MDGs and Viet Nam's Socio-Economic Development Plan 2006-2010

UNITED NATIONS VIET NAM

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The Millennium Development Goals and Viet Nam's Socio-Economic Development Plan 2006-2010

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Ha Noi, November 2005

Foreword

The new 2006-2010 Socio-Economic Development Plan (SEDP) presents the government and people of Viet Nam with an historic opportunity for change. After two decades of reform, the country is on the threshold of new era of economic prosperity and social progress. *Doi moi* policies have released the energy and creativity of the Vietnamese people and returned the country to its rightful place alongside the thriving economies of the East Asia region.

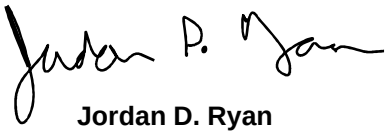
Now the challenge is to maintain the rate of economic growth while at the same time reducing economic and social disparities and building a society based firmly on the principles of justice and freedom.

The Millennium Development Goals provide an internationally recognized benchmark against which Viet Nam can gauge its own progress towards meeting these challenges. The Goals, and the Millennium Declaration of which they form a part, represent a global call to action to refocus efforts on the true objectives of development.

The United Nations agencies in Viet Nam are grateful for the opportunity to participate in consultations on the SEDP with government and other development partners. We offer this publication in the spirit of cooperation and partnership and as a small contribution to the government's planning efforts. The aim of the paper is to consider national objectives from the perspective of the MDGs, and to suggest concrete indicators of social progress relevant to both the MDGs and Viet Nam's specific socio-economic conditions. Our aim for this publication is practical: namely, to help policymakers fully integrate the MDGs into Viet Nam's own national planning mechanisms.

In his recent report entitled 'In Larger Freedom: Towards Development, Security and Human Rights for All', United Nations Secretary General Kofi Annan reminds us of the clear vision of progress that motivated the framers of the United Nations Charter. In linking human rights, development and peace, the UN founders understood that peace will only be achieved when people everywhere enjoy freedom from want and fear and the freedom to live in dignity.

Viet Nam can take great pride in the country's exceptional progress towards realizing this vision on the basis of a nationally owned and implemented strategy. The United Nations remains committed to supporting the country in its continuing efforts to promote these larger freedoms for all Vietnamese people.



Jordan D. Ryan
UN Resident Coordinator

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Abbreviations and Acronyms

CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CERWASS	Centre for Rural Water Supply and Environmental Sanitation
CNSP	Children in Need of Special Protection
CPRGS	Comprehensive Poverty Reduction and Growth Strategy
CWD	Children With Disabilities
EIA	Environmental Impact Assessment
EMIC	Education Management Information Centre
EmOC	Emergency Obstetric Care
FAO	Food and Agriculture Organisation
GER	Gross Enrolment Rate
GSO	General Statistical Office
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDU	Injecting Drug User
IMR	Infant Mortality Ratio
LEP	Law on Environmental Protection
MARD	Ministry of Agriculture and Rural Development
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MOC	Ministry of Construction
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MOJ	Ministry of Justice
MOLISA	Ministry of Labour, Invalids and Social Affairs
MONRE	Ministry of Natural Resources and Environment
MTEF	Medium Term Expenditure Framework
NCFAW	National Committee for the Advancement of Women
NER	Net Enrolment Rate
NIN	National Institute of Nutrition
NSEP	National Strategy for Environmental Protection until 2010 and vision toward 2020
PLWHA	People Living with HIV/AIDS
PRSC	Poverty Reduction Support Credit
RH	Reproductive Health
RWSS Strategy	National Rural Clean Water Supply and Sanitation Strategy up to year 2020
SAVY	Survey and Assessment of Vietnamese Youth
SEDP (2006-2010)	Social Economic Development Plan (2006-2010)
SOWC	State of the World's Children
SFE	State-owned Forestry Enterprise
SPS Agreement	Sanitary and Phytosanitary Agreement (under the WTO)
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VBSP	Viet Nam Bank for Social Policy
VDG	Viet Nam Development Goal
VDT	Viet Nam Development Target (in the CPRGS)
VHLSS	Viet Nam Household Living Standard Survey
VMIS	Viet Nam Multi-Centre Injury Survey
VNDHS	Viet Nam Demographic and Health Survey
VPCFC	Viet Nam Commission for Population, Family and Children
WHO	World Health Organisation
WTO	World Trade Organisation

Chapter 1
Introduction

In September 2000 the largest ever gathering of world leaders approved an historic statement of values, principles and development objectives. The Millennium Declaration articulates a coherent international agenda for the twenty-first century and reaffirms the faith of member states in the United Nations Charter and the organization's mission of promoting peace, equality and human rights.

Through the Declaration, world leaders resolved to achieve eight Millennium Development Goals (MDGs) by 2015. The MDGs stand as a global affirmation of the right to development and a decent standard of living for all. Among the goals agreed at the Summit are commitments to halve the proportion of people with incomes of less than one dollar per day; to ensure access to safe drinking water for all; to provide primary schooling for all children and equal access to education for girls and boys; and to reduce maternal mortality by three fourths. The goals also emphasize the vital importance of reversing the spread of HIV/AIDS, malaria and other diseases, and the responsibility of all nations to foster a new ethic of environmental conservation and stewardship.

Five years on from the Millennium Summit, world leaders have gathered once again in New York to assess progress towards the MDGs and revitalize the unprecedented consensus of the Millennium Declaration. The Government of Viet Nam prepared a national MDG Report for presentation at the Millennium Summit Plus Five that provides details of the country's achievements since 2000 and remaining challenges for the next decade.

The list of achievements documented in the National MDG Report 2005 is impressive. The most recent household survey data indicate that the poverty rate in 2004 was less than half that recorded in 1993. The share of the population living on less than one US dollar per day has fallen even more dramatically. Access to education and literacy rates have continued to improve from already extraordinary levels for a country of Viet Nam's income level. Increased investment in rural infrastructure has provided clean water and sanitation facilities to millions of households.

However, the report also makes clear that Viet Nam still faces important development challenges. Despite rapid economic growth sustained over two decades, Viet Nam remains a poor country. Massive investment is needed in basic infrastructure to support economic development and provide essential social services. Extreme poverty is highly concentrated in remote areas, many of which are inhabited by ethnic minority groups. Income disparities are widening among geographic areas and ethnic groups and also within these locations and groups. Although access to education has improved, the public and policymakers have raised concerns over the quality of education as well as access for certain groups, in particular ethnic minority girls. Access to and the quality of health care varies significantly from place to place and among income groups, with an increasing private expenditure burden for health care presenting a particular challenge. The spread of HIV/AIDS remains a real threat to continued development progress.

The Socio-Economic Development Plan for 2006-2010 presents the government with an excellent opportunity to come to grips with these challenges, and to map out a strategy to promote rapid, sustainable, pro-poor growth in Viet Nam. Detailed planning exercises have been carried out across the full range of economic and social sectors and at the national and provincial levels. Early drafts of the SEDP include a range of ambitious economic and social targets, many of which are directly related to MDGs and the locally elaborated Viet Nam Development Goals (VDGs).

The purpose of this document is to propose additional and refined social targets and indicators derived from the MDGs and adapted to specific conditions in Viet Nam to support the government's planning efforts. The targets and indicators included here are informed by reports and analyses produced by the Millennium Project, an independent advisory body commissioned by the United Nations Secretary-General to propose strategies to help countries achieve the MDGs. One of the main outputs of the Millennium Project to date was the publication earlier this year of *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*. This report presents a number of concrete suggestions including 'quick wins' to promote economic growth and improve the living standards of millions of people. The report also identifies Viet Nam as a potential 'MDG fast track' country that has the capacity to absorb additional overseas development assistance.

The MDGs stand as an international benchmark against which developing countries can measure national progress. Adopting a systematic MDG orientation in the forthcoming SEDP will help the government to maintain focus on reducing extreme poverty, reversing social exclusion and promoting environmental sustainability. The United

Nations agencies are committed to the principle that strategies to achieve the MDGs must be nationally devised and owned. However, the targets and indicators against which progress is measured work best when they meet international standards and build on international experience. Common targets and indicators facilitate inter-country comparisons and, more importantly, reflect our shared ambition to create a world in which all people enjoy freedom from want, freedom from fear and the freedom to live in dignity.

The present document brings together relevant international analysis and experience to distil a limited set of social targets and indicators relevant to conditions in Viet Nam. The document consists of five substantive chapters, each of which concludes with a list of suggested targets and indicators. The concluding section identifies 12 priority targets distilled from the assessment and analysis presented in the main text.

Chapter 2
Poverty Reduction

I. Assessment

According to national household survey data, Viet Nam has already achieved the first Millennium Development Goal of halving extreme poverty by 2015. These data indicate that the national poverty rate fell from 58.1 percent in 1993 to 28.9 percent in 2002. Early analysis of the 2004 Viet Nam Household Living Standards Survey suggests that the incidence of poverty fell further to 24.1 percent last year[1]. The share of the population living on less than one US dollar per day declined from 40 to 11 percent over the same period. The main impetus for poverty reduction in Viet Nam has been economic growth, which has averaged seven percent per annum since the introduction of *doi moi* reforms in 1986. Growth has been pro-poor in Viet Nam in the sense that the rate of poverty reduction has kept pace with the rate of economic growth.

The most significant policy changes associated with the *doi moi* process were put in place in the absence of significant international development assistance and thus were designed and implemented by government with a minimum of external input.

Agrarian reform, which gave farm households control over production and marketing decisions, generated a massive supply response in food crops and export commodities such as rice, coffee, cashew, rubber, tea and pepper. The concomitant relaxation of central controls on the production and distribution of basic goods eliminated the chronic shortages that characterised central planning. The formation of open national markets combined with cautious fiscal and monetary policies ushered in a period of unprecedented price stability. Viet Nam is rightfully proud of this economic record.

	1993	1998	2002	2004
Poverty	58.1	37.4	28.9	24.1
Urban	25.1	9.2	6.6	10.8
Rural	66.4	45.5	35.6	27.5
Ethnic minorities	86.4	75.2	69.3	
Food poverty	24.9	15.0	9.9	7.8
Red River Delta			6.5	4.3
Northeast			14.1	10.6
Northwest			28.1	25.4
North Central Coast			17.3	12.0
South Central Coast			10.7	7.3
Central Highlands			17.0	14.9
Southeast			3.2	2.7
Mekong River Delta			7.6	5.1
Ethnic minorities	52.0	41.8	41.5	
Poverty gap	18.5	9.5	6.9	
Urban	6.4	1.7	1.3	
Rural	21.5	11.8	8.7	
Ethnic minorities	34.7	24.2	22.1	
% of underweight under 5 year olds*			33	
Girls			35	
Boys			31	
% living on less than $1 per day	39.9	16.4	13.6	10.6
Income share of bottom 20%		8.0		
Gini coefficient	0.34	0.35	0.37	

Source: GSO

* In 2000

[1] Preliminary figure released by the General Statistics Office in September 2005.

Yet national averages tell only part of the story. The main challenge facing Viet Nam over the medium term is to sustain and extend the gains achieved thus far while at the same time reducing social and economic disparities.

Viet Nam is poised to move beyond the first MDG to consolidate previous gains and attack persistent and extreme poverty in specific locations. The United Nations agencies have identified three main concerns. **First**, extreme poverty remains heavily concentrated geographically and among ethnic minority groups. This is most apparent in the incidence of 'food poverty', in other words the share of individuals with incomes too low to meet minimum nutritional requirements. The North-West, North-Central Coast and the Central Highlands record the highest food poverty rates. However, the North-Central, North-East, Mekong Delta and Central Coast regions record the highest absolute number of very poor households. In 2002 the average food poverty rate in the richest 10 provinces was only three percent, while the corresponding rate for the poorest 10 provinces was 25 percent. Child malnutrition and mortality are concentrated in the poorest provinces. Mountainous provinces face difficult initial conditions including poor soils, limited access to irrigation and other infrastructure, and a high frequency of natural disasters. Although ethnic minorities make up only 14 percent of the total population, they account for 29 percent of the poor. The rate of poverty reduction among ethnic minority groups is also lower. According to the Ministry of Labour, Invalids and Social Affairs (MOLISA), mountainous provinces account for nearly 70 percent of extremely poor households, and this figure is expected to increase to more than 80 percent by 2010.

Second, millions of Vietnamese people subsist on incomes that are only marginally above the poverty line. More than 10 million people subsist on incomes within ten percent of the official poverty line, and these individuals and households are vulnerable to economic shocks caused by external or domestic factors. The rapid spread of Severe Acute Respiratory Syndrome throughout the region in 2003, the outbreaks of avian influenza in 2004 and 2005, and a sudden and unexpected financial crisis are examples of the kinds of disturbances that could force large numbers of households below the poverty line.

Third, the benefits of the reform process have not been distributed evenly across all strata and segments of society. Evidence has begun to emerge of widening economic and social disparities. Household survey data indicate that the consumption share of the richest expenditure quintile increased by 4 percent between 1993 and 2002, while the share of the poorest quintile fell by 0.5 percent. The gini coefficient on expenditures has risen consistently since the early 1990s. According to these statistics, the distribution of consumption in Viet Nam (0.37) is slightly less equal than in Indonesia (0.34) although significantly more equal than in Thailand (0.43). Asset distribution in Viet Nam is still equitable compared to most countries in the region largely a result of the agrarian reforms carried out in the late 1980s and early 1990s. However, recent evidence suggests that the pace of land concentration has accelerated in the Mekong Delta, and urban land speculation has emerged as an important vehicle of capital accumulation. Wider access to secondary, tertiary and vocational education would help to improve the distribution of regular, skilled employment, which is the most common and sustainable route out of poverty in Viet Nam.

II. Analysis

Poverty is not a sectoral issue. Addressing the concerns identified in the previous section will require a comprehensive, multi-sectoral approach including pro-poor economic policies and public investment in infrastructure and basic services. Consistency is required between the macroeconomic framework and the national poverty reduction strategy. In order to achieve this consistency, the Socio Economic Development Plan should include three elements: i) fiscal policies that prioritise the poor; ii) pro-poor public investment policies; and, iii) the development of public institutions that are accessible to the poor and responsive to their needs.

Pro-Poor Fiscal Policies

Under the revised State Budget Law, fiscal policy is now more transparent and accountable to elected bodies. Spending has increased on basic services and national targeted programmes for poverty reduction during the present plan period. Relative to the global average for lower-middle income countries, public education spending as a share of national income is high, while public health spending is low. Private spending on health and education, including user fees levied by public facilities, is rising as a share of total expenditure. Gaps remain in terms of access to services and increasingly in terms of the quality of services received.

