencies (for example, DFID to WHO in the case of HIV, or several bilaterals to UNAIDS) the large majority of (mainly) bilateral agencies and large NGOs continue to commission or deliver TA through their own channels and with little if any involvement of the government in TA decisions. This is particularly noticeable in the pilots that take place at provincial level where a large number of consulting firms from different countries approach similar situations from widely different perspectives which makes the generalisation of processes and lessons extremely difficult. There are also significant opportunity and transactions costs incurred through this approach.

The issue of technical assistance was not looked at in great detail during this assignment, but two issues emerge:

- Technical assistance is likely to continue in the short to medium term regardless of Viet Nam reaching MIC status, and will continue after that (perhaps) in the form of stronger trade relationships (some health partners are already favouring this kind of TA through "institution to institution collaborations").

- Technical assistance will be key to support improvements in health systems areas of health financing, payment systems, governance, and regulation. TA will also be important to ensure knowledge transfer and adaptation from international approaches to the Vietnamese context, and to build national capacity.

It would be advisable for health partners to better align and harmonise their TA, as too many suppliers advocating for several models would not result in the kind of solutions that the GoV would need in areas such as, for example, health financing.

3.6 Conclusions and recommendations

The attainment of MIC status will not have much impact in terms of health aid budgets and presence of donors as much health aid is guaranteed until at least 2012. Beyond 2013 health aid budgets are likely to decline significantly, but whether or not this will have an impact on the Vietnamese health system depends on how health partners position themselves in important areas of health policy and on whether the external aid to the health sector becomes better coordinated and more effective.

There are important areas of health sector development such as health financing, sector regulation, stewardship and strategic planning, which need urgent attention by health partners and government alike as Viet Nam approaches MIC status. Some of these areas have received some attention in recent years. However, because the support through external aid has been so fragmented the effectiveness, visibility and impact of the response have all been greatly reduced.

Donors interested in helping Viet Nam deal with current challenges, such as the health financing situation described earlier will need to act quickly. On the same note the GoV will also need to move fast and ensure a more effective policy dialogue with health partners that leads to a more joined up and better coordinated programme of work, where the technical and policy related needs of the GoV and the MOH become more apparent. Such response is more likely to take place if progress is achieved in moving towards a programme approach in health (not necessarily a full fledged SWAp).

After reaching MIC status a few health partners will leave and health aid will be reduced. Our sense is that if and when health partners and government eventually decide to target health aid to specific areas of health systems strengthening they will easily find the needed sources of funding and other technical resources for it if they work more effectively together.

The situation above will present the UN agencies with considerable opportunities to continue to support the GoV and Vietnamese institutions in a number of technical areas as long as these agencies position themselves well in health policy areas that are critical to Viet Nam.

Given these issues, current government and donor efforts to achieve a common ground through the Health Partnership Group (HPG) and the Joint Annual Health Reviews (JAHR) acquire additional importance. The HPG, JAHR and the underlying “SWAP philosophy” represent an opportunity for increased engagement and dialogue between government and its health partners at a time of change. Efforts to support these processes should be continued, accelerated and strengthened.

Health partner efforts should also become more focused, perhaps by being based on a more explicit, mutually agreed working framework or “health priorities matrix” that would enable health partners and government to better work together and to align and harmonise their efforts and aid delivery strategies. At the moment much of focus of the JAHR and the HPG seems to be on improved coordination, but it is necessary to define the specific areas to be targeted by such coordination. We strongly recommend that the priorities matrix include the areas of financing, regulation, strategic planning, sector governance and stewardship. These are areas where government officers interviewed for this study all agreed that donors can provide added value through strategic funding and innovation.

Table 1 – Summarised responses to the study questionnaires from 17 health partners
(Source: study questionnaire unless otherwise stated)

Health Partner	Will MIC status affect its ODA to Viet Nam? How?	Current work and plans, Issues and remarks	Q[12]	I
ADB	Not much in terms of ongoing operations but the Madrid 2008 meeting implies ADB will no longer support health programmes after the current one under design.	Main focus is the health sector support project under preparation (HRH, Health Financing, Health Services). Combines elements of policy loan and programme loan. Co-funded by Australia. Exploring links with EC and WB work and plans. Attempting to link it to JAHR process through a policy matrix that becomes the subject of annual reviews.	NO	Y
Australia Aid (AusAID)	No expected changes in the short term – funding guaranteed up to 2012.	AusAID to co-finance World Bank Health Financing Project (US$ 7m) and ADB HSS project (US$10m). Expects more donor harmonisation, including the EC, working on a common policy matrix. Flexible TA line likely to continue.	Y	Y
European Commission	Current country strategy for Viet Nam, in which health is one of the two focal sectors, foresees significant support until 2013 (3 years after Viet Nam possibly becomes a MIC).	To assist the GoV to strengthen its health system with the goal of contributing to the improved health status of people in Viet Nam, in particular those who are poor and near-poor, as a contribution to poverty reduction and the attainment of health-related MDGs.	Y	Y
Finland	No explicit MIC policy. The new Government of Finland white paper on development policy is the basic document for our programme. This is an issue, which has not yet been discussed within the organization.	Finland will continue its support to fight Avian Influenza and for Water & Sanitation projects in small urban areas. Finland also has a number of hospital equipment projects in the pipeline in its concessional credit portfolio. An important issue, which may be looked deeper into in the future is how current health sector reforms and challenges, including increased privatisation of health care, changes the context for the health care equipment projects that we currently have in the pipeline.	Y	NO
France	Not known but probably the MIC status will not affect French cooperation in health much since this is already inter-institutional (between institutions in France and Viet Nam).	No changes expected to current portfolio, estimated at € 1.6m/ annum involving projects like ESTHER, ANRS, Gripalvi, SISEA, Meso-viet Nam, Fasevie, FFI, among others.	Y	N
German development Cooperation (GDC)	GDC will continue to be active in health along the same lines as now. No expected changes as a result of Viet Nam becoming a MIC. Note: information included herein is from presentation by Tran	Pipeline is mainly on Technical Cooperation: (a) Strengthening provincial health systems in Thahn Hoa, Yen Bai, Phu Yen (2008-2010: €12.5m); (b) Strengthening capacity and Stewardship of the MOH (1008-2010: €0.5 million); (c) An extension of (a) to other	N	Y

Table 1 – Summarised responses to the study questionnaires from 17 health partners
(Source: study questionnaire unless otherwise stated)

Health Partner	Will MIC status affect its ODA to Viet Nam? How?	Current work and plans, Issues and remarks	Q[12]	I
JICA	JICA may decrease the level of support and seek to work as a development partner with Viet Nam to jointly assist other countries. Also, some MICs are not eligible for the Japanese Government's Grant Aid scheme, which is generally used for building facilities and providing equipment.	AusAID to co-finance World Bank Health Financing Project (US$ 7m) and ADB HSS project (US$10m). Expects more donor harmonisation, including the EC, working on a common policy matrix. Flexible TA line likely to continue.	Y	NO
Luxemburg	Beyond 2010 Luxembourg will probably focus more on Programme Based Approach rather than isolated projects.	Work will continue on strengthening EPI, Cold Chain, Safe Blood, access to poor people to health care and support to the JAHR process.	Y	No
Netherlands	All on-going programmes will not be extended nor followed up after completion. It was hoped to put all existing support areas on sector budget support by July 2008 but this no longer seems realistic.	Focus of Dutch assistance to date has been on support to national programmes with a pro-poor orientation such as nutrition, health and SRH care to HIV+ families, TB, Safe Motherhood. Pipeline for 2009-2011 period is for €24.4m.	Y	NO
PEPFAR	PEPFAR funding unlikely to change significantly until 2010, then it is hard to predict although source is optimistic that US support for HIV in Viet Nam will continue. For longer term involvement beyond MIC PEPFAR would probably expect higher levels of government funding for HIV programme.	Current level of support of approximately US$ 88m for 2008, US$ 86m in 2009 and US$ 84m in 2010. Same PEPFAR program areas and approaches. Source: Interview with James S Sarn, Country Coordinator PEPFAR	NO	Y
Sweden	The main bilateral cooperation with Ministry of Health was successfully concluded end 2007. There will be no further regular support to the health sector apart from normal trade and business relations.	Pipeline is mainly on Technical Cooperation: (a) Strengthening provincial health systems in Thahn Hoa, Yen Bai, Phu Yen (2008-2010: €12.5m); (b) Strengthening capacity and Stewardship of the MOH (1008-2010: €0.5 million); (c) An extension of (a) to other	Y	NO
UNFPA	Unsure - UNFPA works in about 150 countries which are classified in three categories depending on their reproductive health and other indicators. UNFPA is considering eliminating the income criteria in the definition of the groups of countries to focus exclusively on needs, but even in the latter case country income would be taken into account when deciding on the distribution of resources to individual countries.	The pipeline 2009-2011 is for approximately US$ 1.5m. Part of the US$ 11 available to the CP7 programme would also be allocated to Viet Nam.	Y	NO

