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Health System Strengthening and
Disease and Target-specific Programmes
in Cambodia, Lao People's Democratic Republic
and Viet Nam:

Towards Better Harmonisation

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WHO Collaborating Centre
for Health Systems Research

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Executive summary

In the past decade, a common understanding among actors in global health was that health systems strengthening (HSS) was the lynchpin for the success and sustainability of various health programmes, particularly those implemented in resource-poor settings.

The National Center for Global Health and Medicine (NCGM), Japan has been a WHO Collaborating Centre (WCC) for Health Systems Research since 2009. This document summarises the findings of the assessments and missions the Center conducted in Cambodia, the Lao People's Democratic Republic (Lao PDR) and Viet Nam during the contract period of 2009-2013, focusing on the relationship between HSS and disease and target-specific programmes, i.e. Expanded Programme on Immunization (EPI); control of HIV, tuberculosis (TB) and malaria; and maternal, neonatal and child health (MNCH).

The HSS concept has evolved over time. In 2007, the WHO presented a single HSS framework with six building blocks, namely:

1. Service delivery;
2. Health workforce;
3. Information;
4. Medical products, vaccines and technologies;
5. Financing; and
6. Leadership and governance.

Current global and regional strategies for EPI, HIV, TB, malaria and MNCH all include coordination with other programmes, as well as harmonisation with HSS as their core component. Global HSS support has been spearheaded by the Global Alliance for Vaccines and Immunization (GAVI), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Health System Funding Platform and the International Health Partnership (IHP+).

In observing the six building blocks of health systems from the perspective of disease and target-specific programmes in Cambodia, Lao PDR and Viet Nam, the following notable findings were observed:

- ① **Health service delivery:** Hard-to-reach populations and areas are generally prevalent in Lao PDR, whereas they were specifically defined in Viet Nam (e.g. migration sites). While good collaboration between public health systems and community organizations was observed in Viet Nam and Lao PDR, a lack of service integration still creates missed opportunities, particularly at the community level in Lao PDR.
- ② **Health workforce:** A shortage of skilled health staff is a common system-wide barrier in all three countries. The human resources shortage was particularly illustrated when

new equipment, commodities and techniques were introduced. Disease and target-specific programmes provided annual training for new employees and refresher training opportunities. GAVI and GFATM created additional training opportunities through their HSS support.

- ③ **Health information system (HIS):** HIS integration often faced difficulties. In Cambodia, the Ministry of Health (MOH) and partners tried to centralise HIS in the late 1990s. Insufficient central ability to operate the system, however, caused reporting delays in the centralised system. To overcome this new bottleneck, programmes had to maintain parallel reporting systems.
- ④ **Medical products, vaccines and technologies:** Procurement, supplies and logistics often posed a system-wide barrier for disease and target-specific programmes. The integration of logistics systems was adopted step-by-step, e.g. in southern Lao PDR. Cambodia experienced the negative side of the integrated system, particularly with the system developed for the Central Medical Stores. Limited central capacity caused a shortage of drug supplies, forcing the programmes to revitalise their vertical and separate storage and logistics.
- ⑤ **Health system financing:** A reverse pyramid budget allocation with disproportionately limited allocation to the community level created a pronounced shortage in local operational costs. Results-based financing (RBF) was particularly common in Cambodia, but also seen in Viet Nam. Though the RBF contributed to reallocating budget to local levels, some negative impacts were also reported. These included difficulty in motivating health personnel without RBF once it has been introduced, and reduced incentives to resolve the chronic issue of delayed and insufficient national budget allocation to local levels.
- ⑥ **Leadership and governance:** The importance of national political commitment in implementing health programmes was especially highlighted in Viet Nam. Coordinating and harmonising different disease and target-specific programmes and different external assistance mechanisms was an important aspect of the leadership and governance function of the health systems.

HSS contributed, and can further contribute, to disease and target-specific health programmes in three main areas:

1. Streamlining sector planning and budget allocation;
2. Coordinating and harmonising programmes and players; and
3. Managing sector-common functions, i.e. health sector human resource development (HRD), HIS, supply chain management (SCM) and health social security.

Disease and target-specific programmes, conversely, contributed, and can continue to contribute, to HSS in two ways:

1. Resource and opportunity creation for HSS; and
2. Ensuring high service coverage with community penetration.

HSS and the disease and target-specific programmes are inseparable. Both are integral parts of a comprehensive health system.

The assessments also identified the following three challenges that need to be overcome in order for HSS to better contribute to disease and target-specific programmes and other health interventions:

1. Lack of a clear strategy and action tools for programme harmonisation;
2. Lack of national capacity to maintain coordinated HIS and SCM; and
3. Uncoordinated deployment of human, material and financial resources.

Considering the path towards better harmonisation between HSS and disease and target-specific programmes, the following are areas where new and innovative efforts are needed:

1. In the move towards a single national health plan, the disease and target-specific programmes need to make efforts to align themselves with sector-wide planning as has been pursued in Lao PDR and Cambodia.
2. The service delivery models of the existing disease and target-specific programmes should be transferred to other health programmes which lack established structures and functions (e.g. screening and treating non-communicable diseases).
3. In the face of expanding non out-of-pocket, pooled health financing schemes – such as social insurance, health equity funds and payment exemptions to attain universal health coverage (UHC) – financing of disease and target-specific programmes and HSS need to be appropriately positioned in the overall health financing design.
4. Despite the fact that global and regional strategies for EPI, HIV, TB, malaria and MNCH all advocate harmonisation with HSS, harmonisation alone does not ensure that the foundations of health systems (such as policies and regulations, organizational structures and both client and service provider incentive) are strengthened. Aside from support activities to improve health service delivery, long-term strengthening of the foundation of health systems need to be distinctly programmed and funded.

In order to balance short-term programme demands and mid- to long-term health systems requirements, disease and target-specific programmes need to share mid- to long-term health systems development perspectives.

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Abbreviations and acronyms

ACT	Artemisinin-based combination therapies
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
ART	Anti-retroviral therapy
CHCs	Commune (sub-district) health centres (Viet Nam)
CHWs	Commune (sub-district) health workers (Viet Nam)
CMS	Central Medical Stores (Cambodia)
DOTS	Directly observed treatment, short-course
EPI	Expanded Program on Immunization
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiatives
GVAP	Global Vaccine Action Plan
HC	Health centre
HIS	Health information system
HIV	Human immunodeficiency virus
HRD	Human resource development
HSDP	Health Sector Development Plan (Lao PDR, Viet Nam)
HSFP	Health Systems Funding Platform
HSP	Health Strategic Plan (Cambodia)
HSS	Health systems strengthening
IHP+	International Health Partnership
IRS	Indoor residual spraying
JANS	Joint Assessment of National Health Strategies and Plans (for IHP+)
JICA	Japan International Cooperation Agency
Lao PDR	Lao People's Democratic Republic
LLINs	Long lasting insecticidal nets
MDGs	Millennium Development Goals
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
NCDs	Non-communicable diseases
NCGM	National Center for Global Health and Medicine, Japan
NFM	New Funding Model
NGO	Non-governmental organization
Norad	Norwegian Agency for Development Cooperation
PHC	Primary health care

RBF	Results-based financing
RBM	Roll Back Malaria Partnership
RMNCH	Reproductive, maternal, newborn and child health
SCM	Supply chain management
SCWMF	Sector Common Work Plan and Monitoring Framework
SDG	Service Delivery Grant
SOA	Special Operating Agency (Cambodia)
SWC	Sector Wide Coordination (Lao PDR)
SWiM	Sector Wide Management (Cambodia)
TB	Tuberculosis
UHC	Universal health coverage
UNTAC	United Nations Transitional Authority in Cambodia
VHWs	Village health workers
WCC	WHO Collaborating Centre
WHO	World Health Organization
WPR	Western Pacific Region

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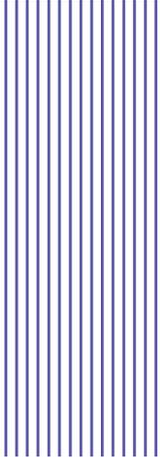
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1. Preface

For the past decade, a common understanding shared among actors in global health has been that health systems strengthening (HSS) is the lynchpin for the success and sustainability of different health programmes, particularly those implemented in resource-poor settings. It is increasingly recognised that disease and target-specific health programmes such as malaria control and immunization, though extensive in coverage and effective, need to align with HSS in order for them to be sustainable.

The National Center for Global Health and Medicine (NCGM), Japan was re-designated as a WHO Collaborating Centre (WCC) for Health Systems Research and entered into a contract with the WHO Regional Office for the Western Pacific Division of Health Services Development on 28 July 2009. For the four-year contract period, the Center undertook the following:

1. Conduct assessments of the impacts of HSS;
2. Conduct assessments of synergies between HSS and primary health care (PHC);
3. Participate in missions to design a training framework by identifying the competencies and training needs of health care providers;
4. Participate in missions analysing synergies between HSS and disease-specific programmes (mainly infectious disease control).

In this report, the term “disease and target-specific programmes” is used to represent the Expanded Programme on Immunization (EPI), prevention and care/support of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS), tuberculosis (TB) control, malaria control, and maternal, neonatal and child health (MNCH). These programmes provide the most functional health care delivery in the context of primary health care, typically with vertical programme structures and budgeting *vis-à-vis* donor support in developing countries including Cambodia, the Lao People’s Democratic Republic (Lao PDR) and Viet Nam.

This document summarises the findings of the assessments and missions conducted by the NCGM as the WCC for Health Systems Research and the Center’s own related research undertaken in the same period in Cambodia, Lao PDR and Viet Nam, three of the priority countries in the Western Pacific Region (WPR), focusing on the relationship between HSS and disease and target-specific programmes.

The report first reviews the relationship between HSS and disease and target-specific programmes in the global context, and then looks at the status of the health systems in Cambodia, Lao PDR and Viet Nam in terms of the six building blocks of health systems (service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance). Based on the findings of assessments and research, the report elaborates the status of each of the building blocks in these countries from the perspective of different disease and target-specific programmes.

The following sections analyse how HSS has contributed, and can continue to contribute, to disease and target-specific programmes, and vice versa, in these countries. It then provides relationship models to interpret these dynamic interactions and interdependence. Last, the document presents conclusions and a potential way forward to better harmonise HSS and the disease and target-specific programmes.