1. *Geographical distribution of recurrent spending:* The government has made a concerted effort to increase spending in poor provinces, including higher spending norms for remote and mountainous provinces in some sectors. Balancing transfers are in place to redistribute resources from rich to poor provinces, and the system has been made more transparent and predictable. However, the relationship between the incidence of poverty and central government transfers is weak, and government spending on basic services in poor and remote areas is lower than in wealthier provinces. Balancing transfers are not sufficient to offset higher revenues in rich provinces. In addition, intra-provincial allocations are less transparent than inter-provincial transfers, even at the commune level where the Grassroots Democracy Decrees require that local authorities publicise spending plans and outcomes. The need to instil greater accountability and transparency at the provincial, district and commune levels has assumed greater importance with administrative decentralization.

2. *National Targeted Programmes:* The national targeted programmes are designed to reduce chronic and extreme poverty, particularly in mountainous and remote regions. A recent evaluation of these programmes conducted by MOLISA and UNDP found that targeting is carried out efficiently and that school fee exemptions and social health insurance in particular have a positive impact on the quality of life of the poor. However, despite the strong commitment of government to these programmes, coverage is still limited. Only one fifth of poor households benefit from education grants and an even smaller percentage of poor households have access to health cards or health insurance. In addition, the targeted programmes include a wide array of interventions including subsidised credit, resettlement, job creation programmes, agricultural extension, investment in infrastructure and sedentarisation of mobile populations. Few poor households participate in more than one of these programmes, reducing their overall impact on extreme poverty. Some programmes are less effective than others, yet the allocation of resources is not linked to evidence of impact. A comprehensive impact analysis of individual components has not yet been carried out.

3. *Over-reliance on User Fees to Finance Services:* Household survey evidence indicates that the private costs of health and education services represent a significant share of total non-food expenditures of the poor and near poor. These costs include formal user charges and informal levies. The cost of a single visit to a district hospital takes up on average over one-fifth of non-food consumption expenditure for a year for a person from the poorest consumption quintile, and as much as 44 percent of the household non-food budget if the illness requires an admission to a provincial hospital. Secondary school fees represent on average 11 percent of annual non-food spending for the poorest expenditure quintile. Moreover, the capacity to pay private fees affects the quality of education received. Rich households pay on average four times the national average for private secondary school classes, with the result that children from better-off households are more likely to progress to upper secondary and tertiary education. Greater delegation of authority to spending units (under Decree 10) creates incentives for educational institutions and health facilities to focus on the provision of fee-paying clients at the expense of basic services for the poor.

4. *Easy wins:* The national targeted programmes supply infrastructure and services to the poor. International experience has shown that programmes to increase demand for services through conditional cash transfers are a useful complement to supply-driven strategies. The Progresa programme in Mexico (now Opportunidades) and the Bolsa Escolar in Brazil are examples of cash transfer programmes to poor mothers conditional on their children's regular school attendance and routine health checks. Other easy wins recommended in Millennium Project Report include free school meals and school milk in provinces recording high rates of child malnutrition.

Pro-Poor Public Investment

Public investment has increased as a share of government spending and gross domestic product during the current plan period. The government has used these extra resources to invest in irrigation systems, roads, clean water, sanitation and other essential infrastructure. The national targeted programmes have released additional funds for infrastructure spending in remote and disadvantaged areas. Analysis conducted by the World Bank shows that public spending on infrastructure in Viet Nam has helped to reduce poverty, and that impact of large infrastructure projects has been greatest in the poorest provinces. The World Bank also found that transport and water and sanitation projects contributed most to poverty reduction.

5. *Investment Priorities:* Public investment increased by 40 percent from 2000 to 2003. Viet Nam will maintain a high rate of public investment in the coming plan period. Irrigation, roads, power, clean water, sanitation and communications in rural areas are the government's main priorities. Improvements to rural roads and water supply reduce the burden on women, who typically bear primary responsibility for delivering clean water and other necessities to households in Viet Nam. The development of urban mass transit systems in Ha Noi and Ho Chi Minh City would reduce transit costs for the poor, the number of traffic accidents and the level of harmful emissions. Investment in schools, health facilities and other essential infrastructure is also vital to improve access to basic social services.

6. *Appraisal of Public Investments:* The challenge over the next five years is to increase the efficiency of public investment and to make sure that the benefits of investment accrue disproportionately to the poor. Under government rules cost benefit analysis is required for the selection of large public investment projects. Cost benefit analysis can help identify projects with the highest economic and social returns, and to eliminate projects with unacceptably high social and environmental costs. Rigorous cost benefit analysis procedures can also categorise projects in terms of their impact on the poor, through, for example, employment creation, access to basic services and other criteria. The government must enforce existing rules and take steps to ensure that investment decisions at the provincial level are subject to the same requirements.

7. *Operations and Maintenance:* A related problem is the disjuncture between capital and recurrent spending in government budgets. Spending on maintenance and operations has not kept pace with new investments in irrigation, roads and other basic infrastructure. The Ministry of Agriculture and Rural Development estimates that 50 percent of large-scale irrigation works do not function properly because of poor maintenance, and that current O&M expenditures represent only 60 percent of the required amount. Spending on road maintenance has increased during the current plan period but still falls short of the government's own minimum cost estimates. Overemphasising new construction at the expense of maintenance and operations reduces the benefit streams derived from public infrastructure and shortens the working life of capital assets. Clearer linkages between investment projects and liabilities are needed to increase returns to public investment.

The Development of Pro-Poor Institutions

Institutions can be defined as the formal and informal rules, laws, norms and conventions that govern political, social and economic behaviour. Pro-poor institutions are accountable, inclusive and consistently promote the involvement of the poor in national development. Viet Nam has rapidly established the institutional architecture of a modern market economy. The pace of change has accelerated in recent years as Viet Nam's links to the global economy have intensified. Yet institutional development remains uneven and the costs of missing or weak institutions fall disproportionately on the poor.

8. *Access to Formal Credit and Savings Instruments:* The government has given the Viet Nam Bank for Social Policy (VBSP) the mandate and capital to expand preferential, unsecured lending to the poor. Most loans are small and provided through credit and savings groups. VBSP is unable to cover operating costs because of the negative spread between lending and savings rates (that is, VBSP's income from lending is less than what it pays out for savings), and therefore the planned expansion of the network will be costly for government. The emphasis on cheap credit also crowds out commercially viable banking services in poor, rural areas, and redirects savings from commercial banks to unsustainable, subsidized lending. Moreover, surveys show that few poor people know about or use formal savings instruments. The government could improve access to savings and credit facilities by accelerating VBSP's planned transition from policy lending to commercially-based micro-lending and savings through a nationwide local branch network.

9. *Migration:* The four-tier population registration system increases the costs of migration, which imposes a tax on the job-seeking poor and exerts a dampening effect on employment generation. The system also restricts access of migrants to basic health and education services. International experience shows that migration cannot be controlled administratively but can be channelled through the careful structuring of incentives. The development of infrastructure (roads, power, ports) in second and third tier cities and towns can reduce the rate of population growth in big cities. National social security cards provide a fairer means of regulating access to services than residence requirements.

10. *Gender Equality:* Viet Nam has a long tradition of promoting gender equality. The results are most evident in primary education and political participation at the national level. However, more accurate information is needed on issues such as the gender balance in upper secondary and tertiary education, domestic violence, sexual harassment in the workplace, trafficking in women and children, patterns of female domestic and international migration, and benefits and conditions of work for female migrants. This information is needed to inform the national gender equity strategy. More work is needed to ensure that women have equal access to income-generating opportunities and resources, such as land and agricultural training, and that women receive equal pay for equal work. Easier access to quality child care and crèches, and improved maternity benefits are needed to help women balance the competing demands of income-generating employment and domestic work. Increasing female representation in political bodies, particularly at the local level, accompanied by relevant and adequate training for female leaders, will help support the development of more gender-responsive policies. A national programme to encourage girls to study technical subjects and seek careers in science and technology-related fields and other non-traditional areas would help reduce the gender division of labour in the professions.

11. *Job creation:* Domestic private firms create more jobs per unit of investment than either state-owned enterprises or foreign companies. Prevailing incentives still constrain the growth of the domestic private sector despite considerable legal and administrative improvements. Local government often lacks the institutional capacity and the political will to encourage private domestic investment or provide an appropriate enabling environment for private sector activity. Strengthened business development services and business associations would help small and medium scale enterprises reduce administrative costs and delays. Legal protection for private firms and recourse to a fair and impartial legal system would stimulate domestic private investment. A clear separation between the regulatory functions of the state and the government's direct involvement in productive activities would clarify incentives and increase transparency. More investment in vocational education is needed to ensure that new entrants into the labour market have the skills that businesses require, and would help older workers to develop their skills or retrain to adjust to market demand.

12. *Food Price Instability:* For the poorest ten percent of the population, rice purchases make up nearly half of the household consumption basket and 80 percent of calorific intake. Given that a majority of the very poor are net buyers of rice, falling rice prices since 1996 have helped to reduce the incidence of recorded poverty in Viet Nam. However, the combined effects of rising oil prices, a weak dollar and drought in rice-producing countries have put upward pressure on rice prices. Although Viet Nam cannot insulate domestic consumers completely from fluctuations in international prices, government intervention is needed to dampen the effects of price instability on the poor. Export taxes are preferable to instructing public companies and agencies to hold stocks since taxes transfer revenue to general government budgets rather than to food exporters.

III. Recommendations

Viet Nam has made rapid progress in reducing poverty through the achievement of rapid, pro-poor economic growth. The main challenge during the next plan period is to make certain that government policies reinforce pro-poor growth and accelerate the rate of poverty reduction. Greater transparency and accountability of fiscal policy, public investment decisions and the development of pro-poor institutions are needed to sustain economic growth and maintain the existing link between growth and increments to the incomes of the poor.

Based on the above assessment and analysis, we recommend that the following targets be included in the Five Year Socio-Economic Development Plan. Where no baseline exists at present, immediate action is needed to collect and process the relevant data to establish appropriate benchmarks.

Target by 2010	Indicator	Source
General Poverty Targets		
Reduce food poverty rate to less than 5% nationwide and no more than 10% in any province or region	Food poverty rate	VHLSS, MOLISA surveys

(Continued next page)

Target by 2010	Indicator	Source
Reduce national poverty rate below 15%, and among ethnic monitories below 30%	Headcount rate of poverty, disaggregated by ethnicity	VHLSS
Reduce national poverty gap ratio below 15 for ethnic minority population	Poverty gap ratio, disaggregated by rural and urban areas, by ethnic group and by region.	VHLSS, MOLISA surveys
Reduce proportion of the population living in houses with substandard roofs to less than 10 percent and less than 20 percent among ethnic minorities	Percentage of the population living in houses with substandard roofs, by rural and urban areas, by ethnic group and by region.	VHLSS, MOLISA surveys
No baseline	Percentage of the population living in houses with dirt or mud floors, by rural and urban areas, by ethnic group and by region.	New survey required
No baseline	Percentage of the population living in houses with more than five people per room, by rural and urban areas, by ethnic group and by region.	New questions in VHLSS required
Child Poverty		
Reduce height for age below 25 % nationwide	Children whose height for age is more than –2 standard deviations below the median of the international reference population.	VNDHS, MOH
All children immunized against six major diseases	Children who had not been immunised against major diseases.	VNDHS, MOH
No baseline	Young children who had a recent illness (within last two weeks) involving diarrhoea and had not received any medical advice or treatment.	New survey required
No children live more than ten kilometres from nearest primary school	Children living 10 kilometres or more from any type of school	Education Management information Centre (EMIC) and GSO
No children live more than ten kilometres from nearest health facility	Children living 10 kilometres or more from any medical facility with doctors.	VHLSS, MOH
All children reach grade 5	Percentage of children reaching grade 5, disaggregated by gender, ethnicity, region and urban versus rural areas.	Education Management information Centre (EMIC) and GSO
Seventy-five percent of girls and boys in the relevant age group have completed lower secondary school.	Lower secondary school completion rate, disaggregated by gender, ethnicity, region and urban versus rural areas.	Education Management information Centre (EMIC) and GSO
Coefficient of variation of expenditure per student in primary and secondary below 25 percent among provinces and between rural and urban areas.	Expenditure per student, primary and secondary school, disaggregated by region and rural versus urban areas.	Education Management information Centre (EMIC) and GSO
Inequality indicators		
Percentage of national income accruing to the bottom 20 and 10 percent of the population exceeds ten and five percent, respectively	Percentage of national income accruing to the bottom 20 percent and 10 percent of the population.	VHLSS

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Target by 2010	Indicator	Source
No out of pocket education expenditures for the bottom consumption quintile	Out of pocket school expenditures for education services by consumption quintile.	VHLSS, MOET
No out of pocket health expenditures for the bottom consumption quintile	Out of pocket school expenditures for health services by consumption quintile.	VHLSS, MOH
Fiscal policy indicators		
Recurrent spending in poorest 10 provinces higher than national average	Recurrent public spending in poorest 10 provinces as share of national average.	MOF
Public spending on education exceeds five percent of GDP	Public spending on education as percent of GDP.	MOF
Public health spending exceeds 2.5 percent	Public spending on health as a percent of GDP.	MOF
Public investment		
85% of rural population has access to 60 litres per day of clean water.	Share of population with access to minimum of 60 litres per day of clean water	MARD, GSO
70% of rural households have access to hygienic latrine.	Share of the population access to a toilet of any kind in the vicinity of their dwelling, including private or communal toilets or latrines.	MARD, GSO
No baseline	Share of the population with no access to telephone within 5 kilometres.	New survey required
Institutional Indicators		
No baseline	Percentage of households using formal savings instruments disaggregated by urban and rural areas and ethnic minorities.	MOF
No baseline	Percentage of households using formal credit instruments disaggregated by urban and rural areas and ethnic minorities.	New survey required
Employment growth per unit of investment in public enterprises is equal to that recorded in private (including foreign-owned) sector.	Employment growth per unit of investment in the public sector, domestic private sector and joint-venture/foreign owned sector.	MOLISA, MOF
No baseline	Regular wage employment as a share of total wage employment (regular plus casual) in the urban and rural sectors.	New survey required
No baseline	Share of the population with no access to radio, television or newspapers at home disaggregated by ethnicity, region and urban versus rural areas.	New survey required
No baseline	Number of women subjected to domestic violence.[2]	New survey required
Half of professionals in science and technology related fields are women	Women as a share of professionals in science and technology-related fields.	MOLISA

[2] According to the United Nations Convention on the Elimination of All Forms of Discrimination Against Women, gender-based violence is defined as, "*Any act...that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in private or public life.*"

Chapter 3
Children

The 2005 Millennium Report 'Investing in Development' recommends five 'Quick Win' actions to combat poverty. Of these, three are specifically aimed at children, focusing on their education, health and nutrition, reflecting the reality that children are at the heart of poverty reduction. There can be no more effective and essential investment in the development of any country than investment in its children. The chapter below summarises the situation of Viet Nam's children and makes a series of concrete recommendations for targets in the Five-Year SEDP that the United Nations believes can strengthen the plan through an improved focus and approach to children.