Table 1 – Summarised responses to the study questionnaires from 17 health partners
(Source: study questionnaire unless otherwise stated)

Health Partner	Will MIC status affect its ODA to Viet Nam? How?	Current work and plans, Issues and remarks	Q[12]	I
UNAIDS	This will be dependent on the capacity of the country to respond to the epidemic and the HIV prevalence. Current donor support and potential withdrawal are key issues related to UNAIDS' work as Viet Nam becomes a Middle Income Country. Level of support by UNAIDS will not change, but types of support may change in line with government and other sector requests.	UNAIDS will continue to uphold the 5 strategic objectives: (a) Mobilizing leadership and advocacy for effective action on the epidemic; (b) Providing strategic information and policies to guide efforts for the AIDS response worldwide; (c) Tracking, monitoring and evaluation of the epidemic and the response; (d) Engaging civil society and developing partnerships; (e) Mobilizing resources to support an effective response.	Y	Y
UNICEF	UNICEF is assessing this issue. UNICEF will maintain its support beyond MIC status, but its focus will shift to priorities and areas where it has comparative advantage. Probably, UNICEF will focus more on equity, right-based and pro-poor policies.	The pipeline for 2009-2011 is for approximately US$ 5.3m.	Y	No
UK DFID	If and when Viet Nam reaches MIC status DFID will reduce its level of support and focus on forms of technical cooperation and trade used in other MICs.	DFID plans to co-finance the World Bank's HIV support programme. Focus on harm reduction. Planned investment is up to £18m but programme is under design. Some commodities (syringes, needles and condoms) will be funded.	Y	Y
US Embassy & PEPFAR	The respondent from the US Embassy considered that MIC status would not affect the US programme much. The National PEPFAR coordinator could confirm aid pledges up to 2010, but not beyond as much depends on the outcome of the US Presidential Elections.	The US is an important health donor, particularly in the area of HIV/ AIDS with US$ 88m planned for 2008 and slightly smaller amounts for the following 2 years. PEPFAR will continue delivering program activities in its 7 focus provinces and contributing ARVs and other commodities in a few additional provinces.	Y	NO
WHO	No firms plans at this stage, but there will likely be a change in the nature of support we provide over the medium term. Work on capacity building and health systems support will likely continue; we expect to reduce our project management work as donors begin to scale back.	WHO will programme $33.2m over 2008-09	N	

Section 4 - Impact of transition to MIC status on communicable diseases

4.1 Introduction

Viet Nam has achieved remarkable improvements in disease control as evidenced by consistently decreasing prevalence rates in TB, malaria, avian influenza and all vaccine preventable diseases, among many others. Such success responds to a combination of factors including: (a) a remarkable economic performance combined with the principles of solidarity and social responsibility; and (b) the focus of the Vietnamese government on cost-effective health interventions effectively implemented through a hierarchical government health system. Donors and development partners share credit for these achievements through financial support and sharing the costs of important commodities. Technical assistance, training and support to programme implementation and innovation in specific areas and provinces have played a role, albeit somewhat donor driven and limited by poor coordination. At the moment the presence of donors remains significant in at least four diseases that are important to Viet Nam: avian influenza, tuberculosis (TB), malaria and HIV. These will be briefly reviewed next [13] .

4.2 Avian influenza, tuberculosis and malaria

Avian influenza: many donors have closely supported the avian influenza epidemic and there is every indication that they will continue to do so (mainly through TA and support to public health laboratories) in an area where there is strong government leadership.

Tuberculosis: much progress has been achieved in tuberculosis control in Viet Nam. The two significant funding sources are the GFATM and bilateral aid from the Netherlands. A Round 9 application to the GFATM is under consideration. While funding needs are covered until 2011 the results of the latest household survey suggest there may be 1.5 times more TB infected people as initially estimated, which might require a stronger response and more resources. Most TB drugs are financed and provided by and through the government. Technical support is being provided mainly through WHO, so the medium term scenario is one of small reliance on donor funding. However, it remains to be seen whether case detection incentives hitherto funded by donors will remain following their departure. Such incentives are considered important at the time of explaining Viet Nam´s high TB case detection rates.

Malaria: Viet Nam has achieved remarkable success in malaria control mainly through effective vector control (ITNs) and the use of artemisinin combination therapies for the treatment of uncomplicated malaria. The estimated annual malaria-related mortality is around 50 deaths, a very small number for such a large country that only two decades ago suffered from one of the worst malaria-related mortality in Asia. While the government funds HR, drugs and programme costs there is high dependency on donors like the GFATM for commodities such as ITNs. Such dependency was highlighted by the GFATM itself in the Round 3 Performance Evaluation when it stated that "…there is concern that the Global Fund is the only international donor providing 60% of the national malaria budget, and this reliance is expected to increase in 2007/2008".

[13] Health partners have been active in supporting many more communicable diseases than the four depicted in this section. These have been chosen after applying the methodology described in Annex 3.

4.3 Donor support to HIV

Brief overview. In contrast to disease control programmes where external funding is comparatively small (although strategically significant), the field of HIV has a significant donor presence, with at least 25 major donors in 2006, implementing an estimated 121 projects country wide and representing between 80-90% of total HIV funding.

In spite of efforts and moderate successes the HIV epidemic in Viet Nam is growing steadily. Progress of the epidemic is annually monitored from sentinel sites in 40 (from a total of 69) provinces.[14] By March 2008 the cumulative numbers were: 162,423 reported HIV positive people, 64,882 reported AIDS cases and 38,648 reported deaths due to AIDS. National HIV prevalence has been estimated at 0.44%, with highest prevalences among injecting drug users (IDUs) (33%), female sex workers (FSWs) (16%) and men who have sex with men (MSMs). The fastest spread of the epidemic is among clients of sex workers as well as among sexual partners of IDUs.

In terms of impact on the national health system, an estimated 5,000 to 10,000 new HIV infections per year can be expected in the next three years.

The last few years have seen a significant expansion of bilateral and multilateral support to the national HIV response. Overall, international support has increased from about US$7-8 million in 2002-04 to around US$ 51.8 million in 2006. In 2006 this represented 91% of the total budget for HIV prevention, treatment, care and support in Viet Nam. Domestic contributions are also on the increase, albeit modestly, from US$ 5 million in 2006 to US$ 9.4 million in 2007 [15].

In line with the Hanoi Core Statement, international development partners have committed to align with the government's strategies and to strengthen national systems. Under the lead of the MPI and MOH, and in order to further enhance management, UN agencies, donors and NGOs have developed a joint GoV-Donor Coordination Action Plan (CAP) for the coordination and utilisation of resources on HIV. This is set within the framework of the 'Three Ones', and aligned with the principles of the Hanoi Core Statement.