2. Relation between HSS and disease and target-specific programmes in the global context

This section looks first at HSS trends in the global health context, then reviews the status of disease and target-specific programmes and their interface with HSS.

As tangible driving forces of the harmonisation between HSS and the disease and target-specific programmes, HSS support schemes of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the Global Alliance for Vaccines and Immunization (GAVI), the Health System Funding Platform (HSFP) and the International Health Partnership (IHP+) are outlined.

2-1. HSS trends in the global health context

1. During the 1990s, under the broad heading of health sector reform, discussions on health systems mainly focused on the reorganisation of central ministries and civil services, decentralization, interface with the private sector, broadening health financing options (including user fees) and fostering managed market competition. The World Bank played a significant role in facilitating the reform¹.

The 2000 World Health Report, *Health Systems: Improving Performance* set the stage for health systems to be a major item on the global health agenda in the 21st century². The report described health systems in terms of three objectives: health, responsiveness to people's non-medical expectations, and fair financial contributions. Health systems were also defined in terms of implementing four functions: stewardship, resource creation (investment and training), service delivery, and financing.

In 2007, WHO presented a single HSS framework with six building blocks³ :

1. Service delivery;
2. Health workforce;
3. Information;
4. Medical products, vaccines and technologies;
5. Financing; and
6. Leadership and governance.

The 2008 World Health Report highlighted the importance of primary health care, a concept defined by the 1978 Alma-Ata Declaration⁴. The emphasis was placed on universal coverage supported by people-centred

1. World Bank. *World Development Report 1987*. Washington DC: World Bank, 1987.
- World Bank. *World Development Report 1993-Investing in health*. Washington DC: World Bank, 1993.
2. WHO. *The World Health Report 2000, Health systems: improving performance*. Geneva: WHO, 2000.
3. WHO. *Everybody's business-strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva: WHO, 2007.
4. WHO. *The World Health Report 2008: Primary Health Care-Now more than ever*. Geneva: WHO, 2008.

service delivery. Strengthening health leadership and mainstreaming health within policies in all sectors were also stressed as necessary reforms for primary health care to adapt to 21st century realities. In the WPR, the regional strategy for health systems is largely based on the updated primary health care concept⁵. Leadership and management strengthening were emphasised as important actions to upgrade health systems.

2-2. Disease and target-specific programmes: Current status and interface with HSS

Current global and regional strategies for different disease and target-specific programmes covered in this document all include coordination with other programmes as well as harmonisation with, or even contributions to, HSS as their core components.

Table 1: Summary of how current global and regional strategies for disease and target-specific programmes embrace health systems strengthening

Programmes	Global/regional strategy documents	HSS aspects in global/regional strategies	
EPI	Global Immunization Vision and Strategy (GIVS)/ Global Vaccine Action Plan	<ul style="list-style-type: none"> To integrate immunization in the health system context To integrate immunization with deworming, IMCI and other primary health care programmes 	
HIV	A New Health Sector Agenda for HIV/AIDS	<ul style="list-style-type: none"> To integrate HIV programme with TB and MNCH HIV programme to contribute more to HSS, including health HRD, pharmaceutical and other materials logistics and health information 	
TB	Regional Strategy for Stop Tuberculosis in the Western Pacific 2011-2015	<ul style="list-style-type: none"> To position the HSS agenda at the centre of the TB control strategy To share a common ground with HSS in universal health coverage, social and financial protection of vulnerable and marginalised populations, human resources, private sector regulation and collaboration with other programmes 	
MALARIA	Global Malaria Action Plan	<ul style="list-style-type: none"> To work together with HSS in the scaling-up phase of malaria control to attain universal coverage and sustain the control 	
MNCH	Global Strategy for Women's and Children's Health	<ul style="list-style-type: none"> All five action areas – country-led health plans, integrated package of essential services, integrated care, HSS and health workforce capacity building – have direct HSS implications 	
EPI	Expanded Programme on Immunization	IMCI	Integrated management of childhood illnesses
HIV	Human immunodeficiency virus	HRD	Human resource development
TB	Tuberculosis	HSS	Health systems strengthening
MNCH	Maternal, neonatal and child health		

5. WHO/WPRO. *Western Pacific Regional Strategy for Health Systems Based on the Values of Primary Health Care*. Manila: Regional Office for the Western Pacific, WHO, 2010.

2-2-1. Expanded Programme on Immunization

The Expanded Programme on Immunization (EPI) was established in the 1970s and has achieved the most extensive service coverage globally⁶. An iconic achievement of the Programme was the global eradication of smallpox in 1980. Currently, the polio eradication programme is primarily focusing on the three remaining endemic countries: Nigeria, Pakistan and Afghanistan⁷.

Published jointly by WHO and UNICEF in 2005, the Global Immunization Vision and Strategy strategically positioned EPI in a changing world⁸. One of four strategy areas is the integration of immunization into the health systems context. Integrating interventions (e.g. integrating immunization with deworming and management of childhood illnesses) is the key strategy outlined.

The Decade of Vaccines, in line with requests made in World Health Assembly resolution 61.15 on the global immunization strategy and with notable support from the Bill and Melinda Gates Foundation, was declared to ensure discovery, development and delivery of lifesaving vaccines globally. Its framework document, the Global Vaccine Action Plan (GVAP), was endorsed by the World Health Assembly in 2012.⁹ In its six guiding principles, a strong immunization system as part of broader health systems and close coordination with other PHC programmes are stressed.

2-2-2. HIV prevention, care and support

Since 1981, over 25 million people worldwide have died of AIDS. HIV remains a long-term global issue with a generally declining, but continuing incidence of new infections.¹⁰ Nevertheless, the programme to fight HIV/AIDS realised a remarkable expansion of anti-retroviral therapy (ART) – even among low- and middle-income countries – that transformed the infection from a terminal illness to a chronic condition. ART spearheaded health care delivery on the basis of continuous follow-up and medication, which may open a potential window of opportunity to treat other chronic communicable or even non-communicable diseases in such countries.

In 2011, WHO proposed a new health sector agenda for HIV/AIDS. The agenda put particular emphasis on the prevention of HIV infection, but it also included strategic directions to more dynamically

6. WHO. *World Health Statistics 2012*. Geneva: WHO, 2012.

7. Independent Monitoring Board of the Global Polio Eradication Initiative. *Polio's last stand?* Geneva: Global Polio Eradication Initiative, 2012.

8. WHO/UNICEF. *GIVS: Global Immunization Vision and Strategy 2006-2015*. Geneva/New York: WHO/UNICEF, 2005.

9. WHO. *Global Vaccine Action Plan 2011-2020*. Geneva: WHO, 2013.

10. UNAIDS. *UNAIDS Report on the Global AIDS Epidemic 2012*. Geneva: Joint United Nations Programme on HIV/AIDS, 2012.

harmonise the HIV programme with HSS. The new directions advocate that the HIV programme be effectively integrated with other health programmes such as TB control and MNCH. The HIV programme is also expected to contribute more to HSS, including health HRD, pharmaceutical and other supply chain management (SCM) and health information systems (HIS).

2-2-3. Tuberculosis control

Since its establishment in 1999, the Special Project to Stop TB (tuberculosis) has made remarkable progress in global TB control, particularly through the application of DOTS (directly observed treatment, short-course). In the WPR, Cambodia, China, the Philippines and Viet Nam have 93% of the regional case-load.

The “Regional Strategy to Stop Tuberculosis in the Western Pacific 2011-2015” set forth three guiding principles including the positioning of the HSS agenda at the centre of the TB control strategy¹¹. The Programme shares common ground with HSS, mainly in universal health coverage, social and financial protection of vulnerable and marginalised populations, human resources, private sector regulation and collaboration with other programmes. Equity is a key value that guides TB control because the disease mainly affects the poor and the deprived. The pursuit of equity is a dimension where the Stop TB Programme shares a common value with HSS.

2-2-4. Malaria control

Over the past decades, there has been substantial progress in malaria control. After the Global Malaria Eradication Programme, which ran from 1955-69, malaria was largely overlooked until the Roll Back Malaria Partnership (RBM) was launched in 1998 as the disease made a dramatic comeback and many first line drugs were failing. The primary prevention tools are long-lasting insecticidal nets (LLINs), indoor residual spraying (IRS) and intermittent preventive treatment for pregnant women (IPTp). The rapid diagnostic test (RDT) and artemisinin-based combination therapies (ACTs) improved diagnosis and treatment. IRS and IPTp are not widely applied in Cambodia, Lao PDR and Viet Nam.

The Global Malaria Action Plan set forth by the RBM Partnership defines two stages of malaria control:

1. Scaling-up of preventive and therapeutic interventions; and
2. Sustaining control over time.¹²

11. WHO/WPRO. *Regional Strategy to Stop Tuberculosis in the Western Pacific 2011-2015: Reaching out to all*. Manila: Regional Office for the Western Pacific, WHO, 2011.

12. Roll Back Malaria. *Global Malaria Action Plan: For a malaria-free world*. Geneva: Roll Back Malaria Partnership, 2008.

HSS is considered a critical part of both stages: the scaling-up of malaria control to attain universal coverage and sustaining the scaled-up malaria control, especially preventive measures, to avoid a resurgence of the disease.

2-2-5. Maternal, neonatal and child health

Maternal, neonatal and child health (MNCH) is not disease specific, but rather is a target-specific initiative comprising public health and clinical programmes. It typically includes family planning and maternal/child nutrition programmes (including micronutrient supplements for both mothers and children and child growth monitoring with or without nutritional supplementation) with a strong vertical structure and planning.

Perinatal care constitutes a core of both maternal and neonatal care requiring rigorous clinical capacity to implement. It forms a continuum of care covering the pre-, peri- and post-natal periods targeting mothers and children in combination with antenatal, postnatal and infant care. In Lao PDR, EPI is considered part of MNCH and falls under the auspices of the National Maternal and Child Health Centre.

Among the eight Millennium Development Goals (MDGs), three are directly related to health, with two directly concerning MNCH.¹³ One Goal is to reduce the under-five mortality rate by two-thirds between 1990 and 2015. The other is to reduce the maternal mortality ratio by three-quarters and achieve universal access to reproductive health over the same period. Despite remarkable progress in the MNCH field in past decades, maternal health goals are considered to be the most difficult MDGs to achieve.

