

## Abstract

*In Vietnam, the transition towards a market-based economy has contributed greatly to poverty reduction, but there are also signs of rising inequalities. This article discusses the consequences of internal and external economic liberalization on children's right to health. It describes how the right of the child to adequate health care is fulfilled in Vietnam and analyzes challenges health policy-makers face during the transition. Policy options are recommended, including increased public expenditures on health, introduction of health insurance, development of culturally sensitive health care programs for ethnic minority children and women, and negotiation of conditions for World Trade Organization (WTO) accession that do not jeopardize Vietnam's successes in implementation of the Millenium Development Goals (MDGs).*

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*Au Vietnam, la transition vers une économie de marché a fortement contribué à la réduction de la pauvreté, mais on y note également des signes de l'apparition d'inégalités croissantes. Cet article traite de l'influence d'une libéralisation externe et interne de l'économie sur le droit de l'enfant à la santé. Il présente la manière selon laquelle les droits de l'enfant à des soins de santé adéquats sont satisfaits au Vietnam et analyse les obstacles rencontrés par les décideurs en matière de santé publique au cours de cette transition. Certains choix politiques sont recommandés par l'étude, notamment l'augmentation des dépenses publiques consacrées à la santé, l'instauration d'une assurance maladie, le développement de programmes de santé publique culturellement appropriés pour les enfants et les femmes faisant partie des minorités ethniques, et la négociation de conditions d'admission à l'Organisation mondiale du commerce (OMC) ne mettant pas en danger les succès obtenus par le Vietnam dans la mise en place des Objectifs du Millénaire pour le Développement (OMD).*

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*En Vietnam, la transición hacia una economía de mercado ha contribuido enormemente a la reducción de la pobreza, pero también existen señales de desigualdades en aumento. En este artículo se estudian las consecuencias de la liberalización económica tanto interna como externa, sobre los derechos de los niños a la salud. Se describe cómo en Vietnam se cumplen satisfactoriamente los derechos de los niños a una atención médica adecuada y se analizan los desafíos que encaran los dirigentes durante la transición. Se recomiendan opciones para tomar políticas, incluyendo el aumento del desembolso público en salud, la introducción de seguros para la salud, el desarrollo de programas para la atención médica que sean culturalmente integrales para niños y mujeres miembros de minorías étnicas y la negociación de condiciones para el acceso a la Organización Mundial del Comercio (WTO, siglas en inglés) que no arriesguen el éxito de Vietnam en la consolidación de las Metas de Desarrollo para el Milenio.*

## CHILDREN'S RIGHTS AND THE MDGs: The Right to Health Within Vietnam's Transition Towards a Market Economy

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**T**he study presented in this article aims to illustrate and analyze ambivalences in the fulfillment of the right to health in Vietnam. Vietnam is particularly interesting in this context because it has an outstanding record in poverty reduction and improvements in child health indicators that are impressive. Child mortality rates are at similar or even lower levels than countries with higher per capita income.<sup>1</sup> This improvement is most likely the result of successful economic policies that have raised household incomes as well as increased investment in basic social services over several decades.

Despite such achievements and strong political determination of the government to improve child rights, the country faces enormous challenges in realizing the right to health because of growing social disparities and the fragile nature of social achievements, including those in the health sector. A current epidemiological change in Vietnam is aggravating this situation. Injuries and accidents have become a leading cause of death and disability, and the health

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costs associated with injuries as well as the loss of family income due to the inability of a breadwinner to go to work can lead to a catastrophic situation for poor households.<sup>2</sup> This situation creates a threat to the right to health. As a United Nations study pointed out, "The current health financing system in Vietnam has led to increasingly inequitable access to health care and to health inequalities."<sup>3</sup> These trends particularly affect access to quality health care for ethnic minority children.

Against that background, this article describes fulfillment of the right of the child to health, and to health care in particular, as laid out in the Convention on the Rights of the Child (CRC) and related Millenium Development Goals (MDGs) with a particular emphasis on social disparities. It describes the overall social progress in Vietnam, including key child health indicators. It analyzes internal and external liberalization trends and their impact on the right to health of Vietnamese children. Finally, the article examines policy options to realize the right to health under conditions of extremely fast social change and transition towards a market economy.