In spite of substantial support and moderate progress from its scale up in 2005 the National HIV response is still far from achieving the targets set.

- Current coverage of anti-retroviral therapy (ART), at around 26-30%, is still far from the 70% government target set for 2010. Also, to date, none of the 80 or so Compulsory Drug Rehabilitation Centres in Viet Nam (with an estimated inmate population of between 40,000 and 80,000 IDUs) has access to ART and to key preventive services (including condoms) even though the IDUs (some of whom are also sex workers) in these centres are probably the at highest risk for spreading the disease. It is unofficially estimated that as many as 50% of them may be HIV positive.

- Even though availability of ARVs has improved markedly there are important differences in access to ARVs between the 7 PEPFAR "focus" provinces, the 20 planned GFATM provinces and the rest of the country (an additional 49 provinces) where the remaining 35% of the HIV-positive people live.

- An effective prevention response is needed to balance the focus on treatment. According to international good practice, coverage of needles and syringes to IDUs needs to reach

[14] *Source: presentation by Nguyen Thanh Long, Director General, VAAC.*
[15] *Source: GOV/UNGASS report January 2008*

80% to have a real impact on the epidemic. Viet Nam is currently well short of this target, but scaling up.

- Concerns have been expressed about the efficiency and longer term sustainability of the response, particularly as many staff involved in the national HIV response receive different types and amounts of incentives, depending on which donor provides the funding. Differences are already apparent between PEPFAR and GFATM provinces.

Likely impact on HIV funding and MIC status. The following international organisations have supported technical assistance and funding for the national HIV response [16].

Bilateral : The United States of America (USAID, CDC/PEPFAR), the United Kingdom (DFID), Norway (NORAD); Australia (AusAid); Germany (GTZ, KfW); France; Canada; Sweden (SIDA), Denmark (DANIDA) and Japan (JICA)

United Nations Organisations: UNAIDS, UNDP, WHO, UNICEF, UNFPA, UNESCO, UNODC, ILO, IOM and UNV.

Multilateral Organizations: The World Bank (WB), Asian Bank for Development (ADB) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

International Non-Government Organizations: Family Health International (FHI); the Ford Foundation; DKT; Population Service International (PSI); CARE, Futures Group/HPI, Pact, MDM, World Vision and Save the Children Fund UK.

Most of the donors mentioned above are unlikely to change their support to the national HIV response as a result of Viet Nam becoming a MIC, since the largest donors in financial terms are bilateral agencies and global initiatives who provide grants, not loans. For example:

- The United States of America (through PEPFAR) is the largest donor in terms of volume of resources (an estimated US$ 59 million per year in total). USAID officers contacted for this study suggested that there are no plans to change allocations through PEPFAR, and that Viet Nam reaching MIC status is unlikely to significantly affect US support to HIV in any significant manner. However, the future of the programme may be dependent on the outcome of the next US presidential election, since PEPFAR is a presidential initiative.

- DFID is another significant donor who contributed about US$ 30 million through the HIV prevention project to end in 2008. Design of a new HIV support programme for an ap proximate value of £18m is under way and will be channelled through and co-finance the World Bank HIV programme – this will continue until at least 2013. DFID is unlikely to provide any additional funding once Viet Nam attains MIC status.

- The Global Fund to Fight Tuberculosis, AIDS and Malaria in the third most significant financial contributor to the national HIV response in Viet Nam.

- Funding from Round 1 (2004-2008) totalled US$12 million. Viet Nam has also secured an additional US$28.7 million from Round 6, with implementation beginning in 2008. It is unclear (at the time of writing this report) whether Viet Nam will submit a Round 8 proposal for HIV.

[16] *Source: GOVN/UNGASS report January 2008*

- Other donors from the list above will continue supporting Viet Nam's response to the HIV epidemic, although bilateral donors are likely to discontinue their development assistance beyond MIC status or may expect higher levels of government funding than those currently committed.

In sum, the funding situation in the short term (up to 2012) looks stable and is unlikely to be affected by Viet Nam reaching MIC status. In the longer term (beyond 2012), the situation may change, particularly if the US government significantly scales down its support. Such scale down would affect important areas such as the availability of ARVs and the financial incentives that these initiatives provide to government or to NGOs for implementation (many large NGOs working in HIV are reported to be highly reliant on US funding). Further, a reduction in donor funding is likely to impact on prevention programmes.

Without a phased increase in government funding, it will be difficult to sustain current efforts to scale up harm reduction programmes.

In the event of a US withdrawal, Viet Nam could still turn to the Global Fund for external support. However, additional GFATM funding would depend on (a) the level of competition in future GFATM Rounds and on the quality of Viet Nam´s proposal; (b) on the emergence of new sources for external finance (of which there is no indication so far); and importantly (c) on the ability of the Vietnamese government to substantially increase its own level of funding for HIV (since GFATM funding is expected to be additional to existing funding rather than the main source of funds, as discussed earlier in the case of malaria).

Implications for Viet Nam and for development partners supporting the national HIV response. Consideration of the implications of current support and its modalities to HIV is needed in the medium to longer term. This is not because of Viet Nam reaching MIC status but because the nature of the epidemic and its likely future costs make it advisable. The following issues emerge as significant:

- In spite of high donor presence Viet Nam is not yet in a position to estimate future costs of managing the HIV epidemic, in part because the harm reduction part of the response is too new for needs to be accurately appraised, and in part because much of the government's energy is devoted to dealing with a large number of donor agencies. Nevertheless, it can be safely forecast that the costs of managing the epidemic within the next decade will be very substantial, and will increase even if and when the HIV incidence goes down, which is not yet the case.

- To effectively manage the epidemic in the medium to long term Viet Nam will need to substantially increase the volume of financial and human resources devoted to it. First, because current levels of external funding are so large and aid modalities so fragmented that they are neither reliable nor sustainable. Second, because current levels of government funding are too low, and because it is not clear what specific areas should be managed by the government, and which areas should be left for donors to fund, particularly as the focus of donor funding in HIV has been, to a large extent, highly donor driven. Third, because failure to address the epidemic at this stage could cost Viet Nam much more in terms of loss of human life and related health care costs in the future. Fourth, reliance on out-of-pocket

- (OOP) expenditure means that unless government and/or donor financial support is scaled up the burden of HIV will be borne to a large extent by Vietnamese families. Many such families might see their lifelong household income and savings compromised, or may eventually chose or be forced to abandon treatment or preventive measures which would be damaging in terms of disease control and survival rates.

- MOH, VAAC and other government bodies will need to be helped to better plan for present and future needs and for strategically planning the HIV response on the basis of realistic scenarios.

- For their part, HIV external partners will need to significantly improve the way in which they work together and with government agencies and civil society. They should also work harder to address the perverse incentives introduced by the financial emoluments provided to HIV workers. Ideally, incentives should become more homogeneous and performance based than they are today.

4.4 Conclusions and recommendations

Avian influenza, TB and malaria: In conclusion, funding to support control of avian influenza will not be affected by Viet Nam reaching MIC status as regional support initiatives and networks are likely to remain in place for control and surveillance.

For tuberculosis and malaria control programmes, financial support is guaranteed in the medium term (up to 2012) but it is highly reliant on GFATM funding. While Viet Nam may well continue to access GFATM after reaching MIC status, access to funding may become more difficult given competition from low-income countries and given that the GFATM would expect higher levels of government funding for essential commodities and drugs than are currently in place. Viet Nam will need to increase government funding in order to qualify for GFATM support.

HIV: In spite of the large donor presence and considerable levels of external funding Viet Nam has yet to fully respond to the challenge of its HIV epidemic and meet the targets the GoV and its partners have set. The HIV epidemic may not be large in comparison to many other countries but threatens serious consequences if prevention, treatment, care and support are not scaled up urgently.