In 2010, the United Nations Secretary-General issued the *Global Strategy for Women's and Children's Health*.¹⁴ It advocates action in five areas:

1. Country-led health plans;
2. A comprehensive, integrated package of essential interventions and services;
3. Integrated care;
4. HSS; and
5. Health workforce capacity building.

All of these points have direct HSS implications.

13. United Nations. "United Nations Millennium Declaration (UN General Assembly Resolution 55/2)". New York: United Nations, 2000.

14. Ki-moon B (UN Secretary General). *Global Strategy for Women's and Children's Health*. New York: United Nations, 2010.

2-3. GFATM, GAVI, IHP+ and HSFP supports to HSS

Various Global Health Initiatives (GHI) that focus mainly on infectious diseases spearheaded global HSS support based on public-private partnerships in the past decade. These initiatives include GAVI, GFATM, IHP+ and HSFP.

GAVI committed US\$ 500 million for HSS between 2006 and 2010 in:

1. Health workforce support targeting those engaged in immunization and other health services;
2. Drugs, equipment, infrastructure and supplies for PHC; and
3. Organization, monitoring, and management of health services.

Preceding this support, GAVI, with support from the Norwegian Agency for Development Cooperation (Norad), assessed system-wide barriers, mainly focusing on those that hindered the expansion of immunization coverage.¹⁵

Similarly, GFATM supported HSS by providing funds to allow countries to respond to health system weaknesses, either through a specific programme or disease effort, or through a cross-cutting approach benefiting the control efforts of more than one target diseases (i.e. HIV, TB and malaria). Under the Fund's New Funding Model (NFM) that replaces the traditional rounds-based funding, countries are still encouraged to allocate a portion of supports for cross-cutting HSS needs. In addition, the inclusion of reproductive, maternal, newborn and child health (RMNCH) in the concept notes (request documents) is guided.¹⁶

IHP+ was launched in 2007 to accelerate progress on the health MDGs. It includes over 50 developing country partners, bilateral donors and international development agencies. These partners share the goals and approach of IHP+ by being signatories to the Global Compact, the founding document of IHP+. IHP+ mainly supports the development of comprehensive national health plans.

15. Hsiao W., and B. Siadat. "In search of a common framework for health systems strengthening". Paper presented at a World Bank, GAVI, Global Fund meeting on health systems strengthening. Washington DC: 25-27; 2009.

GAVI/Norad. *Alleviating System Wide Barriers to Immunization: Issues and Conclusions from the Second GAVI Consultation with Country Representatives and Global Partners*. Oslo: GAVI/Norad, 2004.

16. WHO. *WHO Technical Guidance Note: Strengthening the inclusion of reproductive, maternal, newborn and child (RMNCH) health in concept notes to the Global Fund*. Geneva: WHO, 2014.

GFATM. *Information Note on Health Systems Strengthening for Global Fund Applicants*. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria, 2014.

Facilitated by WHO, HSFP was established in 2009, bringing together GAVI, GFATM and the WB, and linking their support to developing countries' national health plans. They provide a joint platform for HSS that aims at:

1. One comprehensive health plan that integrates both domestic funding and international aid;
2. One joint assessment of the national health strategy;
3. One budget; and
4. One tracking system for funds.

The relationship between IHP+ and HSFP is rather complex. The key development partners forming HSFP (GAVI, GFATM and WB) are also the IHP+ partners, along with other key UN agencies such as WHO and UNICEF, and with larger involvement from country governments and civil society.

The two initiatives are closely related to each other, but with some notable differences. HSFP is more globally oriented, whereas IHP+ is more country oriented.¹⁷ While IHP+ assesses sector strategies, planning and budgeting and the status of health human resources using the Joint Assessment of National Strategy (JANS), HSFP assesses the financial management capacity and systems supporting financial transactions¹⁸ through its financial management assessment scheme.

As of November 2010, there was a discussion between GFATM and GAVI regarding whether to discontinue separate financing proposals under IHP+ and HSFP,¹⁹ but they continued to coexist as of September 2013.

17. Hill P.S., et al. "The Health System Funding Platform: Is this where we thought we were going?" *Globalization and Health*, 2011; 7: 16.

18. HSFP. *Harmonization and simplification of Financial Management*. Geneva: Health Systems Funding Platform, 2010.

19. Ibid.

3. Data collection

Table 2 summarises the assessment missions NCGM conducted as the WCC for Health Systems Research during the 2009-2013 contract period. The assessments used the disease and target-specific programmes mentioned above to trace health systems in the subject countries through document reviews and key informant interviews with health officers at different levels of the public health systems, programme officers from external assistance agencies and country-based WHO staff.

Table 2: List of assessment missions the NCGM conducted during the 2009-2013 contract period in Cambodia, Lao PDR and Viet Nam

Date	Country	Focus	NCGM Staff
Oct 2009	Cambodia	Assessment of interface between TB control/EPI and general health system in Phnom Penh and Siem Reap province	N. Fujita
Oct 2009	Viet Nam	Assessment of interface between malaria control/EPI and general health system in Thanh Hoa and Dien Bien provinces	Y. Matsumoto H. Ohara
Jan-Feb 2011	Lao PDR	Assessment of interface between disease specific programmes and general health system in Vientiane Capital, Luang Prabang and Champassack province	Y. Matsumoto S. Noda

Table 3 summarises HSS-related research and activities the NCGM conducted with its own funding in 2009-2013. The findings of this research are also featured, where appropriate, in the findings and analyses.

Table 3: Research and activities with NCGM's own grant and arrangement during 2009-2012 concerning HSS and disease and target-specific programmes in Cambodia, Lao PDR and Viet Nam

Date	Country	Focus	NCGM Staff
Jan 2009	Lao PDR	Assessment of synergies and costs of MCH services from prenatal to early childhood period in Sekong province	H. Murakami M. Nagai
Feb 2009	Cambodia	Assessment of the impacts of GAVI-HSS in Kompong Cham province	H. Ohara M. Nagai H. Murakami
March 2009	Lao PDR, Cambodia, Thailand	Workshop on disease-specific programmes and health systems strengthening at Japan Association on International Health	H. Murakami et al

4. Overview of health systems in subject countries

This section provides an overview of the status of health systems in Cambodia, Lao PDR and Viet Nam on the basis of the missions and research conducted by the NCGM from 2009-2013, its programme support experiences in these countries and notable existing reference materials including policy documents of the countries.

Table 4: Summary of key characteristics of health systems in Cambodia, Lao PDR and Viet Nam

	Cambodia	Lao PDR	Viet Nam
Health Service Delivery	<ul style="list-style-type: none"> External support agencies play a large part Contracting as a common modality to relate external agencies with sector plan 	<ul style="list-style-type: none"> Mountainous terrain and ethnic diversity pose notable barriers Highly dependent on community outreach 	<ul style="list-style-type: none"> Strong vertical programmes Well-functioning CHCs and VHWs
Health workforce (2010)	<ul style="list-style-type: none"> Doctors: 2.3/10,000 pop Nurses and midwives: 7.9/10,000 pop. 	<ul style="list-style-type: none"> Doctors: 2.7/10,000 pop. Nurses and midwives: 9.7/10,000 pop. 	<ul style="list-style-type: none"> Doctors: 12.2/10,000 pop. Nurses and midwives: 10.1/10,000 pop.
Health information system	<ul style="list-style-type: none"> Integrated HIS vigorously pursued in the past faced a major challenge of national capacity 	<ul style="list-style-type: none"> Unstandardised and incomplete records/reports Lack of vital registration 	<ul style="list-style-type: none"> Meticulous recording and reporting Vertical and parallel reporting systems
Medical products, vaccines and technologies	<ul style="list-style-type: none"> Integrated logistics system with CMS system faced a major challenge of national capacity 	<ul style="list-style-type: none"> Integrated logistics pursued since 2009 Supply shortage notable in some programmes 	<ul style="list-style-type: none"> A large part of essential medicines and vaccines produced in-country
Health system financing	<ul style="list-style-type: none"> External supports still vital to health financing Out-of-pocket payment occupied 42% (2009) 	<ul style="list-style-type: none"> Provinces play a major part in health financing Out-of-pocket payment occupied 51% (2009) 	<ul style="list-style-type: none"> Ensured local public financing for designated national programmes Out-of-pocket payment occupied 58% (2009)
Leadership and governance	<ul style="list-style-type: none"> Sector Wide Management (SWiM) pursued 	<ul style="list-style-type: none"> Sector Wide Coordination (SWC) pursued with SCWMP 	<ul style="list-style-type: none"> Strong national ownership Joined IHP+ in 2010
CHCs	Commune health centres	IHP+	International Health Partnership
HIS	Health information system	SCWMP	Sector Common Work Plan and Monitoring Framework
CMS	Central Medical Stores	VHWs	Village Health Workers

4-1. Cambodia

Health service delivery

Given the country's post-conflict background, health service delivery in Cambodia is highly dependent on external support agencies and "contracting" has been the basic modality that determines the relationship between the MOH and these agencies. In the contracting, the government tendered contracts for management of government health services in districts to private bidders, mostly international development partners including NGOs. Contractors were then held responsible for providing public health and clinical services in line with the Minimum Package of Activities (MPA).²⁰

In the face of a surge of external support, particularly after the multi-party elections led by the United Nations Transitional Authority in Cambodia (UNTAC) in 1993, contracting was institutionalised in 1996 as part of the Basic Health Services Project. By 2003, contracting covered about 11% of Cambodia's population. The approach was then expanded to additional districts.²¹

There have been two types of contracting, namely contracting-in and contracting-out. Contracting-in districts were expected to work within the existing government system for the procurement of drugs, equipment and supplies. Their operating expenses were financed through the government budget in the same manner as ordinary districts. They were required to use existing MOH personnel. Contracted-out districts, in contrast, enjoyed full autonomy. They were allowed to hire and fire staff, could bring in health workers from other parts of the country, and were responsible for their own procurement of drugs, supplies and equipment.²²

A Special Operating Agency (SOA) scheme launched in 2009 further streamlined the contracting system. In the SOA scheme, the district health administration is financed by five sources:

1. Government budget;
2. A service delivery grant (SDG) that is basically a pooled fund created out of development partners' support;
3. User fees;
4. Health equity fund; and
5. Direct financing by development partners.