I. Assessment

Child population:	30.6 million
Under 5 mortality (deaths per 1,000 live births):	23
Infant mortality (deaths per 1,000 live births):	19
Primary NER (% total/male/female):	96/98/92
Grade 5 completion (%):	89
Orphans:	150,000
Children with disabilities:	1,200,000
Street children:	16,000
Child labourers:	23,000
Low birth weight (%):	9
Proportion of children registered at birth (%):	95
Iodised salt use (%):	83
Vitamin A supplementation coverage (%):	55
Children exclusively breastfed for 6 months (%):	15
Clean water and hygiene in schools (%):	
• Kindergarten:	66
• Primary:	68
• Secondary:	72
Measles vaccination coverage at one year (%):	93
DPT3 vaccination coverage at one year (%):	99
Maternal mortality (per 100,000 live births):	165
Births attended by skilled personnel (%):	85

While there is a range of available data on children in Viet Nam, there remain questions about data quality, gaps in data, and in many cases a lack of age disaggregation. Almost all nationally available data comes from government sources. However, there are significant differences in data from different government sources, particularly comparing routine reporting data from administrative systems with survey data.

National aggregate figures do not always fully reflect differences among ethnic minority or remote areas, between girls and boys, and urban and rural areas.

Education: The net enrolment rate (NER) at the primary level has increased to 96 percent, an unusually high percentage for a country in which per capita income is less than US$500 at current exchange rates. However, retention and completion remain a challenge. For example, only 89 percent of pupils reach grade five. Significant differences still exist between the primary NER for boys and girls (98 and 92 percent, respectively) and among ethnic groups. A1999 survey showed that while 93.5 percent of Kinh majority boys were enrolled in primary school, the corresponding figure for of Ba-na boys was 55 percent, and only 51.5 percent for Hmong boys. Similarly, while 93.4 percent of Kinh girls were enrolled, only 60.4 percent of Ba-na girls and 31.5 percent of Hmong girls were attending primary school. The differences in lower secondary were also great. While 65.5 percent of Kinh boys were enrolled in lower secondary school, only nine percent of Ba-na and 7.5 percent of Hmong boys in the same age group were enrolled. Only 8.9 percent of Ba-na girls and 1.6 percent of Hmong girls from the relevant age group were enrolled in lower secondary school as compared to 64 percent of Kinh girls. In 1993, there were around two million adolescents enrolled in lower secondary school; in 2002, there were five million. Upper secondary enrolment rose more sharply, from around 300,000 in 1993 to two million in 2002. However, fewer ethnic minority children are enrolled in lower and upper secondary schools and gender disparities are even more marked among some ethnic groups. In 2001/2002, boys' and girls' gross enrolment rates (GER) were 87/81 percent at lower secondary and 51/47 percent at upper secondary, respectively. Disabled young people are also disadvantaged in terms of access and attendance given their limited opportunities for inclusive education.

Injury prevention: With recent significant progress in combating infectious diseases, injuries, such as drowning and traffic accidents, have become the predominant cause of child deaths. The Viet Nam Multi-Centre Injury Survey (VMIS) of 2001 found injuries were the cause of 75 percent of deaths for children one year and above. This has led the government and donors to revise their positions on child mortality to better reflect new understanding on the role of injuries. In 2001, the government promulgated a National Policy on Accidents and Injuries, as well as a follow up National Plan of Action which identified injuries among the social priorities for the next five-year development plan.

Child protection: With respect to legislation for children, there has been some progress, including the development of the 2004 Law for Protection, Care and Education for Children. Despite this, legislation on children in Viet Nam still has scope for improvement. For example, Vietnamese law defines a child as any person under 16, while the legal definition in the United Nations Convention on the Rights of the Child, to which Viet Nam is a state party, and under the national legislation of all other countries in the region, is 18. The 16 year age limit was retained in the amended 2004 Law. This raises a number of concerns with regard to legal protection of the rights of those 16 to 18, as well as making it difficult to compare child statistics from Viet Nam with those from other countries. There are also inadequate legal provisions on areas such as juvenile justice and child abuse.

Child nutrition: Malnutrition is a major problem. Although the number of underweight and stunted children in Viet Nam has halved over the past 20 years, undernutrition remains high by regional standards. FAO estimates that 23 percent of the population are food insecure or potentially insecure. Undernutrition is worse in ethnic minority areas and among the rural poor and is inversely proportional to mothers' education levels. However, it is not confined to these groups: the bottom income quintile, which includes almost all ethnic minority children, only accounts for 30 percent of undernutrition.

Water & environmental sanitation: There are still nearly 17 million children (52 percent) with no safe water and approximately 20 million children (59 percent) who lack access to sanitation. Regional and provincial disparities persist. Only 67 percent of the rural population had access to safe water in 2002. In urban areas, 10 percent of children have no access to sanitation compared to about 40 percent in rural areas. Access to clean water for the top and bottom 12 provinces was 97 percent and 32 percent respectively, while sanitation access was 75 percent and 12 percent respectively. The bottom 12 provinces are primarily remote and mountainous provinces where many ethnic minorities live. In general, ethnic minorities have benefited less from improvements in sanitation access. With regard to safe water, 87.2 percent of ethnic minority people lack access to clean water and the gap between Kinh and ethnic minority households doubled between 1993 and 2002 according to VHLSS. According to a recent survey, 65 percent of 35,500 schools had access to clean water and 42 percent to sanitary facilities.[3] In reality, however, latrines, if available, are frequently improperly used and maintained, facilities are often insufficient for all students and staff, and separate units for boys and girls may not be available.

In addition, the links between low clean water and sanitation coverage, and diarrhoea, stunting, parasitic worms and malnutrition in children are clear. This has implications for long-term negative health impacts. Approximately 23, 29 and 44 percent of the population is infected with whipworms, hookworms and roundworms, respectively.[4] Sixty to 70 percent of children are infected with roundworms. Arsenic and fluoride contamination of ground water especially in the Red River Delta add to water quality and health concerns.

Maternal & child health: Government surveys put levels of maternal mortality at around 165 per 100,000 live births with maternal mortality higher in remote areas with large ethnic minority populations. A recent Ministry of Health survey on maternal mortality found a rate of 45 per 100,000 live births in Binh Duong province, compared with 162 in Quang Tri and 411 in Cao Bang, for example. Infant and under-five mortality are decreasing, and are comparable to those of much richer countries. High infant and under-five mortality is increasingly confined to ethnic minority areas, and certain groups within those areas.

II. Analysis

Children make up almost 40 percent of Viet Nam's population. Viet Nam's declining fertility rate after a prolonged period of population growth leaves children between 10 and 18 years of age making up around a quarter of the population, generating increased demand for appropriate health services, education, employment and participation opportunities.

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3 National WES Target Programme's survey, 2004(undertaken by the National Target Programme for Rural Water Supply and Sanitation/ CERWASS in MARD).

4 *Southeast Asia Journal of Tropical Medicine and Public Health*, Volume 34 Supplement 1, 2003, "The Current Status of Parasitic Diseases in Viet Nam".

The United Nations in Viet Nam has identified six priority areas with regard to children and poverty reduction which are crucial for the five-year plan.

1. Education: Education is a priority for the government and people of Viet Nam. About 87 percent of children under three are cared for at home, and approximately half of children aged three to five are enrolled in kindergarten or preschools. A growing proportion of preschool education is provided privately, raising concerns about the development of a two-tier system. For preschool education to offer children the best start in life, it must include opportunities to play and an avenue for other services (for example, deworming and vaccinations).

Out-of-school primary-age children are usually ethnic minority children, migrant children or children with disabilities. Primary enrolment for ethnic minority children varies widely between ethnic groups; large disparities are noted above. Global experience demonstrates that children learn best when taught in their own language and can lose approximately two years of education when taught in a different language. However, few ethnic minority students are taught by a teacher from their group, and almost none in their own language. Access to mother tongue and bilingual instruction will be critical to higher access and learning achievement for ethnic minority children. Primary teachers are relatively well qualified. However, in remote, mountainous and ethnic minority areas, primary teachers usually have less than eight years of education, and there are severe shortages of teachers, despite government recruitment efforts.

Although most poor children are exempt from regular tuition fees at primary level, schools often charge parents an array of indirect fees, including construction costs, class funds, transcript fees, electricity fees, notebooks fees, dormitory bed costs and drinking-water fees. Many poor parents, particularly in ethnic minority areas, cannot afford both the loss of labour when a child is at school and the loss of family income to support that child through school, and thus pull their children out. Education expenditures by income quintile show Viet Nam's richest parents spending over 30 times more than the poorest on extra classes, as well as more on textbooks and other learning aids. This is reflected in attainment, with children from rich families having a far better chance of getting into university than poor children.

Drop-outs from lower secondary schools are common in rural areas and urban poor communities. Most often, these out-of-school youth are from poor and migrant families, and families affected by HIV/AIDS. In addition, lower secondary schools, such as ones organized independently by individuals or semi-public schools, necessarily apply user-fees that affect enrolment and attendance.

2. Injury prevention: Drowning is the leading cause of injury-related death of children, far exceeding other causes. Everyday, around 40 children drown, due to a combination of inadequate swimming skills and children being left unsupervised in areas with drowning hazards. Road traffic injury is the leading cause of death in adolescent children. The scale of these deaths increases with age, from the early teenage years to the late teens. Most road and traffic accidents involve motorbikes. Of the estimated 4,100 children under 18 years of age that lost their lives in traffic accidents in 2001, more than 60 percent were either hit by or riding a motorbike. Finally, poisoning and injuries involving sharp objects are equally ranked as the third leading causes of death. Injuries are now a major public health issue threatening children's survival and development and subsequent achievement of the MDGs.

3. Child protection: MOLISA reports that there are 2.5 million children in need of special protection (CNSP) in Viet Nam.[5] There is no formal child protection system or strategy, and few trained social workers and counsellors.

Physical abuse in the home, perpetrated against and witnessed by young children, appears common. Several independent surveys suggest many children witness physical abuse at home and are slapped or hit. Little is known about child sexual abuse. Around three percent of primary-age children in a UNICEF survey reported unwanted touching, and less than one percent said they had been raped or sexually assaulted.

Cross-border trafficking of Vietnamese women and children appears to be increasing. The Ministry of Public Security estimates that 22,000 Vietnamese women and children were trafficked to China in the 1990s with tens

[5] Children in need of special protection (CNSP) includes: exploited or abused children, child laborers, trafficked children, street children, orphans, children in conflict with the law, children infected or affected by HIV/AIDS, children with disabilities.

of thousands of others to Cambodia and other countries. UNICEF research suggests that 15 percent of known females trafficked from southern Viet Nam to Cambodia are under 15 years of age.

Children are denied education through child labour. According to the Institute of Labour Science and Social Affairs, the number of children under 15 years in full time work fell from 4 million in 1993 to 1.6 million in 1998, in line with the rise in secondary enrolment.

The government estimates there are around 16,000 street children, most around 15 years of age and male. The majority do not attend school or receive vocational training, few see a doctor when sick, and most want to go home. Drug abuse and sexual abuse is common, and a high number of street children (15 percent) are thought to be HIV positive.

There are about 1,530,000 orphans in Viet Nam, including about 22,000 children orphaned by HIV/AIDS. There are also about 265,000 children affected by HIV/AIDS[6] and MOLISA reports a total of 8,500 children infected by HIV. In addition, there is no formal system of alternative care for children without primary care givers. A small number of these children are given financial support by the government. An estimated 25,000 children live in institutions. A recent study found that children remain in institutions for long periods; many enter as babies and remain until early adulthood. Few institutions regularly review child placements as per international standards.

There are about 11,000 to 14,000 children in conflict with the law annually. In 2002, around 4,500 children were charged under criminal law, of which 3,100 were found guilty and sentenced. Most crimes (55 percent) involved theft. The administrative justice system is supposed to act as a buffer between children and the criminal justice system, but both routinely direct children into reform schools and detention centres. The number of adolescents in these institutions increased ten-fold between 1995 and 2003. First-time offenders are grouped with serious repeat offenders, and exposed to various health hazards (for example, shared needles and HIV/AIDS). This experience hardens many youth who might otherwise reintegrate smoothly into the community.

Viet Nam has about 1.2 million children with disabilities (CWD), the majority of whom live in poor families. Only a third of all CWD receive government support and less than 10 percent have been enrolled in school.

4. Child nutrition: The causes of Viet Nam's child undernutrition situation begin before and during pregnancy and the first three years of life.

Pregnancy: Maternal nutrition before and during pregnancy greatly affects children's maximum height. The National Institute of Nutrition estimates that 27 percent of pregnant mothers suffer from chronic energy deficiency, and that over 30 percent are anaemic. Even when pregnant mothers have a healthy diet, they may not be able to absorb the nutrients they consume due to parasitic intestinal worms. Prevalence of intestinal worms is between 30 to 50 percent and higher in rural as compared to urban areas.

Birth to six months: Most undernourished children are not born underweight. About nine percent of children were born underweight in 2002, a figure that is comparable to most developed countries. After pregnancy, the most important source of nutrition is breast milk, which ensures optimal nutrition and physical development and protects against illnesses. The rate of exclusive breastfeeding in Viet Nam is about 15.4 percent according to the VNDHS. Babies are typically given rice water and other foods from about two months, reducing the baby's appetite for more nutritious breast milk and increasing the risk of infections.

Six months to three years: Undernutrition persists in children between six months and three years of age, the period when solid foods should be introduced to supplement breast milk. The National Institute of Nutrition estimates that half of children under two years of age are anaemic and that close to 15 percent suffer from sub-clinical vitamin A deficiency. Most meals typically fed to children at this age lack variety and are low in energy density.Undernutrition in young children is closely linked to disease. Around 60 percent of 2 to 5 year-old children are thought to be suffering from parasitic worm infestations. An estimated 20 percent of six to eleven month-old children have had diarrhoea in the past two weeks.

[6] Children affected by HIV/AIDS in Viet Nam include HIV-positive children, children with HIV positive parents, family members, or guardians, children orphaned by AIDS, and children at risk of infection.