It is in the interest of the GoV to better coordinate the response to the HIV epidemic and require development partners to better harmonise and align their own contributions. Funding for HIV relies heavily on two health partners, the GFATM and PEPFAR, whose funding is by no means assured beyond the medium term. The risk of external funding dropping significantly and the small proportion of government funding means that the GoV should consider incrementally increasing its budgetary allocation, particularly in areas that it considers of strategic importance and where high dependency on donor aid may not be advisable. It should also ensure that the poor and the low-income middle classes do not incur catastrophic expenditure as a result of a relative developing AIDS, particularly in areas that are not covered by free anti-retroviral treatment provided by donors.

Annex 1 - Terms of Reference

Terms of Reference for a study on: How external support for Health and HIV is likely to evolve as Viet Nam becomes a Middle-Income Country (MIC)

Background and purpose

Viet Nam will reach MIC status in 2009-10. As a result, some development partners are beginning to plan their exit strategies and Viet Nam's access to concessional lending will be reduced.

While external assistance (aid) accounts for only a small share – roughly 5 per cent -- of overall health spending, it is quite significant in particular areas, such as communicable disease control. Further, external support pays for most of Viet Nam's HIV programme, including provision of Anti-Retroviral Therapies.

This study will explore the implications of the transition to MIC for external support to Health and HIV; present scenarios for how funding patterns may change in future; and make recommendations on ensuring the sustainability of key public health programmes.

It is hoped that this analysis will provide useful intelligence and information during the MIC transition phase. In addition, the report will also serve as a specific input to (i) The Joint Annual Health Review, 2008, which will focus on health financing; (ii) The Viet Nam Development Report 2008, which will look at opportunities for resource mobilization over the medium-term, and (iii) the UNCT working group on aid effectiveness, which will make recommendations on how to strengthen UN engagement with aid effectiveness dialogue in Viet Nam. Finally, this report complements plans to carry out a National AIDS Spending Assessment (a review of spending to date), and to resource estimation for future implementation of the National HIV programme.

Main areas of investigation

The following areas will be investigated from the perspective of both HIV and health; findings will be synthesized and compared in the concluding chapter. Key areas of investigation include:

- Changes to the 'development landscape' in Health and HIV over the medium-term – which partners are in the process of scaling down / phasing out their support? Are any new partners (e.g., China) likely to fill this gap? Do others (e.g., Australia) have plans to increase their funding? What are the policies of the major foundations, such as Pepfar and Global Fund?

- How will these changes affect availability and focus of cash resources and TA, at both central and provincial level (given that many donors provide funds directly to provinces)?

- How does the likely decrease in donor funding compare to likely increases in domestic resources for health, based on economic-growth scenarios and existing government commitments to increase health's share of the public budget? An assessment will be made as to whether this increase can meet rising recurrent funding needs over the medium to long term.

- Are there any other implications for the sector(s) associated with shift from grants to loans and the increasing importance of private finance, noting that a specific aim of government is to increase private investment in the hospital sector?

- In addition to looking at broad funding picture in HIV and Health, the study will look in detail at two specific areas, such as provision of ARTs and support for basic health systems functions such as regulation.

- The study will also address key policy issues that are likely to emerge during the transition to MIC, including:

    - The future of the many 'pilot' programmes in health and HIV, and the potential / desirability for scaling up;

    - Sustainability – this may be a particular issue in HIV, if diversity of funding partners reduces, and an over-reliance on a single donor develops.

    - Ensuring the smooth transition of programmes and activities from donors to government

  Finally, the study will consider the implications of these changes for the role of the UN and civil society, both in relation to provision of technical support, service delivery and from the perspective of providing 'checks and balances' in the policy dialogue as the pool of development partners decreases.

Output

The key output will be a report of 20-30 pages, including recommendations and an executive summary of 2-4 pages, plus annexes. This report will be a product of the UNCT in Viet Nam, with WHO taking the lead role.

Deadline

To feed into the processes outlined above, the report will need to be ready by end-June 2008.

Consultants required

Consultants with skills in budget analysis and forecasting, and familiarity with health and HIV in Viet Nam, are invited to submit expressions of interest, including a proposed budget, by xxxx to Rebecca Dodd at WHO, doddr@wpro.who.int

Annex 2 – Health partners and the projects they support

Note - Unless stated otherwise the source of information in this table is the study questionnaire or data directly provided by the agency

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
Asian Development Bank	Rural Health Project	1. Improving access and quality of PHC care in 14 provinces 2. Strengthening financial management, facilitating government policy 3. Improving MOH management capacity 4. Strengthening communication support to services		2001-2008 (now closed	$68.3 million
	Communicable Diseases Control in the Greater Mekong Subregion	1. Strengthening national surveillance and response 2. Improving CDC for vulnerable groups 3. Strengthening regional co-operation in CDC	Central MOH and provincial	2006-2010	$15 million.
	HIV Prevention Project Among Youth	1. Leadership and strategy support for HIV prevention 2. National mass media program for behaviour change 3. Community-based HIV-prevention for youth	Central MOH and provincial	2006-2011	$20 million (grant)
	Preventive Health System Support Project	1. Upgrading preventive health centers in 46 provinces and four national institutes 2. Training in CDC, laboratory techniques 3. Surveillance system capacity building in 17 provinces	Nationwide	2006-2012	$27.90 (of which $10.14 million as grant)
	Health Care in the Central Highlands	1. Strengthen the capacity of the health system to address the needs of the poor 2. Human Resources Development 3. Upgrade facilities and equipment	Central MOH and 5 central highlands provinces	2004-2009	$25 million (including $5 million co-financed by Government of Sweden)
	Health Human Resources Sector Development Program	Loan has two parts: 1. policy based, funds released based on policy actions 2. project based, focused on training of human resources, planning and management at the central level and management in the service delivery setting.	Central MOH	2009-2013	$70 million (including $10 million grant co-financed by Government of Australia)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	Health Care in the South Central Coast Region	1. Improved planning and budgeting skills in provincial health teams 2. Upgrading facilities and equipment in district hospitals 3. Workforce training 4. Improved quality of care	8 South Central Coast Provinces	2008-2013	$60 million
	Nutrition (2 projects)	1. Nutritious food for 6-24 month old children in poor areas (6 provinces, $2 million) 2. Vitamin A and de-worming distributions – expanding age range and addition of deworming (18 provinces, $1 million)	National Institute of Nutrition and provinces	2006-2010	$3.0 million
Austria	Upgrading the Medical Equipment for 3 Hospitals under Ministry of Public Security	Medical Equipment upgrading	Central Hospitals	2007-2009	Euro 11 million (2010-on, Euro 30 million pipeline)
	Upgrading medical equipment of 15 Central Hospitals under Ministry of Defence (Phase 1&2)	Medical equipment upgrading, capacity strengthening and human resource development	Central Hospitals	Finished in 2007	Euro 29.8 million
	Upgrading medical equipment of Heart Hospitals in Bach Mai (MOH)	Medical equipment upgrading Strengthening of Cardiovascular services of Vietnam Heart Institute.	Central Hospitals	(Pipeline - 2009)	Euro 8.6 million
	Improvement of Cancer Care Diagnostic Services in 3 hospitals of the MOD	Medical equipment upgrading, development of Radiotherapy services, diagnostic capacity and human resource development	Central Hospitals	(Pipeline 2008-2011)	Euro 25.6 million
	Upgrading the medical equipment for Cancer Hospitals under MOH	Medical Equipment upgrading - in planning process	Central Hospitals	(Pipeline)	Euro 10 million.