20. Bloom E., et al. *Contracting for Health: Evidence from Cambodia*. Washington DC: Brookings Institution, 2006.

21. Ibid.

22. Ibid.

In principle, direct financing by development partners is discouraged, whereas development partners are encouraged to contribute to the SDG. Provincial Health Departments function as a commission, while districts function as contractors.²³ Scaling up health service delivery contracting countrywide through SOA is the direction set by the 2008-2015 Health Strategic Plan (HSP).²⁴

Health workforce

Health personnel, particularly medical doctors, are in short supply in Cambodia.²⁵ The country had 2.3 doctors and 7.9 nursing and midwifery personnel per 10,000 population in 2010. Health human resources policy frequently changed, particularly regarding midwifery personnel. Over the past decades, national policy has focused at one time on quantity and at another on quality of such personnel.

Health information system

While the disease control programmes – such as HIV, TB and malaria – have received more support for their specific information systems, a comprehensive approach to the improvement of the production, analysis and use of health related data needs to be further strengthened and developed. Notable constraints in the HIS include the lack of a major commitment for HIS coordination among stakeholders, as well as medium- and long-term plans for HIS improvement. The improvement is especially needed to ensure the accuracy of demographic data sources through census and vital registration information, and in managing data.²⁶

Medical products, vaccines and technologies

Cambodia has a unified public health sector drugs and commodities procurement and supply system in which the Central Medical Stores (CMS) play a principal role. The Essential Drug Bureau of the Department of Drugs and Food in the MOH is responsible for oversight and forecasting and, in conjunction with the CMS, coordination of the drug supply.²⁷

23. Ibid.

24. MOH, Cambodia. *Health Strategic Plan 2008-2015*. Phnom Penh: Ministry of Health, 2008.

25. WHO 2012.

26. Veasnakiry L. and S. Sovanratnak. *Cambodia Health Information System: Review and Assessment*. Phnom Penh: Ministry of Health, 2007.

27. Hall P.E. and C. Chhuong. *Reproductive Health Commodity Security – Country case study: Cambodia*. London: Health Resource Centre, Department for International Development, 2006.

Health system financing

As in the case of Lao PDR, Cambodian health financing is characterised by low absolute and relative government spending on health and a very high proportion of out-of-pocket payment and donor funding.²⁸ In 2009,²⁹ out-of-pocket payments by Cambodian health care clients accounted for about 42% of total health expenditures. Three major pre-payment schemes have been put in place to alleviate the often catastrophic financial consequences of patients' out-of-pocket health expenditures:

1. Mandatory health insurance for formal sector employees (administered by the Ministry of Social Affairs, Veterans and Youth);
2. Community-based health insurance for self-employed and informal sector workers; and
3. A health equity fund³⁰ (Cambodia was the first country to introduce the health equity fund in 2000³¹).

Leadership and governance

Health development partners have tried to coordinate their work along the MOH's Health Strategic Plan (HSP) under a Sector Wide Management (SWiM) framework adopted in 2000. The SWiM concept is also reflected in the HSP 2008-2015 as a strategic means to support harmonisation.³²

4-2. Lao PDR

Health service delivery

Mountainous terrain, sparsely scattered populations and ethnic diversity represent significant barriers to health service delivery in Lao PDR. As a result, service delivery at the community level is heavily dependent on outreach activities in villages. Community health centres and district hospitals are remarkably underutilised. EPI presents the most regular and extensive service delivery window at the community level. The national health plan looking towards the year 2020 emphasises coordination between EPI and MNCH, particularly at the community level, to form a core health services package.³³

28. P.L. Annear. "Cambodia: Developing a Strategy for Social Health Protection". In *Promoting sustainable strategies to improve access to health care in the Asian and Pacific Region*. Bangkok: ESCAP, 2009.

29. WHO 2012.

30. Annear 2009.

31. Noirhomme M., et al. "Improving access to hospital care for the poor: comparative analysis of four health equity funds in Cambodia". *Health Policy & Plan* 2007; 2: 246-262.

32. MOH Cambodia 2008.

33. MOH, Lao PDR. *Health Strategy up to the Year 2020*. Vientiane: Ministry of Health, 2000.

Health workforce

A shortage of health personnel, particularly medical doctors, is a serious health system-wide barrier in Lao PDR. The country had 2.7 doctors and 9.7 nursing and midwifery personnel per 10,000 population as of 2010. These figures are only slightly higher than those of Cambodia.³⁴ A concentration of health personnel in urban areas is, however, more prominent in Lao PDR.

Health information system

Inconsistent and incomplete records and reports of health services are a prevalent problem. Lack of vital registration information, including births and deaths, makes it difficult to estimate target populations for health services. Despite this, a comprehensive HIS is running, partly integrating information derived from the disease and target-specific programmes.

Medical products, vaccines and technologies

Separate logistics systems for EPI, malaria, etc. encouraged the MOH to support an integrated logistics system to harmonise drug supplies for different health services, particularly since 2009. In principle, procurement is handled centrally at the national level. In the field, shortages of medicines for public health programmes, such as iron and folic acid tablets for antenatal care, are prevalent.

Health system financing

Total health expenditure is still low and depends heavily on household out-of-pocket payments.³⁵ In 2009,³⁶ about 51% of health expenditures in Lao PDR were out-of-pocket payments by health care clients. Additionally, the majority of the health budget is supported by external assistance. Currently, 75% of the domestic health budget excluding external assistance is provided by provinces and districts.³⁷ Provinces are key actors in both financing and delivery of health services.

34. WHO 2012.

35. Ahmed S., et al. "Institutional design and organizational practice for universal coverage in lesser-developed countries: Challenges facing the Lao PDR". *Soc Sci Med* 2013, <http://dx.doi.org/10.1016/j.socscimed.2013.01.019>.

36. WHO 2012.

37. Thome J.M., S. Pholsena. "Lao People's Democratic Republic: Health Financing Reform and Challenges in Expanding the Current Social Protection Schemes". In: *Promoting sustainable strategies to improve access to health care in the Asian and Pacific Region*. Bangkok: ESCAP, 2009.

In 2012, about 22% of the population of Lao PDR was covered by pre-payment health financing schemes.³⁸ Four major pre-payment schemes are in place:

1. Mandatory health insurance for civil servants and employees of enterprises with more than 10 employees (administered by the Ministry of Labour and Social Welfare)
2. Community-based health insurance for self-employed and informal sector workers
3. Health care fund for the poor covering people living below the poverty line
4. Exemption of medical fees for maternal and child health care in selected provinces/districts

Leadership and governance

A Sector Wide Coordination (SWC) mechanism for health aligns and directs the contributions and activities of development partners in achieving the country's health objectives. This mechanism was accelerated by the adoption of the Vientiane Declaration on Aid Effectiveness in 2007,³⁹ reflecting the spirit of the 2005 Paris Declaration on Aid Effectiveness.⁴⁰ The coordination mechanism operates at three levels: policy, strategy and technical. A Sector Common Work Plan and Monitoring Framework facilitates joint planning, monitoring and coordination for health policy and health programme implementation in line with the seventh five-year Health Sector Development Plan (HSDP).⁴¹

4-3. Viet Nam

Health service delivery

Viet Nam enjoys strong delivery of key health interventions including the disease-specific initiatives covered in this document. Programmes such as EPI, malaria control, family planning and micronutrient supplementation (in particular vitamin A) achieved extensive community-level coverage and rural penetration with CHCs (commune health centres) and VHWs (village health workers) functioning effectively. A high degree of utilisation of the CHCs is a notable feature that distinguishes the Vietnamese health system from those in Lao PDR and Cambodia.

38. Ahmed 2013.

39. Government of Lao PDR/UNDP. *Vientiane Declaration on Aid Effectiveness*. Vientiane: Government of Lao People's Democratic Republic/UNDP, 2007.

40. OECD/DAC. *The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action*. Paris: Development Assistance Committee, Organisation for Economic Co-operation and Development, 2005/2008.

41. MOH, Lao PDR. *The 7th Five-year Health Sector Development Plan 2011-2015*. Vientiane: Ministry of Health, 2011.

Health workforce

Viet Nam has a relatively large number of doctors per population (12.2 per 10,000 population as of 2010); more than four times that of Lao PDR and Cambodia.⁴² Indeed, almost half of the CHCs have medical doctors. In contrast, there are fewer nursing and midwifery personnel than doctors (10.1 per 10,000 population, almost comparable to Cambodia and Lao PDR).⁴³

Health information system

In hospitals and CHCs, service records are meticulously kept in log books and reporting forms. A large number of log books and reporting forms often overload health staff, particularly commune health workers (CHWs).

Medical products, vaccines and technologies

Essential medicines (i.e. anti-malarial drugs) and vaccines are produced domestically. Notably, the country is producing most of its EPI vaccines. In the mid-2000s, the country faced drug supply problems, mainly for the poor, due to increased drug prices in the public sector.⁴⁴ The issue was vigorously discussed, even in the National Assembly. Drug prices are still a bottleneck to Viet Nam's health system, mainly as a result of inefficient procurement.

Health system financing

Once a programme is designated as national, it is implemented with a high degree of political commitment and often with direct fund transfers from the national to sub-district levels. Other more routine activities, such as MNCH, lack explicit budget allocation at the sub-district and village levels in most places. Results-based financing (RBF) was adopted in EPI in the form of a cash disbursement per fully immunised child.

42. WHO 2012.

43. WHO 2012.

44. Nguyen A.T., R. Knight, A. Mant, QM Cao, and M. Auton. "Medicine prices, availability, and affordability in Vietnam". *Southern Med Review* 2009; 2(2):2-9.

Four major pre-payment schemes are in place:

1. Mandatory health insurance for civil servants and staff of corporations (administered by the Ministry of Labour, Invalids and Social Affairs)
2. Voluntary health insurance
3. Health care fund for the poor subsidising premiums of mandatory health insurance for the poor, near-poor and ethnic minorities
4. Exemption of medical fees for those under 6-years-old

As a result of the amendment of the Health Insurance Law in 2014, the voluntary insurance is planned to be abolished and integrated into the mandatory scheme in coming years. The third scheme was integrated into the mandatory health insurance scheme in 2008.