Iodine deficiency: It is estimated that about 250,000 newborns are at risk of mental underdevelopment because their mothers did not consume iodised salt before and during pregnancy. The national average for iodised salt use is 82.5 percent, but some areas, particularly the Mekong River Delta, have significantly lower coverage. Viet Nam's National IDD Control Programme aims to achieve 90 percent household use by the end of 2005. It is crucial that optimal iodine nutrition is ensured by sustained universal salt iodisation. This requires multisectoral efforts in policy, legislation and enforcement, communication and inspection, monitoring and surveillance.

5. Water & Environmental Sanitation: While the issue of water and sanitation is addressed in greater detail in Chapter 5, there are some child-specific considerations, particularly for access in schools. Few schools have arrangements for hand washing, soap and safe disposal systems for sanitary waste. Facilities are often not designed appropriately for young children and not enough attention is given to separate facilities for girls and boys. Insufficient consultation and involvement of students, parents, teachers, cleaners and school managers, along with unclear or limited guidance, results in school facilities being built without basic water and latrine facilities.

Past government hygiene efforts have tended to concentrate more on providing facilities and less on behaviour change. A growing body of experience recognizes that construction is not enough, and that school-oriented water supply, sanitation and hygiene education contribute significantly to improved health, nutrition and learning performance of children; increased school enrolment and attendance (particularly of girls); and sustained good hygiene and sanitation practices by individuals and communities. Interventions such as these can help achieve the MDGs on education, water, sanitation, child protection, gender equality and health.

6. Maternal & child health: Leading causes of maternal mortality, including bleeding and other traumatic complications, can be prevented or treated through better nutrition during pregnancy and properly attended births. The number of pregnant mothers receiving antenatal checkups increased by 15 percent between 1997 and 2002, when 86.8 percent of mothers had at least one check-up. More women are being seen by doctors and fewer by nurses and midwives. However, checkups do not cover micronutrient supplements or deworming. MOH estimates that only 14 percent of provincial and district hospitals are properly staffed and equipped to manage obstetric conditions. About 15 percent of births are unattended, with wide regional variations. For example, 86 percent of women in northwestern Lai Chau province gave birth without a skilled birth attendant in 2002, compared to less than one percent of women in Ha Noi and Ho Chi Minh City.

Infant and under-five mortality: The risk factors for infant and under-five mortality include low level of education of mothers, high numbers of children, birth spacing of less than two years and lack of access to services.

Immunisation and communicable disease: Improved immunisation is a key cause of improved MMR and IMR figures. Vaccination rates for tuberculosis, polio, diphtheria, pertussis, tetanus and measles have all risen to between 90 and 100 percent. Plans to eliminate neo-natal tetanus by 2005 are on track. However, vitamin A coverage in certain areas (particularly the Central Highlands) remains low. According to the VNDHS, twice as many children in the Red River Delta received all four required vaccinations in 2002 as in the Northern Uplands, where many ethnic minority people live. The VNDHS also found that only 58 percent of children were receiving all recommended required doses of each vaccine by 12 months of age, and only 67 percent by two years of age.

Neonatal mortality: Survey data suggests that the majority of infant and under-five mortality occurs within the first month of life. However, neonatal mortality is not tracked as a national indicator, and most health centres do not record causes of neonatal mortality. More than half of those who die before one month of age are unregistered, and their deaths go unrecorded. Many are registered late, with over 30 percent of registrations taking place after the child has reached six months of age. Major causes of neonatal mortality include haemorrhage, infection, hypothermia and poor nutrition during pregnancy. Preventing or minimising these causes is relatively straightforward: fewer children die during or shortly after birth if mothers are well nourished during pregnancy and give birth at a quality healthcare facility.

III. Recommendations

Based on the above assessment and analysis, we propose the following targets for consideration for the Five-year plan:

Target by 2010	Indicator	Source
Education		
Targets to be advised. Current national completion rates (2003/4) are: Primary: 80.5% Lower secondary: 73.4%Upper secondary: 79.6% *(MOET Education Statistics of preschool, primary and secondary, 2003-4, Feb.)*	School completion rates for primary, lower and upper secondary school disaggregated by sex and ethnic group	Completion rates disaggregated by sex and ethnic group not currently collected systematically; only small research/surveys are available
Preschool: 53% Primary: 99% Lower secondary: 90% Upper secondary: 50% plus sex-disaggregated data for all levels (Primary NER: 96% in 2001/2002)	Net enrolment rates for preschool, primary, lower and upper secondary schools disaggregated by sex	Education Management Information Centre (EMIC) MOET and GSO Education Development Strategy for given data; NER for lower, upper secondary school and sex-disaggregated data for all levels not systematically collected
95%	Percentage of 5 year olds in kindergarten disaggregated by sex	EMIC(MOET)&GSO, sex-disaggregated data not collected systematically
70% (primary)	NER for preschool, primary, lower and upper secondary school of children with disabilities	EMIC (MOET) and GSO, disaggregated data not collected systematically
20%	Government budget for education spending	National Education Development Strategy 2001-2010
Target to be advised. Note: Targets per EFA are: Children/class:creche: 15Children/ class:kindergrtn:25Teacher/class: creche: 2Teacher/class:kindregrtn:1.8	Number of children/class and teacher-children ratio	MOET, via monitoring of Education for All (EFA)
Injury Prevention		
30/100,000 children (39.2/100,000 in 2001)	Child fatality rate from drowning	Viet Nam Multi-centre Injury Survey (VMIS)
10/100,000 children (12.7/100,000 in 2001)	Child fatality rate from traffic accidents	VMIS
50% of young people using helmets	% of young people using helmets	SAVY
Child Protection		
National child protection strategy in place and being implemented	Existence of a national child protection strategic plan/strategy	Commission for Population, Family & Children (CPFC)
70% of CNSP provided with care and support	Number of CNSP provided with care and support in line with international standards	MOLISA, CPFC
30% of all communes/ health care centres have a trained social worker	Number of trained social workers: a) with BA degree; b) with BA, providing professional social work services	MOLISA, CPFC
Greater legal protection for CNSP via development of provisions under laws, decrees, circulars, policies in line with CRC and international standards	Number of relevant laws, decrees, circulars and policies on child protection revised in line with CRC and international standards	CPFC, MOJ

Target by 2010	Indicator	Source
Reduction by 20% by 2010 (23,000 in 2004)	Labour force participation rate of children under 16 years of age	MOLISA
n/a	Number of child-headed households	Data currently n/a but possibly to be collected in the future per MOLISA
Child Nutrition		
25% with all provinces achieving at minimum the national rate (30.7%, 2004)	Children < 5 stunted	NIN (Nutrition surveys)
95% with all provinces achieving at minimum the national rate (82.5%, 2003)	Proportion of households using adequately iodized salt	National IDD Control Programme, MOH
10% (0%, VNDHS 2002); (cf, 15.4% of children exclusively breastfed between 0-6 months, VNDHS 2002)	Proportion of children exclusively breastfed at the age of six months	NIN (Nutrition surveys)VNDHS
80%	Proportion of newborns being weighed	NIN (Nutrition surveys)
6% (from NNS) (5.8% in 2003, Health Statistics Yearbook)	Proportions of newborns weighing less than 2500g (low birth weight babies)	NIN (Nutrition surveys)
80%	Proportion of children aged 0-2 years who have weight monitored regularly (eg, every qtr), recorded on growth chart	NIN (Nutrition surveys)
25% (32% in 2000)	Anaemia prevalence among pregnant women	NIN (Anaemia surveys)
80%	Proportion of Commune Health Stations distributing iron supplements to pregnant women	NIN
90% (52.4% in 2002, NIN)	Proportion of mothers receiving a vitamin A supplement after delivery	NIN (Vit. A programme)
100%	Proportion of children aged 6-36 months who received a Vitamin A supplement in last 6 months (distribution is twice/year)	NIN (Vit. A programme) (99.3% in 2003, NIN)
Water & Environmental Sanitation		
85% of schools[7] with access to safe water supply and sufficient numbers of child-friendly latrines for boys & girls	No. of schools with access to safe water supply and adequate number of separate, appropriate sanitary units for boys and girls, disaggregated by sex, province, and ethnic group	MOET, MARD
Maternal and child health		
97%* (85% in 2002, DHS or 96% in 2003, MOH)	Proportion on deliveries assisted by skilled birth attendants	VNDHS, MOH routine reporting system
60%* (present variation 6.2%-83%)	Proportion of women having one post-natal care visit	VNDHS, MOH plus Household surveys/ CBM
60%* (present variation 6.2-83%)	Proportion of women attending at least three ante-natal check-ups	MOH plus household surveys/CBM
70/100,000 live births* (85/100,000 in 2003, MOH reporting system; 165/ 100,000 in 2001-2, MOH maternal mortality research)	Maternal Mortality Ratio (MMR)	MOH, maternal mortality research/surveys
25/1000 (18/1000 in2004 - Population Change & Family Survey 2004)	Infant (<1) Mortality Rate	MOH, household survey; Population Change & Family Survey 2004)

[7] For WES indicators, schools refer to kindergarten, day care centres, and primary schools.

Target by 2010	Indicator	Source
90%* (86.8% in 2002, VNDHS)	Proportion of women attending at least one ante-natal check-up[8]	VNDHS
80%* (78.5%, 2002,VNDHS)	Proportion of institutional deliveries	VNDHS

* Targets come from the National Strategy for Reproductive Health, 2000.

Annex: Data sources for indicators in box for Chapter on Children, the MDGs and Viet Nam's Five-year Socio-Economic Development Plan

Indicator		Source
Child population	30.6 million	Population Division of the Department of Economic and Social Affairs of the UN Secretariat (2004), "World Population Prospects: The 2004 Revision"
Under 5 mortality (deaths per 1,000 live births)	23 (2003)	Estimated by UNICEF/NY from MICS2000 State of the World's Children (SOWC) 2005
Infant mortality (deaths per 1,000 live births)	19 (2003)	Estimated by UNICEF/NY from MICS2000SOWC 2005
Primary NER (% total/male/female)	96/98/92 (2001-2002)	SOWC 2005 UNESCO Institute of Statistics database
Grade 5 completion (%)	89	UNESCO Institute of Statistics database (2000/2001)
Orphans	150,000	MOLISA (2004)
Children with disabilities	1,200,000	
Street children	16,000	
Child labourers	23,000	
Low birth weight (%)	9 (1998-2003)	SOWC 2005
Proportion of children registered at birth (%)	95 (2004)	M0J Thematic Report (Jan 2005)
Iodised salt use[1] (%)	83 (1997-2003)	SOWC 2005
Vitamin A supplementation coverage (%)	55 (2002)	SOWC 2005
Children exclusively breastfed for 6 months (%)	15 (1995-2003)	SOWC 2005
Clean water and hygiene in schools (%)		CERWASS National survey 2003
• Kindergarten	66	
• Primary	68	
• Secondary	72	
Measles vaccination coverage at one year (%)	93	WHO/UNICEF Review of National Immunization Coverage 1980-2003 in Viet Nam (August 2004)
DPT3 vaccination coverage at one year (%)	99	
Maternal mortality (per 100,000 live births)	165	MOH, Maternal mortality research, 2001-02(85/100,000 in 2003 in MOH reporting system)
Deliveries assisted by skilled attendants (%)	85	VN DHS 2002(96% in MOH routine reporting system, 2003)

[8] The percentage of women undergoing of antenatal check-ups is: 13.2 percent making no visits; 10.1 percent making 1 visit; 47.4 percent making 2-3 visits; 29.3 percent making 4 or more visits (VN DHS 2002).

Chapter 4
Population, Gender and Reproductive Health

I. Assessment

Over the past decade, Viet Nam's rate of population growth has dropped significantly from approximately two to 1.4 percent per annum. Consequently, the population will double in 50 years instead of 35. The fertility rate, defined as the average number of children born to women during their reproductive years, has dropped steadily to 2.2, although it is higher in some disadvantaged regions.

The government has identified reducing the population growth rate as a policy priority. At 1.44 percent, the current rate is higher than the target of 1.22 percent set out in the 2001-2005 SEDP and the ten year target of 1.2 percent as stated in the 2001-2010 Socio Economic Development Strategy. The CPRGS target of replacement level fertility has nearly been achieved. Mortality rates are also decreasing. Disadvantaged regions continue to record higher fertility and mortality rates than average.

While birth rates have decreased, 29 percent of the population is still under 15 years of age. Assuming that current trends continue, the share of the population under 15 will continue to decrease over the next five years.

At the same time, the share of the elderly in the population structure is increasing. The elderly now comprise 6.5 percent of the population. The age dependency ratio (that is, number of people 60 years of age and older per 1,000 people aged 15-59) is projected to increase from 14 in 1999 to almost 17 by 2024. As Vietnamese people have fewer children it is likely that in the future there will be fewer working-age adults available to care for the elderly. In addition, the proportion of elderly people over 75 years of age is expected to increase from 25 percent in 2000 to 30 percent in 2010. Elderly people over 75 years of age are more likely to be women, to live alone and to suffer from health problems. More people in this age group will therefore place increasing demands on existing support and social security systems.

Youth make up a significant proportion of migrants. Migration to cities accounts for approximately half of all spontaneous migration, but significant migration has also occurred to the Southeast and Central Highlands regions.

Population growth rate	1.44
Crude birth rate	18.5
Crude death rate	5.8
Percent population below 15	29.3%
Percent population above 65	6.5%
Dependency ratio (number of elderly per 1,000 people ages 15-59)	14
Total fertility rate	2.2
*Maternal mortality ratio	165
*Contraceptive prevalence rate (any/modern)	75%/63%
*Proportion of births attended by skilled personnel	95.8%
Availability of basic and comprehensive essential obstetric care	NA
Availability of EmOC facilities per 500,000 population	NA
Abortion rate (% of pregnancies)	22%
*Proportion of adults (15-49) living with HIV/AIDS	0.44%
*Number of children orphaned by HIV/AIDS (2003)	2,000 **
Knowledge of HIV-related prevention practices	
Abstinence	5%
One partner	68%
Use condom	50%
HIV prevalence in pregnant women (15-24)	NA
*Condom use rate of contraceptive prevalence rate	7%
Percentage of obstetric and gynaecological admissions owing to abortion	NA
Prevalence of infertility in women (15-49)	NA
Prevalence of positive syphilis serology in pregnant women (15-24)	NA

*** Source: Situation of Families & Children Affected by HIV/AIDS in Viet Nam: A National Overview, UNICEF, 2003.*

Viet Nam has successfully promoted family planning. The contraceptive prevalence rate has increased to 77 percent, with 63 percent using modern methods (56 percent in the 2002 DHS).