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	Contribution to Viet Nam Avian and Human Influenza Project - VAHIP)	1. Support the HRD(Human Resource Development). 2. Capacity Building to respond the Avian Flu Epidemic 3. Training for DH and Communal levels	MOH	started from 2007	80% funding by
	Sector Capacity Support Project (to be co-financed with Luxembourg)	1. Strengthening the capacity for sector policy formulation, planning and budgeting 2. Strengthening the capacity for sector management, including PFM, HRM, HMIS, etc. 3. Strengthening the capacity for sector coordination (HPG; JAHR) 4. Strengthening the capacity for service provision (training for health staff; need-based supply of equipments)	central and decentralized levels	started from 2009	EC-LUX approximately EUR 14.75 m
Australia (AusAID)	Asia Regional HIV/AIDS Project	1. Covering Burma, Viet Nam, China	Central	2002-2007	$A 14.9 million
	Bill Clinton Foundation HIV/AIDS	Care and treatment project		2004-08	$A 4.8 millions
	HIV/AIDS Regional Project	Viet Nam country flexible programme	Central and North-ern Mountainous Region	2004-2008	$A 1 million (2009-2010, $A 2 million)
	Australia-Vietnam laboratory partnership	Other communicable disease prevention and control	Central Coast Region	2004-2008	$A 0.87 million (2009-2010, $A 0.24 million)
	National Helmet Wearing Campaign	NCD prevention and control	Nationwide	2004-2008	$A 0.17 million
	Contribution to Joint GoV-UN programme on Avian Influenza	Other communicable disease prevention and control		2004-2008	$A 5 million

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	Hospital Sector Study	Research	MOH	2004-2008	$A 0.1 million
	Vietnam Delivering Better Health	TA, research and institutional support (some funds channelled through WHO, ADB)	Central, Provincial	2004-2008	$A 1.91 million (2009-2010, $A 22 million)
Belgium	Upgrading of Community Health Services in Hoa Binh Province	1. Accessibility and quality of basic health services in Hoa Binh Province improved 2. Health policy-making capabilities enhanced	Provincial / District / Communal level	2006 - 2010	3 million Euro (including 2.5 million Euro grant).
	Collaboration between Institute of Tropical Medicine Antwerp and National Institute of Malariology, Parasitology and Entomology, Institute for Veterinary Research and National Institute of Geography of Vietnam and regional networks	1. To strengthen at regional level capacities in biomedical and epidemiological research required for the surveillance and prevention of malaria and cysticercosis in Southeast Asia 2. To strengthen sustainable control of parasitic diseases in Southeast Asia	Regional / Central / Provincial level	2008 - 2013	190,000 Euro per annum
	Welcome to Life (Collaboration between Handicap International Belgium and the Centre for Protection of Mother and Child)	1. Preventing disability before and at birth; 2. Detecting disabilities at an early stage; 3. Ensuring that children with disabilities have a place in community life.	Provincial / District / Communal level	2008 - 2010	300,000 Euro per annum
	Save Roads for a Better Life (Collaboration between Handicap International Belgium and the Road Safety Committee of Dong Nai Province)	Decrease road accidents, injuries and fatalities in the 3 target districts of Dong Nai Province including Thong Nhat, Xuan Loc and Dinh Quan	Provincial / District / Communal level	2008 - 2010	645,130 Euro (including 96,769.5 Euro grant)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	Congenital Differences (Collaboration between Handicap International Belgium and Hue College of Medicine and Pharmacy and Provincial Health Service)	1. Detecting congenital malformations; 2. Preventing babies disabilities.	Provincial / District / Communal level	2008 - 2011	183,404 Euro per annum
European Commis-sion	Health System Development Project (HSDP)	1. To strengthen health planning and management capacities; improve the quality of health personnel training; enhance research capacity, and improve the quality of, and access to, community health care services in three provinces of An Giang; Binh Thuan; and Thai Binh, including availability of equipment, drugs & supplies 2. To improve the quality of training in the three National Secondary Medical Schools in Hai Duong, Da Nang and Ho Chi Minh-City	Provincial District Commune	1999 - 2005	$ 29.5 million (Euro 20 million)
	Health Care Support to the Poor of the Northern Uplands and Central Highlands (HEMA Project)	To ensure the provision of high quality preventive, curative and promotive care in the mountainous, minority areas of Lai Chau, Dien Bien, Son La, Gia Lai and Kon Tum provinces.	Communal 60% District 20% Provincial 10% Central 10%	2006 - 2010	$ 26 million (Euro 18 million)
	Vietnam Avian & Human In-fluenza Project (VAHIP) via a Multi-donor Trust Fund administered by World Bank	1. Support the Human Resource Development) 2. Capacity Building to respond the Avian Flu Epidemic 3. Training for DH and Communal levels	Provincial	2007 - 2010	$ 12 million (EUR 8 million) contribution to a total budget of $ 35 million
	Health Sector Capacity Support Project (SCSP)	Strengthen capacity of central MoH, provincial DoH and key sectoral stakeholders in health in the areas of: (i) sector policy (including health financing), planning and budgeting; (ii) management and regulation, including PFM; (iii) coordination; and (iv) delivery of quality health services (with main focus on primary health care and preventive medicines).	18 provinces	2009 - 2012	$ 18.5 million (Euro 12.75 million) of total budget of $21.5 million
	Health Sector Policy Support Programme (SPSP) – phase II of programme based approach	tbd	TBD	2010 - 2013	$ 75 million (Euro 51.25 million)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
Embassy of Finland	1. Improving equipment for Public Hospitals (concessional credits)	Medical Equipment upgrading -Cao Bang hospital equipment project -Viet Tiep hospital equipment project -Dung Quat hospital -Hanam hospital equipment project -Equipment and facilities Investment of Vietnam-Cuba Friendship hospital Dong Hoi - QuangBinh - Investment on medical equipment for new DaNang General Hospital. -Medical Equipment Upgrading Project in Nge Anh Pediatric Hospital	Provincial	Projects in preparation	Euro 28 million approx.
	2. Avian Influenza (Grant)	Contribution to UN programme to fight Avian Influenza	National	2005-2010	Euro 6.5 million
	3. Water supply and sanitation in small towns Phase I 2004 - 2009 (Phase II, 7/2009 - 2013) (Grant)	Building water supply and sanitation schemes in Bac Kan, Haiphong, Hung Yen and Thai Binh. Phase II will expand the number of provinces to Cao Bang, Ha Giang, Tuyen Quang and Yen Bai provinces.	Provincial	2004 - 2013	Euro 34 million
France (AFD, Ministry of Foreign Affairs and Ministry of Health)	Hospital Partnership on HIV	HIV/AIDS	Provincial (Hanoi, Haiphong, HCMC)	2004-2008	$3.52 million (2009-2010 $1.22 million)
	National Research Agency on HIV and viral hepatitis	HIV/AIDS – support to Pasteur Institute, HCMC	Provincial (HCMC)	2004-2008	$0.81 million
	Ecology and epidemiology of Avian Influenza in Southern Countries	Communicable disease prevention and control		2004-2008	$0.21 million (2009-2010 $0.17 million)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	Support to health information system to detect emerging disease outbreaks in SE Asia	Support to Pasteur Institute of Nha Trang and HCMC, and to NIHE, Hanoi (AFD and French MOH)		2004-2008	Euro 28 million approx.
	Meso - Vietnam	Community-based dengue control, Nam Dinh, Nghe An	Provincal	2004-2008	Euro 6.5 million
	Nutrition			2004-2008	Euro 34 million
	Medical education and training	1-year training programme in French hospitals	All hospitals in Vietnam	2004-2008	$3.52 million (2009-2010 $1.22 million)
	Hospital services	Periodic grants from French MOFA, which supports hospital partnerships globally		2004-2008	$0.81 million
	Grants to NGOs	Grants to NGOs for HIV, nutrition, disability and rehabilitation, MCH, family planning, health training	National	2004-2008	
GAVI Alliance	Improvement of Health Services in Cao Bang & Son La provinces	1. Training to VHWs & CHWs 2. Monitoring & supervision of VHWs & CHWs 3. Strengthening planning and management capacity 4. Basic equipment kits & allowances for VHWs & CHWs 5. MOH capacity building	central & 10 provinces	2007 -2010	
Germany GTZ	Improvement of Health Services in Cao Bang & Son La provinces	1: Improvement of Reproductive Health Services 2. Quality Management of Health services in hospitals and health centres 3. IEC of HIV, MCH, RH and ASRH and social health insurance (SHI) 4. Enhance knowledge of health workers if SHI and participation of the target population in SHI	Provincial, district and communal level	on going	
	Join German cooperation project TC (GTZ-DED-CIM-InWEnt) + FC (KfW) 5 Provinces (Yen Bai, Phu Yen, Thanh Hoa, Thai Binh and Nghe An)	1. Capacity development of Health personnel in: - Management of provincial and district health systems - Curative services delivery - Preventive Health service - Hospital (asset) management and MHIS	provincial, district & communal	2008-2013	$0.21 million (2009-2010 $0.17 million)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
		- Waste Management 2. Strengthen the stewardship role of MOH			
Germany KfW	Health & Family Planning III+IV	1. Procurement & distribution of contraceptives 2. Information campaigns	Nation-wide	III. -2006 IV -2009	Euro 18 million
	Health Care- HIV/AID	1. Procurement of goods including contraceptives and labo equipment 2. Materials for education, training & communication	provincial & district	On going	Euro 6.5 million
	Health Program Hospital phase I (5PHs)	1. Medical equipment support 2. Training for management staff	Provincial	Finish 2008	Euro 7. million
	Health Program Hospital phase II (4PHs)	1. Medical and general equipment 2. Comprehensive support on IT system 3. Training for medical/technical & management staff	Provincial, District (only training)	Finish 2008	Euro 9.5 million
	Join German cooperation project TC (GTZ-DED-CIM-InWEnt) + FC (KfW) 5 Provinces (Yen Bai, Phu Yen, Thanh Hoa, Thai Binh and Nghe An)	1. Medical and general equipment 2. Comprehensive support on IT system (hard and soft ware) 3. Training for medical/technical & management staff of the hospital system	Provincial, district and CHC	2008-2013	Euro 17.7 million
	Emergency support for response to the AI Epidemic	1. Equipment for EWARS 2. Mobile Laboratory and sterilization 3. Communication equipment	Central levels; provincial & district	2006-2008	Euro 4 million
	Development Loan support to Viet Duc University Hospital	1. Medical equipment support 2. Training facility strengthening	Central	2007-2009	Euro 5 million.
Global Fund for AIDS TB and Malaria Source: GFATM Website	ROUND 1 HIV	Strengthening care, counselling, support to PLHA and Community Based Activities	PLHA	01/02/2004 -31/01/2008	$ 12 million
	ROUND 1 TB	Reaching Tuberculosis Patients Among High-Risk Groups, Remote Populations and People Living with HIV and AIDS	High Risk Groups	01/06/2006 –31/05/2011	$10 million