## **The Right of the Child to Health**

Every human being needs to be healthy to thrive and develop his or her human capabilities to their fullest potential. This is why health is regarded as a universal human right. The right to health is part of the Universal Declaration of Human Rights (UDHR), the International Covenant on Social, Economic and Cultural Rights (ICSECR), the CRC, and the Millennium Declaration. It is based on a broad understanding of health as a state of physical, mental, and social well-being and not merely as the absence of disease. According to the CRC, the right to health is the right of the child "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."<sup>4</sup>

The right to health encompasses specific policies and programs to reduce infant and child mortality, child morbidity, and malnutrition. Access to family planning serv-

ices, to prenatal and postnatal care, as well as access to drinking water and sanitation, are defined as part of this right.<sup>5</sup> In recent years, additional emphasis has been put on health issues not explicitly covered by the CRC such as adolescent health and mental health. Injury and HIV/AIDS prevention have also become important areas of discussions related to the right to health.<sup>6</sup>

Originally, the child's right to health as part of the CRC was strongly supported by socialist countries. For example, during deliberations that led to the CRC in the 1980s, the Soviet Union and the German Democratic Republic emphasized that the right to health should be provided "free of charge."<sup>7</sup> This legacy remains in political support for the fulfillment of this right in "transition countries" like Vietnam. However, given the relatively high costs of good health care, the right to health has not yet been defined internationally as a right to cost-free access to health care.

In order to assess progress in the fulfillment of human rights, rights need to be translated into specific measurable policy goals for states. Human rights set a standard, and development goals define milestones by which these standards are to be attained. The right to health translates into goals for poverty reduction as well as for the reduction of mortality and morbidity. The following are two examples:

- Millennium Development Goal (MDG) 1 aims at the eradication of extreme poverty and requires that the proportion of people whose income is less than one dollar a day should be reduced by half by 2015 in comparison to 1990. The same reduction should happen for the proportion of people who suffer from hunger and malnutrition.
- According to MDG 4, child mortality should be reduced by two-thirds.<sup>8</sup>

The advantage of such goals is that they define specific benchmarks against which states can be held accountable. At the same time, such quantitative goals bear the risk of a very narrow approach to the right to health — a risk that is particularly high in the health sector, where technical solutions to health problems of children, such as immunization campaigns, often dominate the discussions. The UN High Commissioner for Human Rights highlighted

these risks: "... it is essential to examine the MDGs from the human rights perspective and to acknowledge that they may be too narrow, leaving out important issues and being limited by numeric indicators that purport to assess the achievement of greater dignity and quality of life."<sup>9</sup>

Technical approaches are fundamental to the practical realization of the right to health. Merely technocratic and interventionist approaches, however, usually focus almost exclusively on top-down service delivery by states and tend to ignore broader questions related to the empowerment and participation of clients or patients; for example the right of children to be fully informed about health-related interventions, the possibility of medical treatment of adolescents without parental consent, and confidentiality of medical information or health-related legal protection measures such as minimum ages for marriage and sexual consent.<sup>10</sup> In other words, a rights-based perspective towards health embraces issues that go far beyond the formulation of quantitative goals such as MDG 1 or 4. Generally speaking, a rights-based approach to health calls for due weight being given to the process through which goals have been achieved.<sup>11</sup> This brings questions to the forefront such as: 1) was a certain health goal achieved through participatory processes? and 2) are health policies based on legal frameworks that strengthen service-receivers and clearly spell out the obligation and accountability of the state?

A rights-based perspective to child health also sharpens policy debates concerning the state's obligation to create a safe and supportive environment for children and adolescents.<sup>12</sup> It steers health-related debates towards the analysis of public health budgets and universal systems of health insurance versus fee-based provision of health care and community participation in service delivery. The fact that the right to health care is not a right to cost-free services creates an ambivalent situation for policy-makers. On the one hand, they may not be able to ensure access to health care for all children within the limits of their budgets. On the other hand, they may try to overcome the shortage of funds through the introduction of user fees and private service providers, thereby enhancing a trend towards a two-tier system of health care. This causes increasing disparities in

access to social services with detrimental consequences for the health of children.