However, the country's performance with respect to other reproductive health (RH) indicators is not as good. The maternal mortality ratio is still high at 165 deaths per 100,000 live births, although this marks an improvement

from 250 in 1990. Twenty-two percent of pregnancies end in abortion – an alarmingly high rate. HIV/AIDS prevalence is increasing, especially among youth. The Ministry of Health estimates that the infection rate is 0.44 percent of adults aged 15-49, up from 0.34 percent in 2001, and that a majority of cases affect people between 20 and 29 years of age. Prevalence is still highest among injecting drug users (IDUs) at 30 percent, and female sex workers at six percent. An increasing number of infections attributed to heterosexual transmission.

As noted in Chapter 2, Viet Nam has a long tradition of promoting gender equity. However, limitations on women's access to health care services and information, particularly reproductive health care, are evident in the high maternal mortality and abortion rates. Disempowerment and cultural attitudes towards sexuality make it difficult for women are to negotiate for condom use and to discuss reproductive and sexual health issues with their partners, families and wider support networks. As a result women are vulnerable to sexually transmitted infections, including HIV, unwanted pregnancies, and physical and emotional violence.

Serious gaps remain in the Vietnamese data relating to population, gender equity and reproductive health. Existing data are too often based on administrative reports rather than scientific surveys.

II. Analysis

Population

1. *Population policy:* The government's new Population Ordinance of 2004 relaxes restrictions on family size and spacing, thus bringing the country's population policy more in line with the 1994 International Conference on Population Development endorsed by Viet Nam. Replacement level fertility can be reached by further socio-economic development and appropriate reproductive health information and services for all social groups. Disadvantaged areas require particular attention in order to close gaps with the rest of the country in terms of fertility and socio-economic development more generally.

2. *Age structure:* The Viet Nam Youth Development Strategy to 2010 identifies employment, the prevention of HIV/AIDS and substance abuse as key issues. Vietnamese youth are well educated and literate. However, rising HIV-infection rates and the high incidence of abortion, and the increasing sex ratio imbalances in some provinces are matters of concern. Young people possess substantial reproductive health knowledge, but the information available to them is not always accurate or conducive to protective behaviour. The recent Survey and Assessment of Vietnamese Youth (SAVY) found that youth consider premarital sex improper, although in urban areas one in three single young men report engaging in it. Contraceptive use among youth is low.

Strategic planning for the future is needed to accommodate the growing proportion of elderly in the population. Sixty percent of the elderly are women and four-fifths live in rural areas. The 1999 Survey on the Living Conditions of the Elderly found that while only 26.2 percent of 60 to 64 year olds report poor health, 63.7 percent of those over 75 years are unwell. As noted above, people over the age of 75 are increasing as a share of the total elderly population. Targeted assistance should concentrate on the most vulnerable among Viet Nam's elderly.

3. *Migration:* Migration is a livelihood strategy in which working people seek out opportunities that are not locally available. Non-migrants benefit from remittances and from the information and experience that migrants bring back with them. Migrants often use their savings to establish small businesses in their place of origin, thus contributing to job creation. Migrants are predominantly young adults, and a majority are women. Migrants often lack job security, access to health, social, and occupational insurance and are not able to participate in the government's National Targeted Programmes for poverty reduction.

Gender equality

4. *Gender disparities* in education are discussed in Chapter 3 and opportunities for women in training, land ownership, and decision-making in Chapter 2. It is important to stress the link between gender equity and poverty reduction. Changing the conditions that sustain a gendered division of labour and ensuring equal pay enables women to make full use of their knowledge and skills and thus participate fully in livelihood strategies. Now that there is near gender parity in primary education, equal access to secondary and tertiary levels is a prerequisite

Box 1. Gender, the United Nations and the MDGs

The Fourth World Conference on Women held in Beijing in 1995 reached a consensus on the need to mainstream gender issues in all programmes and policies. The United Nations Secretary General and the recent Beijing Plus 10 Conference in 2005 have underscored the need to support gender equality in order to reach each of the MDGs. Gender equality is not a sectoral issue. Women comprise the majority of people living in extreme poverty (for example, those who earn less than one US dollar per day). A gendered division of labour, domestic violence, unequal access to education and health services and the unequal burden of domestic work and child rearing on women, all exert a negative impact on women's incomes and human development. Women comprise the majority of farm labourers yet often lack control over productive resources such as land, livestock and machinery. The over-representation of women among the poor increases child and maternal mortality and exposes women to higher risk of HIV/AIDS infection. Social and cultural limits on women's physical, social and economic mobility intensify female poverty and increase women's health risks. Limited access to clean water and fuel imposes a heavy burden on women, who spend many hours on unpaid work, providing households with these necessities.

As a signatory to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Viet Nam is committed to incorporating the principle of equal rights for women and girls into the legal system, to establish public institutions to protect these rights and to ensure that discrimination does not occur. Viet Nam has not ratified the Optional Protocol, and therefore does not recognize the competence of the Committee on the Elimination of Discrimination against Women to receive complaints from individuals or groups relating to discrimination against women.

for gender equality in human development. Political participation and empowerment of women, particularly at local levels will also be critical to supporting gender-responsive policies and budgets for men and women. Addressing men's reproductive health needs and redefining men's roles in the twenty-first century are also needed to achieve gender equity.

With regard to sexual and reproductive health, cultural attitudes prevent women, especially unmarried women, from seeking information about reproductive health or discussing protection with their partners. A greater public understanding and awareness of current unequal gender roles is needed to empower women in their sexual and domestic relations with men, reduce the incidence of domestic violence and support more equally shared responsibilities in childcare and domestic work.

Mainstreaming gender issues into public policies, plans and programmes, coupled with accountability mechanisms for enforcement will be critical to realizing equal opportunities for men and women and more balanced development between men and women.

Sexual and reproductive health

5. *Maternal and Child Health:* MDG 5 aims to reduce the maternal mortality ratio by three-quarters. The lack of appropriate information and services in remote and mountainous areas and the low capacity of health practitioners and facilities at local levels to treat maternal and newborn complications are major challenges in Viet Nam. Chapter 3 discusses preventive measures to generate more positive outcomes for mothers and children.

6. *HIV/AIDS:* MDG 6 calls for action to halt and to begin to reverse the spread of HIV/AIDS. Viet Nam needs more reliable data on disease incidence, transmission and treatment. The unavailability of confidential testing, treatment, and care, and discrimination against people living with HIV/AIDS (PLWHA) are key constraints. PLWHA experience employment discrimination, are spurned by their communities, and children from families with a member with HIV/ AIDS are still in some cases rejected by schools and health facilities.

7. *Maternal health and HIV/AIDS* are intrinsically linked with other reproductive health issues. Inadequate family planning services, particularly for youth, increase the number of unwanted pregnancies or abortions. Abortion complications account for 11.5 percent of maternal deaths. Insufficient counselling on contraceptives and sexually transmitted infections (STIs) places individuals at risk of HIV/AIDS. While the contraceptive prevalence rate is high, the use of traditional methods (with a higher risk of failure) is also high. Almost half of abortions occur among women using traditional methods, and only 15 percent among women using modern contraceptives. IUDs

still predominate (57 percent of contraceptive users), with use of pills and condoms a distant second and third (11 and seven percent, respectively). The presence of STIs increases the risk of HIV infection. Although data are lacking on reproductive tract infections (RTIs) and STIs, micro studies record high prevalence rates. For example, a study of 600 women at a family planning clinic in Hue found an RTI prevalence of 21 percent and STI prevalence of 5 percent. A population-based study of 1,163 women in Hai Phong found that 44 percent had reported RTI symptoms over the previous six months. In additional to more reliable data, better access to services of good quality that users perceive as confidential is needed to address these problems.

III. Recommendations

Based on the above assessment and analysis, we propose the following targets and indicators for consideration for the five year plan 2006-2010. A cross-cutting theme in this section is the pressing need to improve and consolidate the availability, accuracy and quality of essential and authoritative data. The formulation of policies relating to migration, gender equality, and reproductive health would benefit from routine and systematic collection and analysis of data in these areas and disaggregated according to sex, age, ethnic minority groups and other disadvantaged population sub-groups. A second cross-cutting issue is the need to concentrate efforts on disadvantaged groups that are at higher risk of falling into poverty.

Target by 2010	Indicator	Data Source
Strengthened communication on RH issues, particularly STDs and HIV/AIDS, through market segmentation and tailored messages: National and sub-national mechanisms developed that advance women and men, girls and boys' participation in designing and monitoring communication programming to achieve behavioural change.	Communication plans related to RH, particularly STDs and HIV/AIDS, of selected relevant ministries and agencies, contains market segmentation and tailored messages.	Activity reports
Achieve substitution level fertility rate for remote and poor areas by 2010	Total fertility rate	MOH routine reporting disaggregated by region
Increase access of youth to health (particularly RH) care disaggregated by sex	Increased proportion of SRH services utilization by youth	MOH routine reporting disaggregated by age
Migration integrated into development policies and programs, particularly those aimed at poverty alleviation	Migration discussed in SEDP, and studies commissioned on the contribution made by migration to poverty reduction	National development documents, MPI documents, MOLISA documents.
Develop strategy to provide supportive services for migrants	Strategy on migration developed	National Assembly documents, SEDP, sectoral and provincial plans
Improved collection of gender-related data and information, and more comprehensive disaggregation of existing indicators by sex; 80% of newly developed policies have incorporated gender analysis and respond to gender issues identified	Percentage of routine data disaggregated by sex; number of newly developed policies that have incorporated gender analysis and are gender responsive	GSO data, ministerial and provincial level reports; National Assembly documents
80% of all leaders in key ministries, branches and provinces receive training in mainstreaming gender in policy and planning	Gender training carried out and gender mainstreaming skills evident in central and provincial policies and plans	NCFAW

(Continued next page)

Target by 2010	Indicator	Data Source
Public accountability framework exists for enforcing development of gender responsive laws, policies and plans with specific repercussions outlined for non-compliance at central and provincial level	Existence of public accountability framework	New monitoring by NCFAW or Women's Union
100% of all ministries and provinces have developed and are implementing gender mainstreaming strategies and plans of action which respond to the specific needs of men and women	Number of ministries and provinces with gender mainstreaming strategies developed, being implemented	Ministry of Planning and Investment documents, (Baseline data can be obtained from NCFAW which tracks POA progress by ministries)
Increased public expenditure allocations which directly benefit women and gender equality goals.	% of total central and line ministrial budgets spent on activities that address gender disparities	Sectoral budgets and plans
Collect baseline data on the incidence of domestic violence.	Baseline study implemented	
Reduce maternal mortality from 165 to 70 per 100,000 live births by 2010	Maternal mortality rate	MOH routine reporting
One comprehensive and four basic EmOC facilities per 500,000 population in all regions	EmOC facilities per 500,000 population	MOH
100% increase in condom use from 7% of CPR to 14%	Condom prevalence rate	VPCFC routine reporting, DHS survey
Reduce gap between IUD use and other modern contraceptives (57% IUD vs. 11% pill, 7% condom)	Contraceptive prevalence rate by method	VPCFC routine reporting, DHS survey
Reduce abortion rate from 22% of pregnancies to 15%	Abortion rate	MOH routine reporting

Chapter 5
Environmental Quality

I. Assessment

Accelerated exploitation of natural resources and environmental pollution have accompanied industrialisation and rapid economic growth in Viet Nam as elsewhere. Urbanisation and increased use of motorised transport present emerging challenges. The government's objective of reducing the incidence of persistent poverty requires investment and policy formulation to promote environmental sanitation, improved management of natural resources, and to protect biodiversity. The costs of ecosystem degradation are borne disproportionately by the poor, who depend more directly on natural resources for their livelihoods. Women and girls, who usually take responsibility for supplying households with water, suffer most from lack of access to clean water. Lack of separate school bathrooms for girls also acts as a disincentive to school attendance.

Rural population with access to clean water (2004)	58%
Urban population with access to safe water (2002)	78%
Forest cover (2004)	6.7%
Protected areas as share of total land surface (2003)	7.5%
Rural population with access to hygienic latrines (2002)	25%
Urban population with access to hygienic latrines (2002)	76%
Collection of solid waste in big cities (2004)	71%
Collection of solid waste in towns (2004)	20%

The environmental MDG with its targets and indica-tors provides an interna-tional framework for the analysis of development from the perspective of en-vironmental protection. These targets and indicators are presented in the Box 2.

Viet Nam has made steady progress towards MDG environmental targets and related Viet Nam Development Targets (VDT) that are included in the CPRGS. Forest cover increased from 28 percent of land area in 1990 to 37 percent in 2004. Land area protected for conservation purposes, most of which is forested, has risen in tandem. It is estimated that the share of rural households with access to clean water was 58 percent in 2004, an increase of ten percentage points over the corresponding figure for 1990. The government has emphasized sanitation in both rural and urban areas, and access to hygienic latrines is rising in both urban and rural areas.

Viet Nam has adopted or revised a number of laws, decrees, and strategies to integrate the principles of sustainable development into country policies in accordance with the MDG Target 9. National policy statements relating to sustainable development include:

- *Strategic Orientation for Sustainable Development in Viet Nam* (Viet Nam Agenda21, approved in 2004);
- *National Strategy for Environmental Protection until 2010 and vision toward 2020* (NSEP)
- *National Rural Clean Water Supply and Sanitation Strategy to 2020* (RWSS Strategy; approved in 2000);
- *Second National Strategy and Action Plan for Disaster Mitigation and Management in Viet Nam 2001-2020.*

Major challenges include ambient pollution, solid waste management and reducing risks from natural disasters. Air and water quality is not yet adequately monitored and rules are not enforced. Most wastewater is untreated, which poses a serious health threat in urban areas, industrial zones and craft villages. Peri-urban areas face acute problems stemming from water pollution. Effluent contaminated with uncomposted organic materials and heavy metals is used as irrigation water, which poses risks to farmers, farm workers and consumers of vegetables and fruit.

The specific problem of arsenic-contaminated drinking water has emerged over the past few years. Arsenic presence in drinking water can increase the risk of adverse pregnancy outcomes and infant morbidity and mortality. Initial research suggests that the problem is quite serious in the Red River Delta and in several other locations, and affects both rural and urban populations.

Viet Nam's solid waste production is growing rapidly, and now amounts to about 15 million tons per year. Towns and cities produce over 80 percent of solid waste, of which 71 percent is collected. However, solid waste is only collected from an estimated 10-20 percent of the urban poor. Collected solid waste normally goes into landfill sites, yet most of these sites do not prevent contaminated drainage water from entering into groundwater and the surrounding surface water.

Box 2. MDG on Environmental Sustainability, Targets & Indicators

Target 9: Integrate the principles of sustainable development into country policies and programme and reverse the loss of environmental resources:

25. *Proportion of land area covered by forest*.
26. *Ratio of area protected to maintain biological diversity to surface area*.
27. *Energy use (kilograms of oil equivalent) per $1 GDP (PPP).*
28. *Carbon dioxide emissions (per capita) and consumption of ozone-depleting chlorofluorocarbons (ODP tons)*.
29. *Proportion of population using solid fuels* (Proposed as additional MDG indicator, but not yet adopted as of August 2005.).