As of 2013, the combined coverage reached nearly 70% of the total population. In 2009, 58% of health expenditure was still borne by health care clients in Viet Nam in the form of out-of-pocket payments.⁴⁵

Leadership and governance

Unlike in Lao PDR and Cambodia, health sector-wide planning, particularly in relation to aid effectiveness, has not been vigorously pursued in Viet Nam. Although the country joined IHP+ in 2010 and undertook a Joint Assessment of National Health Strategies and Plans (JANS),⁴⁶ the health sector largely follows the HSDP for 2011-2015⁴⁷ as part of the five-year national Socioeconomic Development Strategy⁴⁸ that remains within the traditional five-year planning cycle of a socialist country.

The relatively slow process towards sector-wide coordination in line with the sector-wide approach, however, is in part the reflection of the strong national ownership and generally good health outcomes derived from the existing systems.

45. WHO 2012.

46. Trans V.T., et al. *The Independent Assessment of the Process and the Content of the Five Year Health Plan, 2011-15, in Vietnam*. Hanoi: Joint Assessment of National Strategies (JANS) Team, 2011.

47. MOH, Viet Nam. *Five-Year Health Sector Development Plan 2011-2015*. Hanoi: Ministry of Health, 2010.

48. Government of Viet Nam. *Viet Nam's Socio-economic Development Strategy for the Period of 2011-2020*. Hanoi: Government of Viet Nam, 2010.

5. Findings: Status of six building blocks of health systems observed from the perspective of disease and target-specific programmes

This section collates the findings of assessments and research to indicate the status of the six building blocks of health systems as observed from the perspectives of EPI, HIV, TB, malaria and MNCH programmes in Cambodia, Lao PDR and Viet Nam.

Table 5: Key findings of status of six building blocks of health systems observed through EPI, HIV, TB, malaria and MNCH programmes in Cambodia, Lao PDR and Viet Nam

Health system building blocks	Key findings observed through disease- and target specific programmes
Health Service Delivery	<ol style="list-style-type: none"> 1. Hard to reach population/areas generally prevalent in Lao PDR, whereas they were specifically defined in Viet Nam. 2. Good collaboration between public health system and community organisations was observed in Viet Nam and Lao PDR. 3. Lack of service integration still posed missed opportunities, particularly at the community level of Lao PDR. The service integration was also considered to reduce administrative workload.
Health workforce (2010)	<ol style="list-style-type: none"> 1. Shortage of skilled health staff was a common system-wide barrier in all three countries. 2. The human resources shortage was exemplified particularly when equipment, commodities and techniques were newly introduced. 3. Disease and target-specific programmes provided annual programme based training of new employees and refresher training opportunities. 4. GAVI and GFATM created additional training opportunities through their HSS supports.
Health information system	<ol style="list-style-type: none"> 1. The HIS integration often faced difficulties. 2. Cambodia vigorously pursued an integrated HIS in the late 1990s, but faced a major challenge of national capacity to maintain it.
Medical products, vaccines and technologies	<ol style="list-style-type: none"> 1. Procurement, supplies and logistics often posed a system-wide barrier to disease-specific programmes. 2. The integration of logistics systems was adopted step-by-step (e.g. in southern Lao PDR). 3. Cambodia vigorously pursued an integrated logistics system in the late 1990s, but faced a major challenge of national capacity to maintain it.
Health system financing	<ol style="list-style-type: none"> 1. A reverse pyramid budget allocation with disproportionately limited allocation to community level was causing a prominent shortage of local operational costs. 2. Results-based financing (RBF) was particularly common in Cambodia, but also seen in Viet Nam. 3. Though the RBF contributed to reallocate budget to local levels, some negative impacts were also reported.
Leadership and governance	<ol style="list-style-type: none"> 1. Importance of national political commitment in implementing health programmes was highlighted, particularly in Viet Nam. 2. Coordinating and harmonising different disease and target-specific programmes was an important aspect of the leadership and governance function of the health systems. 3. Related with above, coordinating different external assistances was also an essential aspect of leadership and governance.

5-1. Health service delivery

Profiles of hard-to-reach populations and areas differed from one country to another, requiring different service delivery mechanisms, particularly along the spectrum from facility-based to community-based services.

In Viet Nam, although overall service coverage was higher than in the other two countries, malaria control faced a barrier in the form of a very specific hard-to-reach population: migratory workers forming new endemic areas, especially around new construction sites for development projects.

In contrast, in southern Lao PDR, the majority of the population could not reach health facilities easily. For example, in Sekong province, only 45% of the population could reach a health facility, indicating the comparative importance of community-based services. In fact, village outreach was the main means of service delivery for MNCH and EPI. Antenatal care (ANC) was often conducted in villages with relatively high coverage, but with high drop-out rates from the first (ANC1) to the third (ANC3) visit onward. Immunization marked the highest coverage among all services targeting mothers and children. The proportion of deliveries attended by skilled birth attendants was at best one-third and postnatal care coverage was at best 20%, observed in Sekong province in 2009.

Good collaboration between public health systems and communities – a prerequisite for the success and sustainability of PHC, including disease and target-specific programmes – was seen in Viet Nam and Lao PDR. In Viet Nam, malaria control and EPI demonstrated an effective interface with community organizations such as Women's Unions, Youth Unions and National Construction Fronts. Such interface with local organizations was also well-structured in Lao PDR, providing examples of good practices for other Member States in the Western Pacific.

Though global and regional strategies for most disease and target-specific programmes advocate better coordination between programmes in the context of HSS, it does not seem easy to accomplish. For example, in southern Lao PDR, while EPI provided excellent service contact opportunities both at health facilities and in communities, even very simple interventions such as physical checks and growth monitoring of infants had often not been done. EPI and MNCH integration were stipulated as national policies, but the actual application in the field still requires additional practical ideas, trials and operational research.

The assessment of malaria and EPI in Lao PDR also identified two specific aspects of service coordination that had HSS implications. The provincial health accounting office recognised that the accounting

workload would be reduced if community visits for malaria work were integrated with visits for other programmes. The programme also faced difficulty in assuring the quality of malaria diagnosis in both public health laboratories that test surveillance specimens and clinical laboratories that test clinical specimens in health facilities because they were governed by different departments of the MOH.

5-2. Health workforce

Shortage of skilled health staff was a common system-wide barrier in all subject countries. In Cambodia, the shortage was seen as a bottleneck to both the TB programme and EPI. In Viet Nam, EPI faced difficulty in inheriting programme experiences from its successful implementation over the past decades due to staff turnover – particularly the retirement of core staff – indicating that human resources development is not a one-time intervention, but rather a long-term investment.

The human resources shortage was exemplified particularly when equipment, commodities and techniques were newly introduced or enhanced in the health systems. In Viet Nam, for example, microscopes to diagnose malaria were provided by GFATM at the sub-district level, but there were insufficient staff at that level that could use them properly, creating a gap between material and human resources. In Kampong Cham, Cambodia, GAVI-provided RBF increased MNCH financial resources, but imbalances between financial, human and material resources still obstructed service delivery in some locations.

As described above, the disease and target-specific programmes, particularly infectious disease control, provided opportunities for programme-based annual training for new employees, as well as refresher training. In each of the countries, for example, standardised training on malaria and EPI enabled local health staff to provide better services with assured quality and safety.

GAVI and GFATM created additional training opportunities through their HSS support. From 2008, GAVI supported a nine month certification course in Viet Nam for VHWs in order to improve the quality of their work in villages. Also, GFATM supported a three month training course on malaria control for new VHWs and a refresher course for workers who had already been trained. Local authorities, however, were concerned about the sustainability of these training courses because the support was only pledged for a limited duration. This was particularly true for the GAVI course because it had been newly established by GAVI, separate from the existing training system, and was considered difficult to sustain after GAVI's support finished.

Staff training was considered a potential area where different disease and target-specific programmes

could work together in harmony in the future. In Sekong province of Lao PDR, for example, there were two separate training programmes for MNCH and EPI, but the MNCH training also featured EPI and vice-versa, suggesting the potential for the future integration of the two.

5-3. Health information systems

The interface between HSS and disease-specific programme provides a tangible aspect of the information system: how the programme-specific reporting systems interact with the sector-wide HIS. Indeed, one of the strengths of the disease and target-specific programmes is their robust internalised reporting systems, typically reflected in effective malaria and EPI reporting systems from the community level all the way up to the central level.

In Lao PDR, malaria reporting was partially integrated into the national HIS, which enabled the Statistics Unit to validate the data for malaria cases by comparing the data from HIS and the malaria programme. Malaria data was largely consistent between those filed in the HIS and those kept at malaria stations. However, GFATM reporting requirements forced the malaria programme to continue to use its specific reporting forms in addition to the HIS form, complicating the entire reporting process. As of 2009 neither MNCH nor EPI reporting were integrated into the national HIS in southern Sekong province. Rather, the community health staff submitted five different reporting forms, each covering different programme components of MNCH-EPI.⁴⁹

In Cambodia, the MOH and its partners tried to centralise HIS in the late 1990s. Insufficient central capacity to operate the system, however, caused reporting delays in the centralised system. To overcome this new bottleneck, the programmes had to maintain parallel reporting systems.

5-4. Medical products, vaccines and technologies

Supply chain management (SCM) also poses a system-wide barrier to disease and target-specific programmes. In Viet Nam, for example, EPI was impeded by insufficient cold chain and vaccine delivery systems in remote areas. Similarly, lack of microscopes and malaria diagnostic capability at the commune (sub-district) level hindered programme implementation. In Lao PDR, a shortage of iron and folic acid tablets impeded antenatal care and forced mothers to buy them for a fee at private pharmacies.

As in the case of the information system, the integration of formerly programme-specific SCM progressed

49. Lattanavong P., et al. Report: Assessment of MCH/EPI service synergies along life-course of mothers and children in Sekong Province, Lao PDR. Vientiane: National MCH Centre, Lao PDR, 2009.

at different rates in different programmes and countries. In southern Lao PDR, a unified storage system was adopted, abolishing separate storage and logistics for malaria. Local health authorities consider this an improvement in stock management efficiency by simplifying the information flow. The storage condition of ACT drugs was also improved by using the unified regional warehouses.

Cambodia experienced the negative side of the integrated system, as it did in the information system, particularly with the system developed around the CMS (see 4-1. Medical products, vaccines and technologies). Limited central capacity caused a shortage of drug supplies, forcing the programmes to revitalise their vertical and separate storage and logistics.