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	ROUND 3 MALARIA		Vector Control	01/01/2005 -31/12/2009	$ 22.7 million
	ROUND 6 HIV	Strengthening HIV care, treatment, support and community based activities	Community, commodities	01/01/2008-31/12/2012	$ 28.7 million
	ROUND 6 TB	Support to Mid-Term Development Plan for TB in Viet Nam	MOH	01/01/2008-31/12/2012	$ 10.6 million
	ROUND 7 MALARIA	1. Medical equipment support 2. Training for management staff	Vector Control		$ 29.9 million
Japan	In-country training program in Cho Ray Hospital for Strengthening Human Resources in the Southern Area of Vietnam (Phase 2)	TC: Health Training	HCM (Central institution) and provincial hospitals in the Southern Region	2004-2009	¥ 60 million ($0.5 million)
	The Project for Strengthening Health Services Provision of Hoa Binh Province	TC: Hospital Services and Health Training	Hoa Binh (Provincial - District)	2004-2009	¥ 300 million ($ 2.7 million)
	The Project for Improvement of Medical Services in the Central Region of Vietnam	TC: Hospital Services and Health Training	Hue (Hue Central Hospital) and 14 provincial hospitals in the Central Region	2005-2010	¥ 600 million ($ 5.4 million)
	The Project for Capacity Development for National Institute of Hygiene and Epidemiology (NIHE) to control emerging and re-emerging infectious diseases	TC: Communicable Diseases Prevention and Control	Hanoi (Central institution)	2006-2009	¥ 300 million ($ 2.7 million)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	The Project for Strengthening Capacity for Measles Vaccine Production	TC:Communicable Diseases Prevention and Control	Hanoi (Central institution)	2006-2010	¥ 500 million ($4.6 million)
	The Project for Functional Enhancement of Bach Mai Hospital	TC: Hospital Services and Health Training	Hanoi (Central institution)	2000-2005	¥ 1,100 million ($10 million)
	The Bach Mai Hospital Project for Strengthening Training Capacity for Provincial Hospital	TC: Health Training	Hanoi (Bach Mai Hospital) and provincial hospitals in the Northern Region	2006-2009	¥ 200 million ($1.8 million)
	Nghe An Reproductive Health Project (Phase 2)	Mother and Child Health / Family Planning	Nghe An Province (Provincial - Commune)	2000-2005	¥ 600 million ($5.4 million)
	The Project for Capacity Building for Dissemination of Community based RH Promotion Approach	TC: Health Training	Ha Nam, Ninh Binh, Thanh Hoa, Nghe An (Provincial - Commune)	2006-2009	¥ 200 million ($1.8 million)
	The Project for Improvement of Bach Mai Hospital	Grant Aid: (Govt of Japan): Facilities and Equipment	Hanoi (Central institution)	1998-2000	¥ 6,000 million ($54 million)
	The Project for Improvement of Medical Equipment for Da Nang General Hospital	Grant Aid (Govt of Japan): Equipment	Da Nang (Provincial)	2005	¥ 300 million ($ 2.7 million)
	The Project for Construction of Facilities of Measles Vaccine Production	Grant Aid (Govt of Japan): Facilities and Equipment	Hanoi (Central institution)	2003-2006	¥ 2,100 million ($19 million)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	The Project for Improvement of Medical Equipment for National Hospital of Pediatrics	Grant Aid: (Govt of Japan): Equipment	Hanoi (Central institution)	2004	2008-2011
	The Project for Improvement of Hoa Binh General Hospital	Grant Aid: (Govt of Japan): Facilities and Equipment	Hoa Binh (Provincial)	2007	¥ 1,000 million ($9.1 million)
	The Project for Improvement of Hue Central Hospital	Grant Aid: Facilities and Equipment	Hue (Central institution)	2004 - 2006	¥ 2,800 million ($26 million)
	The Project for Establishment of BSL 3 Laboratory at National Institute of Hygiene and Epidemiology	Grant Aid (Govt of Japan): Equipment	Hanoi (Central institution)	2008	¥ 900 million ($8.2 million)
	Regional Medical Development Project	Yen Loan: Equipment	Thai Nguyen, Lang Son, Ha Tinh (Provincial)	2006	¥ 1,800 million ($16 million)
Luxembourg	Bilateral Cooperation (only projects from 2007 are shown)	Cold Chain-Blood Safety; 2007-09; €2.7 million Cold Chain EPI; 2007-09; €4.2 million Cao Bang/Backan Health; In formulation; 2007-2010; €4 million Medical Equipment Management; in formulation; €2 million Study Fund; 2007-08; €35,000	Various – as specified	2007-2010 (see details to left)	Euro 12 million
	Multilateral Cooperation and NGOs (only projects from 2007 are shown)	WHO – Improvement of capacity; 2007-09; €348,837 UNICEF – Child Friendly Program; 2007-10; €2,124,743 NGOs - Ref centre for Spinal Cord Trauma; 2007-09; €398,354	Various – as specified	2007-2010 (See details to left)	Euro 2.87 million
Netherlands	National Targeted Programmes	TB Control (Euro 8 million) Human Resources Development (Euro 11.5 million)	Central and Provincial	2008-2011	Euro 32.2 milllion