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation:

30. *Proportion of population with sustainable access to an improved water source, urban and rural*.
31. *Proportion of population with access to improved sanitation, urban and rural*.

Target 11: Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers.

32. *Proportion of households with access to secure tenure*

Recycling is on the rise, and some people earn their living from collecting and sorting waste, and then selling recovered materials to collectors and industry. These workers are exposed to significant health risks from hazardous waste, and need protection in the form of tightly enforced regulations on the disposal of hazardous materials.

Only a small part of Viet Nam's hazardous industrial waste is disposed of safely, and large stockpiles exist of confiscated and otherwise unused agricultural chemicals. Capacity is in place to incinerate half of all hospital waste only.

The livelihoods of many of the poorest Vietnamese depend on natural resources, in particular sloping forest land. Secure access is a critical pre-condition for food security and poverty reduction, especially of ethnic minorities and women headed households. However, much of this land is degraded and sometimes not accessible to them.

Viet Nam is prone to natural disasters, including river floods, cyclones, and drought. More than one million people require emergency relief each year. Global climate change is likely to result in more erratic incidence and intensity of cyclones, rain and drought. A key problem in flood prone areas is the failure of water supply and sanitation systems during emergencies. The percentage of households with flood-proof facilities in flood prone provinces is thus a suitable indicator for inclusion in the SEDP.

Finally, a key constraint on environmental policy is the limited availability of reliable data. Information on some of the environmental indicators related to the MDGs is still not collected systematically. Efforts are now under way to improve national environmental monitoring and reporting systems, but progress has been slow.

II. Analysis

Forest cover, forest quality and forest-based livelihoods

1. *Forest cover:* The existing target of expanding forest cover by 43 percent by the year 2010 is realistic and achievable. However, the target should be more specific. The SEDP should distinguish between total forest cover, plantation forests, natural forests, and protected forests for conservation of biodiversity (nature reserves).

The National Strategy for Environmental Protection (NSEP) calls for an increase in total mangrove forest areas to 80 percent of the 1990 level by 2010. Local authorities, business people, and farmers/fishers are expanding shrimp cultivation in coastal areas. Shrimp cultivation contributes to the national economy and local employment, but at the cost of mangroves along the coast. Loss of mangroves is associated with increased risk of storm surges and reduced natural fish and shrimp breeding. Monitoring and reporting mangrove forest cover in addition to careful cost-benefit analysis of the net contribution of shrimp production is needed.

Forest management policies must take into account the livelihoods of forest workers, local people who depend on 'non-timber forest products', crop farmers and cattle herders. Conservation should not come at the expense of these people, many of whom are extremely poor. Local people need improved access to forests of various types, sloping land for agriculture and terraced land (or land to be terraced in future). Women and ethnic minorities in particular require more secure land tenure, and access to extension services and capital for livelihood development.

2. *Biodiversity:* Viet Nam's rich biodiversity is under threat due to habitat loss. The number of endangered species of flora and fauna has risen. The total land surface of protected area and the total marine protected surface are good indicators for biodiversity conservation. An SEDP target of increasing both would be appropriate. Most current nature reserves in Viet Nam are forests and 7.5 percent of land surface is now protected. Increasing this to nine percent would be a modest and appropriate target, for example creating protected corridors between existing nature reserves. There is one marine protected area and more are at an advanced planning stage. There is no need at this stage for a quantitative target. The combination of these could then remain lower than the current target in the NSEP, which proposes to increase by 1.5 fold the total protected area, and includes marine protected areas. Although increasing protected areas is important, losses also occur within nature reserves. Strengthening regulations and the management capacity of reserves is essential for the protection of biodiversity.

Solid waste management, health and livelihoods

3. *Solid Waste Management:* The targets for solid waste collection, recycling, and safe disposal should be realistic and aligned to the NSEP. Investment sources other than the central or provincial budgets must be identified to develop sanitary landfills and modern hazardous waste treatment facilities. A system of waste charges is needed that covers the costs of development, operation and maintenance of such facilities.

In 2003 Viet Nam committed itself to clean up the most polluting and polluted establishments with a well prioritised plan, which is also included in the NSEP. Implementation is ongoing and should be completed in the next SEDP period. Successful implementation depends on resource mobilisation from polluters and local authorities, and may require additional support from the central budget and donors.

Wastewater, health, and peri-urban livelihoods

4. *Waste-water:* The central government and local authorities are investing in urban sewerage and drainage systems and wastewater treatment plants. Urban wastewater treatment targets should be aligned to NSEP, which calls for completion of sewerage and drainage systems and for 40 percent of municipalities to put in place wastewater treatment systems by 2010. This target may be difficult to reach because currently very little wastewater is treated in Viet Nam and concrete policies and plans for reaching the targets are not yet formulated. These targets should be reviewed critically and possibly adjusted. The draft PRSC also calls for policies on wastewater management for urban areas in the short term.

Although public expenditure on the environment is increasing, investment sources other than central or provincial budgets must be identified. Wastewater charges are now regulated by Decree 67/2003/ND-CP. These charges will generate resources for investment in clean technology through the Viet Nam Environmental Protection Fund (40 percent of wastewater charges), and for other aspects of environmental management. These charges are thus not exclusively dedicated to the development and maintenance of sewerage systems and wastewater treatment facilities. In other words, they are not wastewater *treatment* charges. Charges must be set to ensure a reasonable level of profits, and revenues from charges must accrue directly to service providers in order to attract private investment into wastewater treatment systems.

Water supply, environmental sanitation, and health

5. *Water supply:* The national RWSS Strategy provides a strong basis for reaching rural water supply targets. The National Target Programmes on poverty reduction can mobilise financial and other resources for investment, improve the quality of delivery, and improve monitoring. An urban water supply target for 2010 has not yet been formulated. Investment must increase significantly if Viet Nam is to reach the target of 85 percent coverage given the current level of 58 percent. Investment should be prioritized in localities that lag furthest behind.

A programme of action to address the arsenic problem is under development. Early drafts suggest that quantitative targets cannot yet be set. Intermediate targets for the period 2006-2010 should include: (a) a comprehensive

survey of the incidence and extent of arsenic pollution of drinking water supply sources; (b) a survey of the health impact of arsenic contamination; (c) a national database of arsenic and other toxic elements in the water supply; and (d) completion of information, education and communication (IEC) materials on the health impact of arsenic poisoning, and guidelines on monitoring and using water supply sources.

6. *Sanitation:* The RWSS Strategy national target stipulating that 70 percent of rural households should have hygienic latrines and good personal hygiene practices should be included in the SEDP 2006-2010. Viet Nam's targets would then be consistent with the updated MDG-target agreed at the 2002 Johannesburg Conference on Sustainable Development, which was endorsed by the government.

How realistic the sanitation targets prove to be depends largely on the official definition of what constitutes a 'hygienic' latrine or bathroom and the identification of appropriate statistical sources. Greater investment in awareness raising campaigns is needed to encourage individual households to prioritise the construction, use and maintenance of hygienic private bathrooms. Models of good practice have already been developed, but the rate at which these models are presently adopted and replicated is a key issue.

Natural disasters, lives and livelihoods

7. *Natural disasters:* Viet Nam has well developed Early Warning Systems, including hydro-meteorological data communicated by the mass media and through other channels; search and rescue and evacuation capacities; mechanisms to deliver relief to affected people; and capacities in disaster preparedness and mitigation. Investments in structural measures to reduce risks are also underway and planned, including reinforcement of dykes and the development of resettlement areas in the Mekong Delta. The draft Second National Strategy and Action Plan for Disaster Mitigation and Management in Viet Nam 2001-2020 should be finalised as soon as possible.

The CPRGS target of reducing by half 'the rate of poor people falling back into poverty due to natural disasters and other risks' can be assessed with data from the Viet Nam Household and Living Standards Surveys (VHLSS), at least as an approximation. Such assessments would facilitate learning relating to reducing vulnerability and mainstreaming preparedness and responsiveness into poverty reduction strategies and plans.

Implementation of environmental legislation and agreements

8. *International agreements:* Viet Nam has made several international commitments, which have begun to be reflected in national legislation and strategies. Implementation mechanisms are also being developed. For example, Viet Nam has signed up to the Convention on Climate Change and is in the process of adopting the Clean Development Mechanism based on the Kyoto Protocol. This activity is included as a 'trigger' in the Poverty Reduction Support Credit (PRSC). Viet Nam expects to accede to the WTO in the near future. WTO rules include a number of environment-related provisions. The PRSC also includes a government commitment to establish a national sanitary and phytosanitary (SPS) notification authority, and to develop an action plan on food safety and animal and plant health.

9. *Public participation:* Popular participation is a vital component of environmental management. Participation is key to land use planning, pollution monitoring, formulation and monitoring of implementation of Environmental Impact Assessments (EIAs), forestry management, and integrated water management. Effective participation requires skill development at the community level, for local leaders and ordinary citizens and especially women and ethnic minority people. The Grassroots Democracy Decree (79/2003/ND-CP 7 July 2003) provides for participation with respect to issues such as land use planning. The revised Law on Environmental Protection (LEP) goes some way towards defining popular rights relating to monitoring environmental quality. However, the specification of rights relating to participation in monitoring pollution, and in the formulation, approval and monitoring of, for example, the environmental impact of industrial development, may be required in legislation that is not exclusively environmental. Concrete channels are needed to enable the public to hold polluters accountable under the law. In general terms, information needs to become more accessible to the public, and this is also articulated to some extent in the revised LEP. This could also improve enforcement of environmental legislation.

One measurable indicator of the accessibility of information is the percentage of annual EIA reports that are fully accessible to the public through the internet. A target of full publication of all EIAs including agreed pollution-mitigation measures by 2010 would ensure that the government is providing the public with all necessary information to facilitate greater involvement in monitoring and decision making. The financial costs of meeting such a target would be minimal.

III. Recommendations

The following are recommendations for environmental targets and indicators in Viet Nam's SEDP (2006-2010). They are extracted from section 1 and 2, and existing Strategies.

Target by 2010	Indicator	Data Source
Total forest cover 43%	Forest cover as percent of total land area	MARD; GSO
9% of total land area is protected	Protected land area as percent of total land area; total marine area protected	MONRE (MARD, Ministry of Fisheries); GSO
Rehabilitate and increase total mangrove forest area to 80% of 1990 level	Total mangrove forest area as percent of mangrove forest area in 1990	MARD; GSO
Ensure that the names of both husband and wife appear on newly issued land-use right certificates	Land use rights certificates with names of both spouses as percent of total land use rights certificates issued	MONRE; GSO
Individual and collective land use rights in mountainous and other areas inhabited by ethnic minorities ensured and enforced	Number of collective land use rights officially issued to ethnic minority communitiesNumber of individual land use rights certificates issued in ethnic minority dominated communities	MONRE; GSO
90% of domestic and industrial solid waste collected	Solid waste collected as percent of total solid waste produced	MONRE; GSO
60% of hazardous waste treated in modern facilities	Hazardous waste treated properly as percent of total hazardous waste produced	MONRE; GSO
100% of medical waste treated in modern facilities	Medical waste treated properly as percent of total medical waste produced	MOH; GSO
40% of municipalities have separate drainage and sewerage systems meeting minimum standards	Number of municipalities with separate drainage and sewerage systems as percent of total municipalities	MOC; GSO
85% of rural population has access to 60 litres per day of clean water	Number of rural people with access to 60 litres per day of clean water as percent of total rural population	MARD; GSO
70% of rural households have access to hygienic latrines	Number of rural households with hygienic latrines as percent of total rural households	MARD; GSO
Reduce incidence of households falling back into poverty due to natural disasters by half	Number of households falling back into poverty as a result of natural disasters as percent of total households	MARD; MOLISA; GSO
Issue National Disaster Mitigation Strategy	Strategy approved	MARD
Approve national action plan for SPS, food safety and agricultural health	Action plan approved	MARD
Approve a programme of action for dealing with arsenic-contaminated drinking water	Programme approved	MONRE; MARD
Resolve the establishments that seriously pollute the environment across the country	Decision 64/2003/QD-TTg completely implemented	MONRE
100% of completed EIAs including pollution mitigation measures posted on public websites	Total completed EIAs published on public websites as percent of total approved EIAs	MONRE

Chapter 6
Financing and Delivering Quality Health Services

Introduction

Viet Nam is making progress towards reaching most of the health-related Millennium Development Goals, which have been adapted to the local context in the form of Viet Nam Development Goals (VDGs). However, to sustain the improvements in health outcomes, there are challenges that need to be addressed. A Socio-Economic Development Plan (SEDP) that adequately addresses the needs and challenges of financing and delivering quality health services can serve as an important means of ensuring that the MDGs and VDGs are achieved.

Previous chapters have addressed reproductive health issues and children's health. This chapter discusses financing and delivery of health services more generally, and assesses the current situation in the four key areas of the health system: namely, financing, health service provision, human resources and governance. The chapter also provides recommendations relating to the sustainability of health improvements and proposes indicators for monitoring progress.

MDG Indicator	Baseline (1990)	Targets adapted by Viet Nam development goals	Latest data (MOH)
Goal 4: Reduce child mortality			
Indicator 1: Reduce infant mortality rate	44	Reduce to 30 per 1,000 live-births by 2005 and 25 by 2010	30 (2002)[9]
Indicator 2: Reduce under-five mortality rate	58	Reduce to 36 per 1,000 live-births by 2005 and 32 by 2010	38 (2002)
Indicator 3: Proportion of 1 year old children immunized against measles	86.7%	Not applicable/stated	97% (2004)
Goal 5: Improve maternal health			
Indicator 1: Maternal mortality rate	249	To 80 per 100,000 live-births by 2005 and 70 by 2010	85 (2004) 165 (2002)
Goal 6: Combat HIV/AIDS, malaria and other diseases			
Indicator 1: HIV/AIDS prevalence among 15-24 year old pregnant women	Not available	Not applicable/stated	Prevalence among adults aged 15-49 years of age: 0.28% (2002)
Indicator 2: Contraceptive prevalence rate	Not available	Not applicable/stated	78.5% (2002)
Indicator 3: Number of children orphaned by HIV/AIDS	Not available	Not applicable/stated	Cumulative: 21,000 (2001)[10]
Indicator 4: Prevalence and death rates associated with malaria	Not available	Not applicable/stated	Morbidity: 2.8/1,000 peopleMortality: 0.078/ 100,000 people (2002)
Indicator 5: Proportion of population in malaria risk areas using effective malaria prevention and treatment measures	Not available	Not applicable/stated	Number of people using insecticide-treated nets: 10 million (1998)[11]
Indicator 6: Prevalence and death rates associate with tuberculosis	Not available	Not applicable/stated	New TB patients every year: 130,000[12]
Indicator 7: Proportion of TB cases detected and cured under DOTS	Not available	Not applicable/stated	Full DOTS coverage reached in 1998
Goal 8: Develop a global partnership for development			
Indicator 1: Proportion of population with access to affordable essential drugs on a sustainable basis	Not available	Not applicable/stated	80% (1997)

[9] UNICEF (2002) The state of the world's children.