5-5. Health systems financing

The reverse pyramid status of health budget allocation, in which allocation to central and provincial levels far surpasses that to district and community levels, caused a prominent shortage in local operational costs for major disease and target-specific programmes. The unit cost analysis of MNCH-EPI in Sekong, Lao PDR showed that overhead costs (costs spent at national and provincial levels regardless of the service quantity at the service units) constituted the majority of the unit cost of all MNCH-EPI services.⁵⁰ In Viet Nam, more than half of the malaria budget was spent at the central level, although this included centralised equipment and commodities procurement. As a result, local transportation costs for CHWs to implement the programmes were insufficient.

RBF was a common solution in Viet Nam and Cambodia to curb such local fund shortages. In Viet Nam, RBF applied to EPI (see Section 4-3, Health system financing) improved motivation among VHWs. Also, both in malaria control and EPI, incentive payments to CHWs provided precious additional income for them. In Cambodia, RBF started in 2002 through contracting or HSS support through GAVI. It ensured the timely disbursement of staff incentives as supplements to their often delayed salaries from the MOH budget. It strengthened the capacity for financial management with increased accountability, particularly at the district level. Health centre (HC) staff incomes increased markedly, enabling them to live decent lives with income from their health sector jobs alone. HCs revenue increased both by disbursement through RBF and increased user fees with increased patient visits. Due to its result-based nature, the RBF introduction in 2007 boosted MNCH visits to HCs in Kampong Cham, Cambodia,⁵¹ though the sharp utilisation response was short-lived, and utilisation soon reached a plateau, long before the coverage approached 100%.

50. Lattanavong 2009.

51. Matsuoka S., et al. "Performance-based financing with GAVI health system strengthening funding in rural Cambodia: A brief assessment of the impact". *Health Policy & Plan* 2013; 29 (4): 456-465.

Behind many notable benefits, the assessments and research identified several limitations of RBF. In Viet Nam, though RBF boosted motivation among VHWs, it subsequently became difficult to motivate them without the incentive. In Cambodia, RBF did not resolve the fundamental issue of delays in government budget allocations and re-allocation at mid-level health administrations before reaching the field. Rather, RBF consolidated direct local public financing by development partners by bypassing the MOH. In the context of MNCH in Kampong Cham, RBF could not always overcome impeded service delivery due to shortages of human and material resources. Furthermore, because RBF does not immediately improve the capacity of health personnel, it did not effectively ensure the technical quality of HC services. Last, RBF was relatively costly. In Kroch Chhmar Health Operational District of Kampong Cham province, with a total population of 100,527, approximately US\$ 80,000 was budgeted for MNCH-related RBF in 2009.

Accounting is another dimension of financial management that was observed to have an HSS implication. In Lao PDR, at the time of the assessment in 2011, provincial health authorities had a plan to unify separate accounting systems for different programmes into a single integrated system that would enable them to appropriately allocate budgets according to local priorities. However, it has not been realised as of July 2014.

5-6. Leadership and governance

The first aspect of leadership and governance elaborated by the assessment was the political commitment of national governments to different programmes. In Viet Nam, the success of malaria control and EPI was attributed to the Government's high political commitment, along with strong national steering committees that enabled the effective implementation of the programmes.

The second aspect was the level of capacity each government demonstrated in coordinating and harmonising different disease and target-specific programmes. In Cambodia, strengthening of district health management was attempted through the participation of decision-makers in the integrated supervision and support of health centre staff. In Sekong province, Lao, PDR, MNCH and EPI planning and budgeting were separate at the provincial and district levels, largely due to the distinct budget lines set forth for each of them. Despite this, the collaboration between MNCH and EPI was generally good and supervisory visits usually covered both programmes.⁵²

The last aspect of leadership and governance that stood out was how the national governments coordinated different sources of external assistance. In Lao PDR, the malaria planning and budgeting process and timing were largely determined by GFATM requirements, and thus were difficult to integrate

52. Lattanavong 2009.

with sector-wide planning and budgeting. Also, in Sekong province, Lao PDR, external support largely affected MNCH and EPI services provision.⁵³ It was particularly notable that the discontinuation of such support could cause significant service disruptions. In Viet Nam, some key informants shared the view that increased international donor support could weaken Government leadership and social mobilisation.

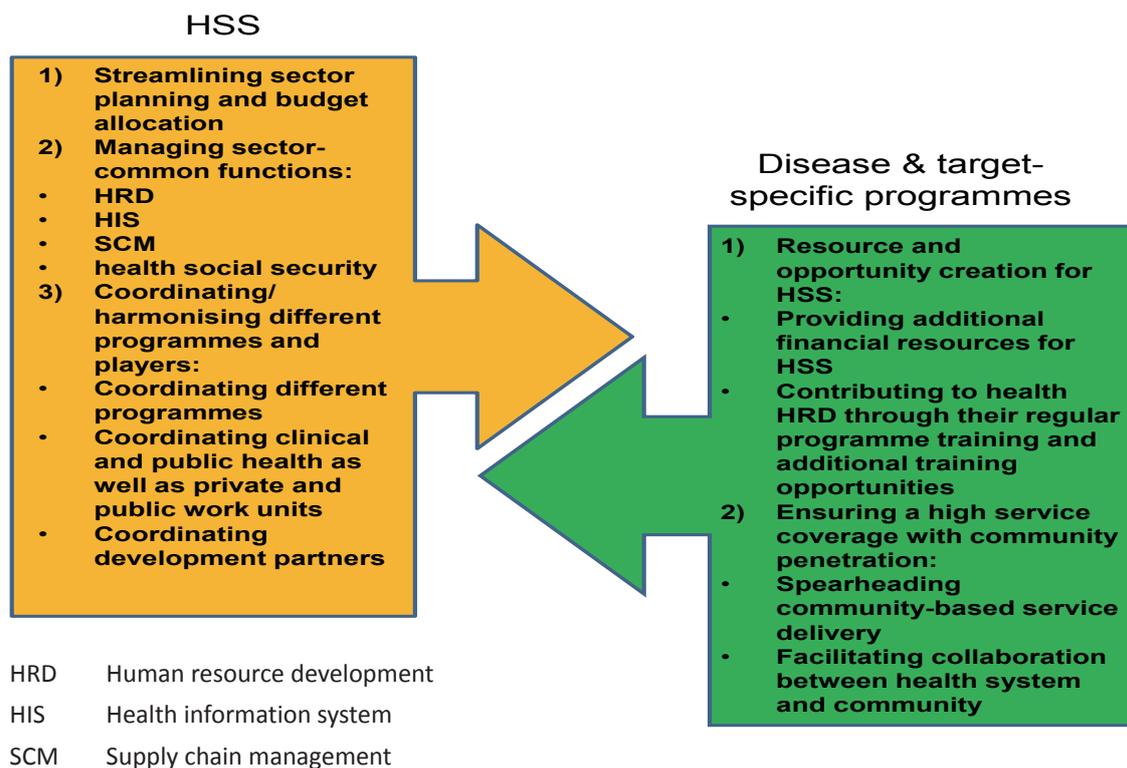
As described above, external support is essential for Cambodia, Lao PDR and Viet Nam to implement disease and target-specific programmes, but the countries face challenges in linking these programmes firmly to the overall HSS framework based on national health plans. In Cambodia, for example, various RBF schemes operate in fragmented ways. The fragmentation was in three dimensions: geographical areas, service components and time. The fragmentation in time occurs because most externally supported schemes are time-limited, usually within 5 years. Thus, various efforts towards sector coordination, such as the development of common work plans and monitoring frameworks, are undertaken, particularly in Cambodia and Lao PDR, to maximise aid effectiveness.

53. Lattanavong 2009.

6. Analysis 1: How has HSS contributed, and can further contribute to, disease and target-specific programmes?

On the basis of the findings described above, HSS has contributed, and can continue to contribute, to disease and target-specific programmes in several ways.

Figure 1: Summary of how HSS has contributed and can further contribute to disease and target-specific programmes and how disease and target-specific programmes have contributed and can further contribute to HSS (cf. Section 7, Analysis 2)



HSS contributions to disease and target-specific programmes are classified into three main categories:

1. Streamlining sector planning and budgeting:

Health sector-wide planning is an increasingly important HSS function to coordinate different health programmes. While the existing sector plans usually do not fully integrate budgets in Cambodia, Lao PDR and Viet Nam, budget allocation is another critical aspect of HSS, though not easy to streamline. As observed in Cambodia, the GHI can provide programmes with additional financial resources (in this case

through RBF).⁵⁴ However, ironically, such arrangements not only fail to resolve the fundamental issue of delays in government budget allocations and misallocations of budget at lower administrative levels, but also consolidate auxiliary cash flows directly from development partners to local health facilities. Streamlining budget allocation is an aspect where HSS can further contribute to health programmes.

2. Managing sector-common functions:

HRD: Strengthened HRD is not only an essential element of improved services in all health programmes, but also critical in maintaining already well-functioning programmes such as EPI, considering the staff turnover. A shortage of skilled health staff was a common system-wide barrier in all subject countries. Staff training is an area where different disease and target-specific programmes can work together in harmony in the future, and HSS can facilitate such harmonisation. Although not in the scope of this document, a project conducted in Myanmar by the Japan International Cooperation Agency (JICA) in collaboration with NCGM tried to integrate different programmes' training targeting PHC workers at the community level.⁵⁵

HIS: HSS can potentially utilise the HIS platform to facilitate the integration of information systems. However, this poses a particular challenge to HSS (see "Lack of national capacity to maintain coordinated HIS and SCM", below). As observed in Lao PDR, the reporting requirements of external support agencies may split HIS. Also, the country's attempt to integrate MNCH-EPI did not automatically facilitate the integration of the information systems. The findings suggest the need to make a flexible decision as to whether to pursue integrated HIS or continue to use programme-specific information systems, taking into consideration the existing management capacity.

SCM: As mentioned in section 5-4 ("Medical products, vaccines and technologies"), in some settings the integrated SCM worked, whereas in others it did not. Similar to HIS, the findings support a flexible decision as to whether to pursue an integrated logistics system or to continue to use parallel, programme-specific systems, taking management capacity into consideration. Generally, however, it is more cost-effective if SCM is integrated.