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
		Safe Motherhood Initiative, covering 14 Northern and Central Mountainous provinces (Euro 6.7 million)			
	Special Innovate Interventions	HIV/AIDS, Harm Reduction (Euro 4 million) Community Based Social Support Networks for HIV widows and children (Euro 1.5 million)	Central and Provincial	2008-2011	Euro 5.5 million
	Other projects	Reproductive Health, and HIV/AIDS education and outreach (Euro 3.8 million) National Institute for Nutrition Health – HIV/AIDS policy support (Euro 16 000)	Central and Provincial	2008-2011	Euro 4.0 million
	(Past support for health and reproductive health)	(Programmes and projects as outlined above)	(Central and provincial)	(2004-2007)	(Euro 14.8)
Sweden (SIDA)	Vietnam-Sweden Health Cooperation on Health Policy and Systems Development	1. Policy development 2. Capacity building 3. Competence development	Ministry of Health and provincial levels	2002-2007	SEK 104.6 million ($15.8 million)
	Co.financing ADB Health Care in the Central Highlands	1. Improve availability of, and access to, quality health services, especially for the poor and disadvantaged 2. Improve affordability and utilisation of health services, especially for the poor 3. strengthen the capacity of the health system to address effectively the health needs of the people	Provincial levels	2004-2009	Contribution of SEK 48 million ($7.3 million) to ADB project
	Strengthening leadership and multisectoral collaboration for successful implementation of the National HIV/AIDS Strategy (Co-financed with UNDP)	1. Strengthen the Party's leadership and multisectoral collaboration 2. Strengthen the leadership role and multisectoral collaboration of People-elected bodies and government agencies at different levels	1. Committee for Social Affaires of National Assembly 2. Central Party Commission for Popularization and Education 3. Three provinces	2004-2008	SEK 16 million ($2.4 million)
UNAIDS	Overall policy, monitoring and evaluation,	Strategic information, knowledge sharing and account ability, support to coordination of	National	2007-2010	US$3 million

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	partnerships and coordination of the HIV response	national efforts, partnerships building, advocacy, and monitoring and evaluation, including estimation of national prevalence and projection of demographic impact			
UNFPA	1. Safe Motherhood Initiative 2. UN-Kon Tum joint project 3. VINAFPA-UNFPA strengthening the accessibility and quality of reproductive health care project 4. Maternal and Child Health project 5. Program - EC/UNFPA Reproductive Health Initiative for Youth in Asia (RHIYA) 6. Program - Sixth Country Programme (CP6) 7. Program - Seventh Country Program (CP7)		National & 7 Provinces	2006 - 2010	Total Project and program value: $39.1 million (but some is regional) Projection 2009-10: $12.6 million
UNICEF SCF- UK SCF-US UNFPA UNDP WHO	Child Care Support Program Source: JICA Technical Mission 2007 Table version 03/06/2008 Each donor will support from $3-5 millions for each cycle, duration 2-4 years.		All levels when all organisations are considere		
United Kingdom (DFID)	Preventing HIV in Vietnam Project (PHP)	PHP supports 4 Government Action Plans under the HIV National Strategy, including: 1. Harm Reduction Action Plan 2. Behavioural Change Communication 3. Capacity Building 4. STI Prevention and Treatment	Central Provincial District Commune	Finish June 2009	DFID: £16.4 million Norway: 10 million NOK Vietnam: 3.6 billion VND
	Joint HIV Prevention Project in Vietnam (this is the continuity of the current World Bank HIV Prevention Project (2005-2011) Funded by DFID and World Bank	Supporting 7 action plans under the HIV National Strategy, with focus on Harm Reduction: 1. Harm Reduction Action Plan 2. Behavioural Change Communication 3. Capacity Building 4. STI Prevention and Treatment 5. Care and Treatment 6. Preventing Mother to Child Transmission 7. M&E	Central Provincial District Commune	2009-2012	DFID: : £18 million World Bank: $17 million Government: a fraction of $3.5 million (contributed for the 2005-2011 period under the World Bank HIV Prevention Project)

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
United States (PEPFAR and USAID)	Good Clinical Practice training	Research and Study	Central	2004-2008	$120 000
	Support people with disabilities in Danang and surrounding areas	Disability and Rehabilitation	Danang		$1 million
	Research study in Vietnam on infectious diseases	Research and Study	Central		$1.7 million
	Avian and Pandemic Influenza	Development of Influenza Surveillance Network in Vietnam	Central		$1.5 million (2009-2010: $1 million)
		Community Mobilization for Enhanced Surveillance and Prevention of Avian Influenza in Vietnam (Development of a Model)	Dong Thap, Hai Hung		$600 000
		Surveillance and Response to Avian and Pandemic Influenza in Vietnam	Central		$2,9 million (2009-2010: $2 million)
		Rapid Response and Containment	Central		$333 000
		Influenza vaccine development	Central		$3 million
		1. Avian Influenza Behavior Change and Communications Support Activity (AI/BCC)	High risk provinces		$5.5 million
		Capacity Building to Prevent and Control AI in the Greater Mekong Sub region	Hung Yen and Can Tho		$1.8 million
		Poultry Supply Project - Raise SPS	TBD		$1.68 million
		Immediate Technical Assistance to Strengthen Emergency Preparedness for Highly Pathogenic Avian Influenza	Central		$10.4 million
		M&E strategy development	Central		$300 000

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
		AI Diagnosis Workshop and Collaborative applied research on HPAI in Domestic Poultry	Central		$400 000
		Strengthening Epidemiological Capacity and Health Communications in Vietnam	Central		$2.2 million
		Field Epidemiology Training Program	Central		$500 000
		Commodities			$24.7 million
	HIV/AIDS	Prevention of Mother-to-Child Transmission	Northern Mountainous Region, North Central Region, Red River Delta, South East Region, Mekong River Delta Region		$7.15 million
		Abstinence/Be Faithful			$10.22 million
		Condoms & other prevention			$33.66 million
		Blood Safety			$1.45 million
		Injection Safety			$2.89 million
		Palliative Care			$36.65 million
		Treatment			$25.65 million
		TB/HIV			$6.25 million
		Orphan and Vulnerable Children			$5.77 million
		Counseling and Testing			$14.89 million
		ARV Drugs			$33.96 million
		Lab Infrastructure			$9.35 million
		Strategic Information			$17 million
		Other Policy/System Strengthening			$13 million
		Condoms and drugs (commodities)			$30.1 million

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	Total USG			**2004-2008**	**$291.25 million**
World Bank	National Health Support Project	1. Commune and district health centers 2. Three priority national programs (malaria, TB, ARI) 3. MOH planning & management capacity	District and communal levels	Finished 2003	$ 127.3 million
	Population and family Health Project	1. Provincial Service Delivery 2. Behaviour Change Communications 3. Contraceptive Supplies 4. management & Institutional Development 5. Family Planning Service delivery model initiatives	District and communal levels	Finished 2003	$129.6 million (in which: Gove: $8.6 m, IDA: $50m, ADB:$41m, KfW Grant: $20m)
	Regional Blood Transfusion Centers Project	1. Build 4 Regional Blood Transfusion Centers in Hanoi, Hue, Ho Chi Minh city and Can Tho 2. Capacity building	Central hospitals	2002 - 2008	$47.5 million (IDA fund: $38.2m, Gov: $9.3m)
	HIV/AIDS Prevention Project	1. Provincial implementation of HIV/AIDS action plans 2. National HIV/AIDS policy and program 3. Project management at CPMU & PPMUs	National and 18 provinces + 2 cities	2005 - 2011	$38.5 million (IDA: $35m, Gov: $3.5m)
	Mekong Regional Health Support Project	1. Protecting the poor and near poor 2. Curative care quality and capacity 3. Preventive Health 4. Human Resources Development 5. Project management, Monitoring and Evaluation	National and Provincial	2006 - 2012	$85 million (IDA: $70m, Gov: $10m; PHRD grant: $5m)
	Vietnam Avian Influenza control and preparedness project	1. Human Influenza control in the Agricultural sector ($17.2m) 2. Influenza Prevention and Pandemic Preparedness in the Health Sector ($16m) 3. OPI integration & coordination, result M&E, Project management ($4.8m)	National and Provincial	2007 - 2010	$38 million (IDA:$20m, Gov: $3m; PHRD grant:$5m; foreign multilateral institutions: $3m)
	GAIN Trustfund for Iron Fortified Fishsauce project	Reduce prevalence of iron deficiency anemia by making affordable iron-fortified fish sauce available to the population at risk	National	2005 - 2008	$ 3 million
	Northern Upland Project (NUP)	1. Health Network Strengthening 2. Capacity Strengthening 3. HCFP contribution 4. Health facility strengthening 5. Project management	District and communal levels	2008 - 2014	$ 66 million