[10] Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2002) World population prospects: The 2000 revision.

[11] UN Millennium Project (2005) *Coming to grips with malaria in the new millennium.* Task Force on HIV/AIDS, Malaria, TB, and Access to Essential Medicines, Working Group on Malaria.

[12] WHO (2005) Revision of country health profile in Viet Nam.

I. Assessment

1. Health financing

The Vietnamese health financing system is currently characterized by low overall spending on health (5.2 per cent of GDP), low public investment in the health sector (1.5 per cent of GDP), low coverage of social health insurance and safety nets (30 per cent of the population) and large out-of-pocket payments (more than 70 per cent of health expenditure, mainly on user fees and drugs).[13] The proportion of out-of-pocket payments would be even higher if informal payments were included. Out-of-pocket payments are regressive – they impose a disproportionate burden of health expenditures on poor households – and present a significant barrier to utilization of health services. Decree 10, which introduced wide-ranging autonomy for public health facilities, has increased pressure on health facilities to collect user fees, which may have significant implications for financial access to services.[14]

It has been estimated that around three million people become poor annually because of health expenditures.[15] The poor are vulnerable to the 'medical poverty trap', in which poverty leads to poor health, which in turn leads to higher health care expenditures, loss of income and then deeper poverty. It is difficult to be prepared for the costs of illness because medical expenditures are typically unexpected and the magnitude of the expenditures is not known. Poor people try to cope with medical expenditures by borrowing money, selling assets, reducing budgets for food, taking children out of school or changing health-seeking behaviors.[16] They also change their health-seeking behavior by seeking less and delayed health care, which imposes human and economic costs on themselves and society.

To address the high level of out-of-pocket payments and poverty associated with health care expenditures, the government has established an ambitious goal of achieving universal coverage of social health insurance by 2010. It has also taken a bold step to address the burden of health expenditure by establishing the Health Care Fund for the Poor, which finances free health services and approved drugs for 14.3 million poor people. While the Health Care Fund for the Poor has increased the coverage of financial protection mechanisms in Viet Nam, the current combined coverage of social health insurance and the Health Care Fund for the Poor is still only about 30 per cent of the population. The number of beneficiaries covered under the Health Care Fund for the Poor will increase in the near future, as the government will establish new poverty criteria that will increase the number of people classified as poor in Viet Nam.

2. Health service provision

It is widely recognized that availability and quality of primary care is the key to the health of the whole population. A functioning primary care system can deal with the majority of the most common conditions, such as acute respiratory infections and diarrhea. At present people lack confidence in primary health care services, particularly local level services, and thus many patients bypass the lower levels. This has implications for efficiency and equity. Even at central levels the quality of diagnosis and treatment, not least with drugs, is unsatisfactory. Unnecessary and expensive diagnostic procedures and multi-drug treatment, often with expensive imported drugs rather than generic and essential drugs, are common practices.

Because Viet Nam is at present going through an epidemiological transition, with increasing numbers of deaths and illnesses caused by non-communicable diseases, the country is facing a double burden of disease. Continued vigilance and support is needed to prevent the resurgence of communicable diseases and address stubborn, longer-term problems in Viet Nam, such as malnutrition, which remain serious health issues today. The country also has to deal with emerging public health issues, such as HIV/AIDS. At the same time, the country is increasingly facing the burden of chronic conditions such as cardiovascular diseases, cancer, diabetes, accidents

[13] WHO (2002) Viet Nam National Health Accounts.

[14] Government of Viet Nam (2002) Financial Regulations Applying to Revenue Raising Public Service Entities, Government Decree no. 10/2002/ND-CP, 2002.

[15] WHO Commission on Macro Economics and Health (2001) Poverty and Health. Working Paper No. WG1:5.

[16] Ministry of Health (2002) Viet Nam Health Report 2002.

and injuries. Many chronic conditions, often affecting an increasingly elderly population, can be self-managed in close contact with primary care services, and steered to specialist care only when necessary. At present patients with chronic conditions are often admitted to hospitals for long periods of time.

At the level of service providers, health facilities traditionally rely on a health staff-centred approach that reduces the scope for patient participation and responsibility. Ensuring that health staff understand the negative impact of this uneven relationship and are trained to communicate effectively with patients would improve the treatment process.

3. Human resources

There are a remarkably large number of health workers in the Vietnamese health system: more than 240,000 in 2004. More nurses are being trained and nursing care is being developed. However, nursing has not been fully recognized as a profession and discipline in its own right. At present there is a lack of specifically trained professional staff for managing health services. There is a lack of trained health staff to deal with emerging chronic diseases such as cardiovascular diseases, cancer and diabetes.

At present there are few physiotherapists available in the health care system to deal with the increasing number of people with disabilities due to accidents and injuries. There is a lack of social workers to assist the growing number of elderly people, who may not have younger relatives to support them. There is also a lack of staff trained in mental health.

4. Governance

Good governance depends on political and bureaucratic accountability. Policymakers and health staff need to be held accountable to laws, roles and regulations. The promotion and enforcement of a transparent budgeting and accounting process is an important part of governance. The government also has a responsibility to establish laws, standards, roles and regulations for the private sector. This has not yet been done in a satisfactory manner. When regulations are in place, effective monitoring and enforcement are essential. Insufficient resources have been allocated to the enforcement of regulations to ensure that health services are of sufficiently high quality. A quality assurance system also needs good data. The quality of the data collected is at present often uneven.

The ambitious programme of decentralization that Viet Nam has embarked on has resulted in a shift of resources, accountability and responsibility from the central to the provincial and lower levels, which now make decisions on almost half of total government budget expenditures. This increases pressure on provincial and local institutions, many of which already face capacity constraints in providing leadership in the health sector.

II. Analysis

1. Health financing

The development of social health insurance and safety nets in health is at a critical juncture. Continued funding of the Health Care Fund for the Poor will help to ensure that the poor are provided with access to health services. Subsidization of contributions for the near poor may be necessary to increase the coverage of social health insurance. This is one of the reasons that increased public investment in health is necessary.

Shifting from individual to household-based insurance would improve coverage rates and reduce adverse selection, particularly for children. For example, under the current system many poor parents face the choice of insuring some children while excluding others. They naturally insure higher risk children and pay out of pocket for healthy children. Insuring households rather than individuals would therefore help pool risks. Social health insurance for all households would render superfluous the need for special provisions to provide free coverage for children less than six years of age. Instead, such funds could be used for the Health Care Fund for the Poor and to subsidize contributions for the near poor.

The potentially negative effects of liberalization of the health insurance market should be explicitly recognized and carefully considered. Commercial health insurance may have a role to play in providing supplementary benefits in addition to compulsory social health insurance. However, allowing private health insurance companies to provide full benefit packages could siphon off high-contributing, low-risk households and leave social health insurance with a pool of low-contributing, high-risk households. The result would be an unsustainable, low-quality public system existing alongside an elite, high-cost system for the wealthy.

Resources need to be allocated and utilized effectively and efficiently. This has in the past been done well. However, there is evidence that mobilized public funding is currently not invested proportionately to the burden of disease, which has implications on efficiency and equity. For example, urban areas tend to benefit more than rural and remote areas from investments in infrastructure, material and human resources. In addition, curative services are often prioritized at the expense of preventive services, a tendency that increases when health services are privatized. Part of the reason for this skewed pattern of resource use is that needs-based mechanisms for resource allocation, cost-effectiveness analysis and other priority-setting tools are not well utilized. Other reasons include political constraints, vested interests, and weak empowerment of marginalized groups.

It is important to recognize that health development is to a large degree dependent on the overall socioeconomic development in the country. To increase the effectiveness of investments in health, close alignment is needed with broader national development processes, such as the SEDP 2006-2010, the Comprehensive Poverty Reduction and Growth Strategy (CPRGS) and Medium-Term Expenditure Frameworks (MTEFs).

2. Health service provision

There is an urgent need to improve the quality of services delivered in the health sector. Quality is related to salaries and incentives, perceptions, attitudes, retraining and management procedures. Primary health care, particularly at the commune health station level, suffers from a lack of adequately trained and motivated staff. Comprehensive and consistent strategies are needed to ensure that health workers are adequately remunerated and appropriately distributed. To ensure that remote and mountainous areas have access to health facilities that have medical doctors and an appropriate mix of other health workers, special incentives for serving in remote areas may need to be considered. Strengthened primary care services would reduce bypassing and improve the functioning of the referral mechanism, with positive implications for the efficiency of the health system. It is also important to recognize the importance of strengthening the "back-referral" mechanism, in other words to ensure that patients who are treated at higher levels of the health system are followed-up properly at the primary care level. In addition, as mentioned above, the overemphasis on curative care rather than preventive care places an undue burden on both the health system and patients. Increasing the availability of preventive health services is greatly needed.

Capacity in management and administration of health services is weak. Appointment of hospital managers is often not based on competence, appropriate skills or performance, but on clinical excellence or "political merit". Many hospital managers have not been trained in hospital administration and management.

3. Human resources

As described above, Viet Nam has a large number of health workers. However, the mix of health workers is not optimal and there is a need to train workers in the fields of physiotherapy, mental health and social work. The quality of the health care staff, particularly with regard to curative care, is one of the main health concerns in Viet Nam.

Salaries for all categories of health workers are far too low, and at present health workers have to find alternative sources of income. There are two main possibilities to generate additional income. One is to have another job. In the countryside farming is important. In the cities workers often set up small-scale business and many of these are related to selling drugs or private medical practice. Another way to survive is to take "envelope" money, or informal payments from patients.

There are few incentives for the health staff to be more results-based or performance-based in their work. Also, training should be refocused. More balance is needed between training oriented towards hospital clinical care and local community health care using active learning methods.[17]

4. Governance

The roles and duties of policymakers and providers must be clarified to improve governance and accountability. Otherwise there is a great risk that provision of health services becomes "everyone's duty, but no one's responsibility". Policymakers are accountable to providers and the population. Providers have the right to expect consistent and rational leadership and guidance from policymakers. The population has the to right to expect access to health services that are appropriate, available, affordable and equitable. Systems to enable people to participate in decision-making and monitoring are not well established and the public does not have a strong voice in decisions relating to their health. The participation of civil society and their awareness and responsibility of their role in holding officials accountable must be encouraged. Providers are accountable to both policymakers and the population. Regulations to ensure accountability are weak and the amount of resources allocated to enforcement is much too low.

III. Recommendations

For the five-year SEDP to effectively support the achievement of the health MDGs and VDGs, the government should consider incorporating the policy recommendations listed below as well as the proposed indicators.

Many of the health indicators now used in Viet Nam reflect past and present health problems but not future ones. In addition to data related to the MDGs and VDGs, there is therefore a need to add indicators related to specific emerging non-communicable diseases and conditions. Because the MDGs and VDGs do not measure quality of care per se, there is also a need to add indicators that measure the quality of health services. The indicators should be disaggregated by socio-economic status, gender, ethnicity, geographic region and urban/rural location so that these aspects are considered when planning and monitoring health development.

1. Prioritized issues to address

- To ensure sufficient resources for the delivery of health services, general government expenditure from all sources on health should be at least 2.5 per cent of GDP and at least 50 per cent of total expenditures on health by 2010.

Proposed indicator	Target by 2010	Latest figure	Source
General government health expenditure as proportion of GDP	2.5%	1.5%	National Health Accounts (NHA)
General government health expenditure as proportion of total health expenditure	50%	29.2%	NHA

- To improve and sustain the quality of care at the primary health care level, the proportion of patients who receive treatment according to national guidelines for indicator diseases at commune health stations should be at least 90 per cent by 2010.

Proposed indicator	Target by 2010	Latest figure	Source
Proportion of patients given treatment according to national guidelines for indicator diseases at commune health stations	90%	Data currently not collected	To be determined (TBD)

[17] Royal Tropical Institute, Amsterdam (2001) Implementing Community Oriented Teaching in Medical Education, a Case from Viet Nam, Bulletin 348.

- To improve and sustain the quality of care at the primary health care level, the proportion of patients who have been treated (or has brought a relative to be treated) at commune health stations who adhere to prescriptions and instructions from health staff should be at least 80 per cent by 2010.

Proposed indicator	Target by 2010	Latest figure	Source
Proportion of patients who adhere to prescriptions and instructions from health staff at commune health stations	80%	New	TBD

2. Financing

- Increase government investment in the health system, balancing needs for curative and preventive health services.
- Decrease the proportion of out-of-pocket health expenditures through pre-payment mechanisms, such as social health insurance and the Health Care Fund for the Poor.
- Improve the effectiveness and efficiency of resource utilization by promoting the use of needs-based mechanisms, cost-effectiveness analysis and other criteria for prioritizing investment in interventions and services.
- Develop long-term investment plans for reaching the MDGs related to health and incorporate them in the SEDP, MTEFs and other socio-economic development mechanisms.
- Monitor the effects of Decree 10 on financial access to, and utilization of, health services.

Proposed indicator	Target by 2010	Latest figure	Source
Total health expenditures as proportion of GDP	7.5%	5.2%	NHA
Total health expenditures per capita	50 USD	23 USD	NHA
General government health expenditure as a proportion of GDP	2.5%	1.5%	NHA
General government health expenditure as proportion of total health expenditure	50%	29.2%	NHA
Out-of-pocket expenditure as a proportion of total private health expenditure	50%	87.6%	NHA
Proportion of general government health expenditure allocated to commune level	15%	2.7%	NHA
Proportion of total population covered by social health insurance	100%	23.5%	Viet Nam Social Security Agency
Proportion of Health Care Fund for the Poor target population receiving benefits	100%	76.7%	Ministry of Health[18]

3. Service provision

- Improve the quality of primary health care services by introducing innovative performance incentives to health workers, especially in disadvantaged areas.
- To meet changing needs and to use resources more efficiently, restructure health service provision by:
  - redefining roles, objectives and boundaries between primary, secondary and tertiary care;
  - expanding the range of services that primary care delivers, including preventive care;
  - enhancing referral mechanisms; and
  - creating alternative, appropriate and cost-effective care settings such as nursing and home care, and community care and support.