Health social security, including health insurance: In an aim to attain UHC, non-out-of-pocket health financing schemes – such as social insurance, health equity funds and systematic payment exemptions – are being introduced in Cambodia, Lao PDR and Viet Nam. Some parts of disease and target-specific

54. Matsuoka 2013.

55. NCGM. *Annual Report 2011: Bureau of International Medical Cooperation, National Center for Global Health and Medicine, Japan*. Tokyo: National Center for Global Health and Medicine, 2011, p. 31.

health programmes, mostly clinical interventions such as delivery and neonatal care in MNCH, are expected to attract more clients as a result of decreased financial barriers with the expansion of the health social security schemes.

3. Coordinating/harmonising different programmes and players:

Coordinating different disease and target-specific programmes: The Sector Wide Coordination (SWC) mechanism in Lao PDR and the Sector Wide Management (SWiM) framework in Cambodia pose useful platforms in which HSS can facilitate coordination and harmonisation. These coordination mechanisms are expected to contribute to better programme and aid efficiency by getting the most out of the available (often scarce) resources while minimising workloads and transaction costs.

Coordinating clinical and public health, as well as public and private units: As the assessment of malaria control in Lao PDR revealed, medical facilities and public health systems could be better harmonised, for example to form a more integrated laboratory network to derive better malaria diagnosis at local levels.

Coordinating development partners: The sector coordination mechanism provides a platform to better harmonise different development partners. By putting the MOH in the driver's seat, it also ensures the ownership and leadership of the countries concerned.

The assessments also identified the following three challenges that need to be overcome for HSS to better contribute to the disease and target-specific programmes and other health interventions:

1. Lack of a clear strategy and action tools for programme harmonisation:

In the difficult geographic conditions of southern Lao PDR, the precious EPI outreach visits were not used for simple additional interventions such as physical checks and growth monitoring of infants, despite the national policy stipulation of MNCH-EPI integration. For the service integration designed under HSS platform to be functional, a clearer strategy with operational action tools needs to be developed.

2. Lack of national capacity to maintain coordinated HIS and SCM:

The assessments also identified the need for enhanced national capacity to manage sector-common functions, particularly integrated HIS and SCM.

3. Uncoordinated deployment of human, material and financial resources:

Provision of microscopes without skilled human resources did not derive better malaria diagnosis

in Viet Nam, whereas RBF without human resources intervention derived limited improvement in MNCH service delivery in Cambodia. National health plans need to coordinate investments in human, material and financial resources to avoid such mismatches. HSS is in a position to actively promote and support the development of a national health plan taking this important aspect into account.

7. Analysis 2: How have disease and target-specific programmes contributed, and can further contribute, to HSS?

The previous section reviewed how HSS has contributed, and can further contribute, to disease and target-specific programmes and other health interventions. This section, conversely, elaborates ways in which disease and target-specific programmes such as HIV, TB, malaria, EPI and MNCH have contributed, and can further contribute, to HSS.

Disease and target-specific programmes mainly contributed to HSS in two ways:

Resource and opportunity creation for HSS:

Providing additional financial resources for HSS: Disease and target-specific programmes, through various GHI, provided new resources for HSS. As mentioned in section 2-3 above, GHI focusing mainly on infectious diseases, in particular GAVI, GFATM, HSFP and IHP+, have spearheaded global HSS support. For such resource mobilisation mechanisms supporting HSS to continue, it is essential to demonstrate how HSS enhances health by contributing to disease and target-specific programmes and other health interventions as highlighted in section 6 above.

Contributing to health HRD through regular programme training and additional training opportunities:

The disease and target-specific programmes, particularly infectious disease control, provide opportunities for annual training of new employees and refresher training for their own programmes. Furthermore, GAVI and GFATM create additional training opportunities through their HSS support in the subject countries, mainly targeting the community level.

Ensuring high service coverage with community penetration:

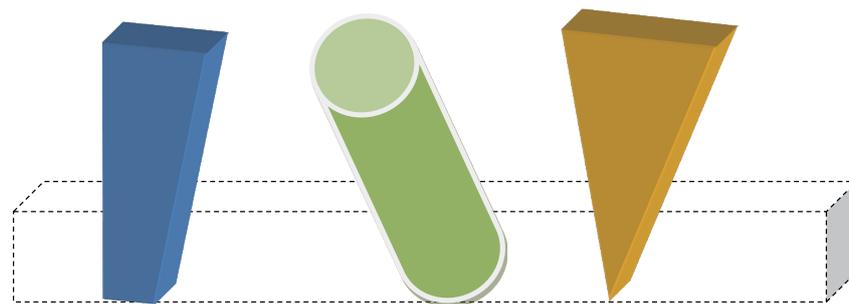
Spearheading community-based service delivery: In Lao PDR, EPI spearheaded community outreach in terms of penetration and expansion, with which MNCH is now collaborating. Thus, the disease and target-specific programmes can establish a bridgehead for more integrated, broad-based health services particularly in remote communities.

Facilitating collaboration between health systems and communities: In Viet Nam and Lao PDR, programmes such as malaria control and EPI demonstrated effective interface with community organizations such as Women's Unions, Youth Unions and the National Construction Front. Such solid collaboration constitutes a basis for universal and community-based service delivery.

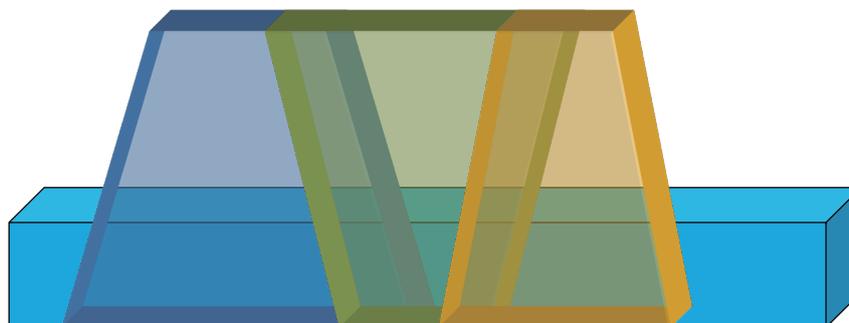
8. Analysis 3: Relation models between HSS and disease and target-specific programmes – How can both contribute to sustainable health systems?

Figure 2 depicts a relation model between HSS and the disease and target-specific programmes. The first figure shows a simplified model in which the disease and target-specific programmes stand on their own as dissociated sub-systems of the entire health system. In resource-limited settings, this model often represents a large part of reality partly because the disease and target-specific programmes are intended to provide services to communities where there is a lack of common health systems capacity. The lower figure shows an idealised model of how disease and target-specific programmes can be better coordinated and harmonised on a solid base of health systems.

Figure 2: Relation model between HSS and the disease and target-specific programmes



Disease and target-specific programmes as dissociated sub-systems



Disease and target-specific programmes integrated upon a solid health systems base

The above figures, particularly the lower one, illustrate the fact that the common health system base and the disease and target-specific programmes are inseparable. In fact, one is a part of the other and they are mutually dependent. Both of them are integral parts of a comprehensive health system.

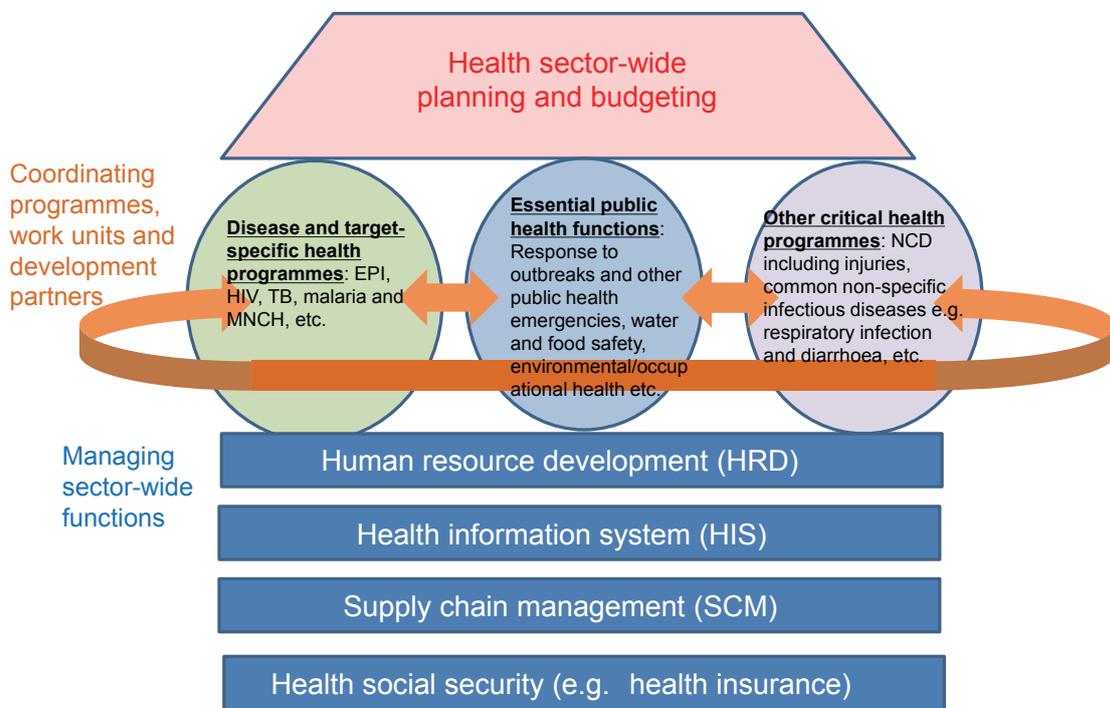
What do the empty base in the upper figure and the blue base in the lower figure represent in reality? They represent common institutions and functions of health systems. These common institutions and functions include sector-wide planning and budgeting, managing sector-common functions (i.e. HRD, HIS and SCM and health social security) and programme coordination and harmonisation. These were elaborated in Analysis 1 above in terms of how HSS has contributed, and can further contribute, to disease and target-specific programmes and other health interventions. The base also represents sector-common resources, including human, financial and material.

Though the disease and target-specific programmes (EPI, HIV/AIDS, TB, malaria and MNCH) provide the foundation of health service delivery in Cambodia, Lao PDR and Viet Nam, they do not represent all necessary health services. There are also essential public health functions, such as outbreak response, water and food safety and environmental/occupational health. Furthermore, diagnosis and treatment of common, but unspecific infectious diseases such as respiratory infections/pneumonia and diarrhoea, and prevention, diagnosis and treatment of common non-communicable diseases (NCDs) such as hypertension, diabetes and injuries are as essential as the existing disease and target-specific interventions. In Cambodia, Lao PDR and Viet Nam, particularly the former two, the control of NCD has not been well established.