Donors	Project Title	Component or Objectives	Target Level	Period	Input total (currency indicated)
	Northern Central Coast region	1. Provincial Health Support with the demand and supply side interventions 2. Pilot results based financing model 3. Support governance and management roles at central level 4. Project management, monitoring and evaluation	District and communal levels	2009 - 2014	Pipe line: $ 62 million
World Health Organization	Country support programme for Viet Nam	Technical support to MOH in a range of areas	National and Provincial	2008-09	$33.2 million

Annex 3 - Study methodology and limitations

Study methodology

The study was conducted by an international consultant - Javier Martinez- acting as team leader with the invaluable help Dr Nguyen Dinh Cuong, a Vietnamese health systems consultant acting as research assistant. The study was commissioned and coordinated by Rebecca Dodd from the WHO Country Office in Viet Nam. The total duration of the study, including data collection and the visit to Viet Nam by the international consultant was approximately 4 weeks in June 2008.

The data collection phase included the distribution of a questionnaire to health development partners combined with data collection from available documents, databases and/or websites (DAD in the MoH, OECD/DAC, WHO, the World Bank, the Asian Development Bank, The Economist Intelligence Unit, UNAIDS, etc).

There was a good response from health development partners to the questionnaire, and the main responses in relation to changes at MIC status and immediate plans have been summarised in a table shown as Annex 2.

Information from the questionnaires and data searches was then contrasted with development partners and government officers in Hanoi by the international consultant during a period of 10 days. The names of people interviewed for this study, most in person in Hanoi and a few other elsewhere by phone and email are included as Annex 4.

The available completed questionnaires are available with the WHO Office in Hanoi and have not been included in this report.

This report is meant as an informed estimate based on available data. Apart from the limitations of the study per se (see next heading) one should add those linked to estimating the impact of future scenarios in a field like development assistance that changes so rapidly and is subject to so many internal and external influences.

Therefore, a simple methodology was used to estimate key changes and their impact:

- Main areas of health assistance and their volumes were estimated mainly from the MOH DAD database and from additional information from the questionnaires.
- The ***importance*** of these areas was estimated according to the following parameters:
    - Significant ***volume*** of donor funding, or significant number of donors, or a significant difference in the levels of funding found between donors and government;
    - The ***strategic importance*** of donor support was looked at in relation to: (a) its overall contribution to Health Systems Strengthening and to the health of the poor (as most donors focus their assistance on poverty and the poor); (b) the public health externalities of donor supported interventions, understood as their potential impact on other diseases and on the general well being of the population; (c) the complementarity and added value of funding or TA provided by donors in terms of maximising the effectiveness or impact of government programmes and government funding.
    - The degree of ***ownership*** by the government of the initiatives piloted or supported (technically or financially) by the donors.

On the basis of this analysis the following areas emerged as worthy of deeper analysis and understanding during the study:

- Communicable disease Control: specifically support to commodities for TB, malaria and HIV, and programme support to the national HIV response.
- Training, capacity building and salary incentives delivered as part of existing pilots or as apart of support to national programmes (the 10 national target programmes) or to health systems strengthening efforts.
- Health systems strengthening initiatives (including sector H&A initiatives) supporting policy making, strategic planning, health financing (in many forms), sector performance monitoring, sector regulation and health legislation.
- The area of support to provincial health authorities or health facilities (particularly hospitals) emerged as important but could not be properly assessed due to lack of time and insufficient English written data available to the consultant.

Limitations of the study

Even though there was an excellent degree of collaboration from health development partners and government officers towards this study it is important to be aware of its limitations.

The first limitation is that few development partners were found to have formal exit strategies when Viet Nam becomes a MIC, and most could only speak of their plans for health assistance with a three year horizon ie until 2011 and not beyond. This did not surprise the authors as it is consistent with the forecasting ability of most development agencies around the world.

A second limitation was the differences in figures for spent or planned aid budgets depicted in different databases, particularly the OECD/DAC, the MOH DAD and the information provided in the questionnaires. For example, significant differences were found between pledged and spend health aid budgets. It was also difficult to estimate the proportion of total health spending represented by external ODA, as figures varied from the oft quoted “less than 5%” to the 2.1% from the latest 2007 National Health Accounts (NHA). However, since this was not a study to accurately assess health financing or even health aid flows but to link these to specific areas and to identify trends and likely changes the said limitations in the quality of data did not represent obstacles to the analysis. Of all the data sources on health aid the MOH DAD was found to be the most accurate in terms of representing current focus of donor funding, even if a few important financing sources (including the Global Fund to fight AIDS, Tuberculosis and Malaria – GFATM) were not shown in the DAD. Quality of information was better for the field of HIV thanks to updates from VAAC and UNAIDS.

The third limitation of this study was time or, to put it more precisely, to adjust the expectations of the terms of reference to what was realistically feasible in such a short time. On the other hand there was a need to complete the study around the time when other processes and outputs such as the 2008 Joint Annual Health Review (JAHR) or the ongoing design of the new ADB health programme or the new World Bank/DFID HIV programme were taking place.

Annex 4 - List of people met and interviewed

In Chronological order of meetings

Peter Annear	Health Financing consultant, WHO Regional Office
Jean-Mark Olivé	Representative, WHO Hanoi
Graham Harrison	SHS, WHO Hanoi
Becky Dodd	SHS, Aid Effectiveness WHO Hanoi
Fujita Masami	HIV WHO Hanoi
Nguyen Kim Phuong	Health Economist, WHO Hanoi
Giampaolo Mezzabotta	Disease Control (TB) WHO Hanoi
Antonio Montresor	Disease Control (Malaria) WHO Hanoi
Amber Cernovs	Second Secretary (Health) Australian Aid
Nguyen Thu Hang	Senior Programme Manager (Health), Australian Aid
Sarah Bale	International Coordinator for JAHR, DPF, MOH
Nguyen Hoang Long	Deputy Director, DPF, MOH
Jean Jacques Bernatas	Health Attaché, French Embassy
Lisa Studdert	Head of Health Unit, ADB Hanoi
Bridget Crumpton	Programme Manager, DFID Hanoi
Le Van Thanh	Program Officer, Social sector, EC
Sandy Lieberman	Senior Economist, Te World Bank (Hanoi)
James Sarn	Coordinator PEPFAR, US Embassy
Nguyen Van Kinh	Deputy Director VAAC
Jonathan Pincus	Senior Economist, UNDP
Dao Thanh Huyen	JAHR Consultant/Programme Approaches
Eamonn Murphy	Country Director, UNAIDS

BY phone or email

Mark Pearson	Health Economist, HLSP Institute
Matt Howett	Health Economist, WHO Barcelona (PhD in Viet Nam)
Henrietta Wells	Health Specialist, South Asia, HLSP

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