[18] Ministry of Health (2004b) Report: Assessment of one-year of implementation of examination for the poor in accordance with Decision 139/2002/QD-TTg of the Prime Minister.

- Improve management by training a pool of professional hospital managers and strengthening information systems needed to measure performance.

Proposed indicator	Target by 2010	Latest figure	Source
Communes with health stations	100%	98.7%	Ministry of Health
Communes with medical doctors	90%	67.8%	Ministry of Health
Villages with health workers	95%	93.3%	Ministry of Health
Proportion of patients given treatment according to national guidelines for indicator diseases (commune health station, district hospital for emergencies and chronic diseases)	90%	New	TBD
Proportion of patients who adhere to prescriptions and instructions from health staff at commune health stations	80%	New	TBD

4. Human resources

- Assure adequate salaries and introduce performance-based career schemes as measured against quality of care criteria as well as experience.
- Assure the distribution of staff according to health needs especially for disadvantaged areas.
- Strengthen nursing care and develop nursing as a discipline in its own right.
- Train new health care and hospital managers.
- Develop new staff for long-term rehabilitation of traffic accident victims and stroke patients as well as new programmes and staff for social work and care of the elderly and disabled.
- Train new staff for mental health interventions.

Proposed indicator	Target by 2010	Latest figure	Source
Number of medical doctors per 10,000 population	7	5.88	Ministry of Health
Number of nurses per 10,000 population	9	6.04	Ministry of Health
Ratio nurses/medical doctors	1.3	1.03	Ministry of Health

In addition, the following indicators are relevant: the number of mental health workers, social workers, and physiotherapists per 10,000 population, and the proportion of health workers of different categories present at health facilities. These indicators are not currently monitored in Viet Nam. If they are to be included as indicators of progress in the health sector in the SEDP 2006-2010, the following key considerations should be taken into account. First, it will be necessary to organize a data collection and analysis system, identifying who and how data will be collected and analyzed. Second, targets must be ambitious to provide incentives for progress, but they must also be realistic.

5. Governance

- Strengthen the inspection system to ensure that quality standards, such as for safe and rational use of drugs, are agreed upon, monitored, and enforced.
- Accountability should be sought close to the level where services are delivered and should involve patient satisfaction indicators. Local stakeholders should be given the opportunity to participate in the planning and the evaluation of decisions in the health system.
- Develop a comprehensive framework with laws and regulations related to private health care services, including the pharmaceutical sector.
- Improve the quality of the health management information system.

6. Health outcomes and proxy indicators

Proposed indicator	Target by 2010	Latest figure	Source
Traffic accident deaths per 10,000 vehicles	9	14	Ministry of Health[19]
Deaths from acute myocardial infarction per 100,000 population	0.90	1.00	Ministry of Health
Deaths from stroke per 100,000 population	TBD	0.99	Ministry of Health
Prevalence of cancer	TBD	Disaggregated by type	Ministry of Health
Malnutrition (weight for age)	20%	26.6%	Ministry of Health
Prevalence of male smokers	TBD	56%	National Health Survey 2001-02[20]

In addition, the following indicators are relevant: deaths from suicide per 100,000 population, prevalence of disabled people, proportion of population who use motorbike helmets, and proportion of population able to swim.

[19] Government of Viet Nam (2001) Decision 197 on National policy on accidents and injury prevention.

[20] General Statistics Office and Ministry of Health (2003) Viet Nam National Health Survey 2001-02.

Chapter 7
Summary and Recommendations

Viet Nam has made rapid progress towards achieving the Millennium Development Goals. Yet difficult challenges remain. The development of the Socio-Economic Development Plan for 2006-2010 presents a strategic opportunity to tackle the most pressing of these challenges and propel Viet Nam towards the national objectives of peace, prosperity and equality.

This report has proposed a set of concrete social indicators based on the MDGs and adapted to the specific conditions of Viet Nam. As an internationally recognized set of goals with clear targets and indicators, the MDGs represent a global benchmark against which all countries can measure their development progress. The MDGs also help countries and donors to focus their efforts on improving conditions for the poorest people, specifically those who do not have enough to eat or lack access to basic health and education services.

A theme that threads through this document is the urgent need to improve data collection, distribution and analysis in Viet Nam. Although tremendous progress has been made in recent years, information is still lacking on a wide range of basic development indicators. Moreover, surveys and analysis still present results in a highly aggregated form. It is often difficult to track progress by gender, among specific minority groups or by age cohort. The United Nations agencies in Viet Nam urge the government, donor organizations, research institutions and others to pay greater attention to the quality of data, improve coordination of data collection efforts, and ensure the collection and disaggregation of data by age, gender and ethnic group to provide a stronger basis for more targeted and effective policies.

This report has presented a range of targets and indicators to link the SEDP 2006-2010 to the MDGs. Although all of these indicators are important, some prioritization is desirable in view of resource and capacity constraints. By way of conclusion, we have identified 12 priority indicators drawn from the previous chapters. To support the broader goal of equity, we also recommend that a minimum standard is reached for each of these indicators within each province or at a lower sub-national level. These priority indicators address the main challenges in social development that Viet Nam will face over the coming plan period, and all relate directly to the achievement of the MDGs by 2015.

1. *Food poverty*: Reduce measured food poverty according to minimum calorific requirements to less than five percent nationwide. By 2010 food poverty should not exceed 10 percent in any province or region (MDG 1, Target 2).

2. *Poverty gap*: Reduce the poverty gap ratio (a measure of the aggregate income or consumption deficit of the poor relative to the poverty line) below 15 for the ethnic minority population (MDG 1, Target 1).

3. *Child nutrition*: Reduce stunting by 2010 to 25 percent of children with no province reporting stunting incidence greater than 30 percent. (MDG 1, Target 2).

4. *Primary school completion*: MOET should move from enrolment to completion, disaggregated by sex, as the appropriate indicator of educational progress, since the latter is a better measure of the quality of education. MOET should identify and own the actual target for primary and secondary completion rates. The national target should include a minimum completion target that every province must include in their provincial SEDP (MDG 2, Target 3).

5. *Out of pocket costs of education*: Formal and informal fees for public primary and secondary education should be eliminated during the next plan period. The formal and informal costs of education have risen over time, and richer households pay more, ensuring higher quality education for their children. The development of a two-tier education system, in which the poor leave school early and can access only inferior services, will lead to slow income growth among the poor and greater economic inequality (MDG 2, Target 3).

6. *Maternal and child health*: An increase in the proportion of deliveries assisted by skilled birth attendants to 97% with no province lower than 85%. This is an important quality indicator to supplement quantitative indicators on maternal mortality and neonatal mortality that are already included in early drafts of the SEDP (MDG5, Target 6).

7. *Strengthened communication about reproductive health issues, particularly STDs and HIV/AIDS, through market segmentation and tailored messages*: National and sub-national mechanisms developed that encourage the participation of women and men, girls and boys' in designing and monitoring behaviour change communication programming interventions. There is much information available about reproductive health and HIV/AIDS, but it may not be reaching the appropriate target groups, such as unmarried youth and high-risk groups. Communication must be accompanied by increased accessibility of condoms and user-friendly services (MDG 6, Target 7).

8. To ensure sufficient resources for the delivery of health services, general government expenditure on health should be at least 2.5 percent of GDP and at least 50 percent of total expenditure on health by 2010 (MDG 4,5, 6).

9. *Migration policies*: Move from four tier resident permit system to national social security registration system (including national social security cards or numbers) to enable migrants to access essential health and education services (MDG 2, 4, 5, 6).

10. *Gender mainstreaming*: Gender mainstreaming strategies and plans of action developed and effectively implemented in each ministry and each province, with a public accountability mechanism in place to support enforcement. Government organizations need to consider and address systematically and comprehensively women and men's specific needs and priorities in all sectors and at all stages of policy/programme development (MDG 3, Target 4).

11. *Special use forest area*: The rate of special use forest area preserved should increase to nine percent of total land area from 7.5 percent in 2003 (MDG 7, Target 9).

12. *Hygienic latrines*: Seventy percent of rural households will have hygienic latrines and good personal hygiene practices. A sub-indicator would be the percentage of households with flood-proof facilities (MDG 7, Target 10).

Appendix

The Millennium Development Goals, Targets and Indicators

Goal 1. Eradicate extreme poverty and hunger

Target 1.

Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Indicators

1. Proportion of population below $1 (1993 PPP) per day (World Bank)[a]
2. Poverty gap ratio [incidence x depth of poverty] (World Bank)
3. Share of poorest quintile in national consumption (World Bank)

Target 2.

Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicators

4. Prevalence of underweight children under five years of age (UNICEF-WHO)
5. Proportion of population below minimum level of dietary energy consumption (FAO)

Goal 2. Achieve universal primary education

Target 3.

Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Indicators

6. Net enrolment ratio in primary education (UNESCO)
7. Proportion of pupils starting grade 1 who reach grade 5 (UNESCO)[b]
8. Literacy rate of 15-24 year-olds (UNESCO)

Goal 3. Promote gender equality and empower women

Target 4.

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Indicators

9. Ratio of girls to boys in primary, secondary and tertiary education (UNESCO)
10. Ratio of literate women to men, 15-24 years old (UNESCO)
11. Share of women in wage employment in the non-agricultural sector (ILO)
12. Proportion of seats held by women in national parliament (IPU)

Goal 4. Reduce child mortality

Target 5.

Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Indicators

13. Under-five mortality rate (UNICEF-WHO)
14. Infant mortality rate (UNICEF-WHO)
15. Proportion of 1 year-old children immunized against measles (UNICEF-WHO)

Goal 5. Improve maternal health

Target 6.

Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicators
16. Maternal mortality ratio (UNICEF-WHO)
17. Proportion of births attended by skilled health personnel (UNICEF-WHO)

Goal 6. Combat HIV/AIDS, malaria and other diseases

Target 7

Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Indicators
18. HIV prevalence among pregnant women aged 15-24 years (UNAIDS-WHO-UNICEF)
19. Condom use rate of the contraceptive prevalence rate (UN Population Division)[c]
19a. Condom use at last high-risk sex (UNICEF-WHO)
19b. Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (UNICEF-WHO)[d]
19c. Contraceptive prevalence rate (UN Population Division)
20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years (UNICEF-UNAIDS-WHO)

Target 8.

Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Indicators
21. Prevalence and death rates associated with malaria (WHO)
22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures (UNICEF-WHO)[e]
23. Prevalence and death rates associated with tuberculosis (WHO)
24. Proportion of tuberculosis cases detected and cured under DOTS (internationally recommended TB control strategy) (WHO)

Goal 7. Ensure environmental sustainability

Target 9.

Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Indicators
25. Proportion of land area covered by forest (FAO)
26. Ratio of area protected to maintain biological diversity to surface area (UNEP-WCMC)
27. Energy use (kg oil equivalent) per $1,000 GDP (PPP) (IEA, World Bank)
28. Carbon dioxide emissions per capita (UNFCCC, UNSD) and consumption of ozone-depleting CFCs (ODP tons) (UNEP-Ozone Secretariat)
29. Proportion of population using solid fuels (WHO)

Target 10.

Halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation

Indicators
30. Proportion of population with sustainable access to an improved water source, urban and rural (UNICEF-WHO)

31. Proportion of population with access to improved sanitation, urban and rural (UNICEF-WHO)

Target 11.

By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

Indicators
32. Proportion of households with access to secure tenure (UN-HABITAT)

Goal 8. Develop a global partnership for development

Indicators for targets 12-15 are given below in a combined list.

Target 12.

Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.

Includes a commitment to good governance, development and poverty reduction - both nationally and internationally

Target 13.

Address the special needs of the least developed countries.

Includes: tariff and quota-free access for least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction

Target 14.

Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)

Target 15.

Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries (LLDCs) and small island developing States (SIDS)

Indicators
Official development assistance (ODA)
33. Net ODA, total and to LDCs, as percentage of OECD/Development Assistance Committee (DAC) donors' gross national income (GNI)(OECD)
34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) (OECD)
35. Proportion of bilateral ODA of OECD/DAC donors that is untied (OECD)
36. ODA received in landlocked developing countries as a proportion of their GNIs (OECD)
37. ODA received in small island developing States as proportion of their GNIs (OECD)

Market access

38. Proportion of total developed country imports (by value and excluding arms) from developing countries and from LDCs, admitted free of duty (UNCTAD, WTO, WB)
39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries (UNCTAD, WTO, WB)
40. Agricultural support estimate for OECD countries as percentage of their GDP (OECD)
41. Proportion of ODA provided to help build trade capacity (OECD, WTO)

Debt sustainability

42. Total number of countries that have reached their Heavily Indebted Poor Countries Initiative (HIPC) decision points and number that have reached their HIPC completion points (cumulative) (IMF - World Bank)
43. Debt relief committed under HIPC initiative (IMF-World Bank)
44. Debt service as a percentage of exports of goods and services (IMF-World Bank)

Target 16.

In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

Indicators
45. Unemployment rate of young people aged 15-24 years, each sex and total (ILO)[f]

Target 17.
In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Indicators
46. Proportion of population with access to affordable essential drugs on a sustainable basis (WHO)

Target 18.
In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

Indicators
47. Telephone lines and cellular subscribers per 100 population (ITU)
48. Personal computers in use per 100 population and Internet users per 100 population (ITU)

Footnotes:

[a] For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

[b] An alternative indicator under development is "primary completion rate".

[c] Among contraceptive methods, only condoms are effective in preventing HIV transmission. Since the condom use rate is only measured amongst women in union, it is supplemented by an indicator on condom use in high-risk situations (indicator 19a) and an indicator on HIV/AIDS knowledge (indicator 19b). Indicator 19c (contraceptive prevalence rate) is also useful in tracking progress in other health, gender and poverty goals.

[d] This indicator is defined as the percentage of population aged 15-24 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. However, since there are currently not a sufficient number of surveys to be able to calculate the indicator as defined above, UNICEF, in collaboration with UNAIDS and WHO, produced two proxy indicators that represent two components of the actual indicator. They are the following: (a) percentage of women and men 15-24 who know that a person can protect herself from HIV infection by "consistent use of condom"; (b) percentage of women and men 15-24 who know a healthy-looking person can transmit HIV.

[e] Prevention to be measured by the percentage of children under 5 sleeping under insecticide-treated bednets; treatment to be measured by percentage of children under 5 who are appropriately treated.

[f] An improved measure of the target for future years is under development by the International Labour Organization (ILO).

The Mission of the United Nations in Viet Nam

The United Nations, in partnership with the government and people of Viet Nam, works to ensure that all Vietnamese people enjoy an increasingly healthy and prosperous life with greater human dignity and expanded choices. Collectively and through its individual agencies, the United Nations cares and creates opportunities for the poor and most vulnerable, and for youth, to whom the future belongs.

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