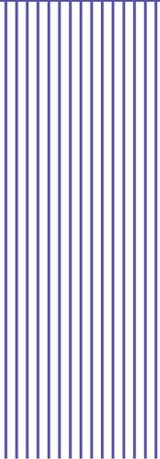
Figure 3 illustrates another relation model encompassing health sector-common functions and their relations to the existing disease and target-specific programmes, essential public health functions and other critical health programmes. Figure 3 shows that the sector-common functions fostered by HSS – namely streamlining sector planning and budget allocation, coordinating and harmonising different health programmes and players, and managing sector-common functions – support not only existing disease and target-specific health programmes, but also essential public health functions and other critical health programmes. Sector planning and budget allocations provide a general policy direction under which health programmes operate. Coordinating and harmonising different health programmes and players is expected to provide better service synergies and increased efficiency. The sector-common functions – including HRD, HIS, SCM and health social security – provide foundations on which health programmes can function properly.

Figure 3 shows a future ideal. In reality, the disease and target-specific programmes (plus some essential public health functions such as outbreak response) are standing firmly on their own, and other components are trying to catch up.

Figure 3: Relation model comprehending health sector-common functions and their relation with disease and target-specific initiatives, essential public health functions and other critical health programmes



- EPI Expanded Programme on Immunization
- HIV Human immunodeficiency virus
- TB Tuberculosis
- MNCH Maternal, neonatal and child health
- NCD Non-communicable diseases



9. Conclusions and the way forward

Following is the list of conclusions drawn from this research:

1. Over the past decades, the HSS concept has evolved and provided a common understanding that HSS is a lynchpin for the success and sustainability of different health programmes, particularly those implemented in resource-poor settings. Current global and regional strategies for EPI, HIV, TB, malaria and MNCH all include coordination with other programmes as well as harmonisation with HSS as their core component.
2. GAVI, GFATM, HSFP and IHP+ spearheaded global HSS support in the past decade.
3. Observing the six building blocks of health systems from the perspective of disease and target-specific programmes in Cambodia, Lao PDR and Viet Nam, the following notable findings were elaborated:

Health service delivery: Hard-to-reach populations and areas were generally prevalent in Lao PDR, whereas they were specifically defined in Viet Nam (e.g. migration sites). Good collaboration between public health systems and community organisations was observed in Viet Nam and Lao PDR. Lack of service integration still poses missed opportunities, particularly at the community level in Lao PDR.

Health workforce: Shortage of skilled health staff was a common system-wide barrier in all three countries. The human resources shortage was particularly exemplified with the introduction of new equipment, commodities and techniques. Disease and target-specific programmes provide annual training of new employees and refresher training opportunities. GAVI and GFATM created additional training opportunities through their HSS support.

Health information system: HIS integration often faces difficulties. Cambodia vigorously pursued an integrated HIS in the late 1990s but faced a major challenge in terms of national capacity to maintain it.

Medical products, vaccines and technologies: Procurement, supplies and logistics often pose a system-wide barrier to disease-specific programmes. The integration of SCM was adopted step-by-step in southern Lao PDR. Cambodia, on the other hand, vigorously pursued an integrated SCM in the late 1990s, but faced major challenges in terms of national capacity to maintain it.

Health system financing: A reverse pyramid budget allocation with disproportionately limited allocations to the community level caused a significant shortage of local operational costs. RBF is particularly common in Cambodia, but is also seen in Viet Nam. Although RBF contributed to the reallocation of budget to local levels, some negative impacts were also reported.

Leadership and governance: The importance of national political commitment in implementing health programmes was particularly highlighted in Viet Nam. Coordinating and harmonising different disease and target-specific programmes in terms of different external assistance was an important aspect of the leadership and governance function of health systems in the country.

4. HSS contributed, and can further contribute, to disease and target-specific health programmes in three main aspects:
 - a. Streamlining sector planning and budget allocation;
 - b. Coordinating and harmonising different programmes and players; and
 - c. Managing sector-common functions (i.e. health HRD, HIS, SCM and health social security).

Disease and target-specific programmes, conversely, contributed, and can further contribute, to HSS in two main aspects:

- a. Resource and opportunity creation for HSS; and
- b. Ensuring high service coverage with community penetration.

HSS and the disease and target-specific programmes are inseparable. In fact, one is a part of the other and they are interdependent. Both of them are integral parts of a comprehensive health system.

5. The assessments also identified the following three challenges to overcome for HSS to better contribute to the disease and target-specific programmes and other health interventions:
 - a. Lack of clear strategy and action tools for programme harmonisation;
 - b. Lack of national capacity to maintain coordinated HIS and SCM; and
 - c. Uncoordinated deployment of human, material and financial resources.

Considering the way forward towards better harmonisation between HSS and the disease and target-specific programmes, the following are areas where new and innovative efforts are needed:

1. **Aligning disease and target-specific programmes with sector-wide planning and other HSS aspects:** The disease and target-specific programmes need to make efforts to align themselves with the

sector-wide planning pursued in Lao PDR (SWC) and Cambodia (SWiM). The support schemes for programmes such as GFATM and GAVI at the country level also need to align their planning and reporting requirements to those of the recipient governments, trying to avoid as much as possible the demand for separate multi-year planning with or without costing and reporting. However, such harmonisation may take time and can only be attained in a step-by-step fashion.

- 2. Transferring service delivery models of the existing disease and target-specific programmes to other health programmes:** The service delivery models of the existing disease and target-specific programmes should be transferred to other health programmes that lack established structures and functions. These services include diagnosis and treatment of common, but unspecific infectious diseases such as respiratory infections/pneumonia and diarrhoea, as well as prevention, diagnosis and treatment of common NCDs such as hypertension, diabetes and injuries. ART for HIV and DOTS for TB, for example, may provide useful operational models for continuous follow-up and medication for the chronic NCDs (despite the need to mobilise relatively large financial resources to sustain the services). It is apparent that health systems are not solely aiming to sustain and strengthen the disease and target-specific programmes covered in this document (i.e. EPI, HIV, TB, malaria and MNCH), but also to strengthen other important health services that are not yet well established.
- 3. Appropriately positioning financing of disease and target-specific programmes and HSS in health financing reform towards UHC:** In the face of expanding non-out-of-pocket health financing schemes – such as social insurance, health equity funds and systematic payment exemptions in Cambodia, Lao PDR and Viet Nam – in an attempt to attain UHC, financing of the disease and target-specific programmes and HSS need to be appropriately positioned in the overall health financing design. The disease and target-specific programmes have mostly been centrally financed with no or limited user fees apart from clinical services for MNCH. Ear-marked external support, especially through GFATM and GAVI, have played important roles in financing these programmes. However, there is a trend to diversify fund sources for such programmes from ear-marked external supports and direct government budget allocation alone to other emerging financing mechanisms including health insurance. For example, Viet Nam is attempting to integrate HIV treatment into the health insurance benefit package.^{56, 57} Philippines included TB-DOTS in the benefit package of its National Health Insurance (PhilHealth).⁵⁸

56. Tran BX, et al. *Potential impacts of expanding social health insurance coverage for patients with HIV/AIDS in Vietnam* (oral presentation abstract in proceedings). Melbourne: 20th International AIDS Conference, 2014.

57. Abt Associates. *Sustainable Financing of HIV/AIDS services for PHLIV in Vietnam-the contribution of Social Health Insurance: A pilot model for Ninh Binh and Dong Thap Provinces*. Hanoi: Abt Associates-USAID/HPI Vietnam, 2013.

58. Romualdez AG. "TB-DOTS in the Philippines: impact of decentralization and health sector reform". Bull WHO 2007; 85(5): 399-400.

Although HSS directly contributes to UHC through service expansion and its sector financing function (building block 5), the financing of HSS itself through newly introduced non-out-of-pocket financing schemes is considered difficult. Revenues from and allocated budget for such schemes are usually ear-marked for the provision of clearly defined health service packages, whereas most of HSS costs are indirect costs and overhead, and hence need direct budget allocations. Therefore, the existing HSS financing through the disease-specific initiatives is considered to be a very rational choice and deserves to be continued with increased efficiency and effectiveness.

- 4. Long-term strengthening of the foundation of health systems need to be distinctly programmed and funded:** Though harmonisation between HSS and disease and target-specific health programmes is the key theme of this document, such harmonisation alone will not automatically ensure HSS in Cambodia, Lao PDR and Viet Nam. Disease and target-specific programmes can *support* health systems mainly through resource and opportunity creation and ensuring high service coverage with community penetration as described in Analysis 2 above. However, *strengthening* health systems requires more comprehensive improvement in fundamentals such as policies and regulation, as well as organization and incentive systems to optimise the behaviours of both clients and service providers to maximise outcomes.⁵⁹ *Strengthening* health systems, therefore, will not take place solely from the interface between HSS and disease and target-specific programmes, but rather demands designated policy and technical input into the very foundation of health systems and their sector-common functions. Aside from the *support* activities to improve health services, long-term *strengthening* of the foundation of health systems need to be distinctly programmed and funded.

NCGM has supported the development of nursing and midwifery legislation in Cambodia since 2010 and in Lao PDR since 2011 through JICA. These interventions are examples of health systems *strengthening* efforts to cater to health system-wide HRD at its foundation rather than programme-based health systems *support*. Programme-based HRD focuses more on human resources needs to ensure present service deliveries, whereas health system-wide HRD that NCGM supports focuses more on mid- to long-term institutional development. This discrepancy in focus sometimes poses problems.

For example, a category of midwives in Lao PDR developed in line with the former is facing a barrier in career development because they do not hold bachelor's degrees in nursing, which is required for their entry into master's degree programmes. This shortfall is hindering the formation of a critical

59. Chee G., et al. "Why differentiating between health system support and health system strengthening is needed". Int J Health Plann Mgmt 2013, 28: 85-94.

mass of midwives with master's degrees that is expected to form the faculty of midwifery education in Lao PDR. To fill such gaps between short-term programme demands and mid- to long-term health system requirements, disease and target-specific programmes need to share mid- to long-term health systems development perspectives.



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