Another important aspect in the debate about fulfillment of the right to health is that quantitative goals can be achieved despite the persistence of strong disparities.<sup>13</sup> A rights-based approach to child and adolescent health emphasizes equity and non-discriminatory fulfillment of the right to health and calls for a disaggregated analysis of data.<sup>14</sup> From a human rights perspective particularly, the implementation of the MDGs without “discrimination” is a key challenge. The human rights principle of non-discrimination requires states to adopt special social protection policies and programs for vulnerable population groups. Special attention needs to be given to children who are economically marginalized, belong to groups that are socially discriminated against, or are otherwise excluded from full realization of their rights. The obligation of states to undertake special efforts to support and protect vulnerable groups from further impoverishment and marginalization is a fundamental concern for the fulfillment of human rights.<sup>15</sup>

### **Transition Towards the Market Economy and Social Rights of Children**

Thirty years ago, the war in Vietnam ended and left the country devastated. The Vietnamese people suffered hunger, and the economy was in a state of constant crisis. In 1986, after a decade of fierce efforts towards reconstruction and rehabilitation, Vietnam began a reform process called *Doi moi*, which aimed to establish a market economy in the centrally planned socialist economy. Consequently, the agricultural sector as well as other economic sectors were deregulated, rural state cooperatives were dismantled, farmers were allowed to decide what crops to grow, and prices were liberalized. Vietnam’s success in early liberalization was based on a policy of gradualism and selective liberalization, where certain tariffs and subsidies were maintained in a way that enabled growth in the domestic economy and through exports.<sup>16</sup> Since the early 1990s, these measures have resulted in unprecedented yearly economic growth rates of between six and nine percent, which boosted Vietnam’s integration into the world economy and con-

tributed to the genesis of a significant private business sector. In only a few years, Vietnam became the world's second largest exporter of rice and coffee and became an important supplier for other agricultural and seafood products.<sup>17</sup>

Parallel to this impressive economic success, poverty rates were halved and the overall living conditions of the population significantly improved.<sup>18</sup> Vietnam's human development index increased constantly between 1995 and 2003. Life expectancy reached 69 years and is comparable to countries with a per capita income three to four times higher. Likewise, the survival and development conditions for Vietnamese children improved radically: under-five mortality rates and malnutrition rates fell sharply and primary education became accessible for almost all Vietnamese children.<sup>19</sup> In other words, Vietnam has achieved most of the MDGs well ahead of time.

### **Rising Disparities**

These strong economic and social improvements were accompanied by a relatively mild increase in income disparities. The income-related Gini coefficient of Vietnam did not change much over the years, and remained at a relatively equitable level of 0.4.<sup>20</sup> At the same time, social disparities and gaps in access to basic social services widened, especially between ethnic groups.<sup>21</sup>

Vietnam has a population of around 80 million inhabitants, out of which 13% belong to one of 53 ethnic minority groups. Although most ethnic minorities in Vietnam have improved their living conditions over the past years in absolute terms, poverty rates among the Chinese minority and the Kinh (Vietnam's ethnic majority) fell faster and stronger than for most ethnic minorities.<sup>22</sup> Therefore, the overall proportion of ethnic minorities among the poor in Vietnam is 36% — disproportionately high.<sup>23</sup> Ethnic minorities in the Central Highlands, a region which was hard hit by falling world market prices for coffee, have become even poorer in recent years.<sup>24</sup> Consequently, the United Nations has underscored the need to provide special support to ethnic minorities to protect their rights, including their right to health care.<sup>25</sup>

The Committee on the Rights of the Child has raised

similar concerns in its latest *Concluding Observations on Vietnam*: "The Committee acknowledges that, while the transition to a market economy has increased economic growth, it has also had a negative impact on the implementation of economic, social, and cultural rights of children, for instance by increasing the financial burden on households for health and education services." The Committee expressed concerns about "the lower level of development indicators for ethnic minorities (which) appears to indicate the existence of some level of societal and institutional discrimination specifically in their access to health and education."<sup>26</sup>

Indeed, basic health indicators for many ethnic minorities remain lower than those of children from the Chinese and Kinh. Child mortality rates are higher than the average, and children from very poor ethnic families suffer from different diseases caused by hunger and malnutrition. The diet of many ethnic minority households is poor and unbalanced, and worsens during the lean season when caloric intake can fall to less than 20% of the required minimum.<sup>27</sup> Malnutrition, especially among children under five years, is much higher than the national average and 46% have stunted growth.<sup>28</sup> Given possible under-reporting of child deaths in rural and mountainous areas, disparities may be even higher than these figures suggest.<sup>29</sup>

### **International and Internal Liberalization in the Health Sector**

The impressive achievements of the Vietnamese health sector in the past years as well as the worrisome health disparities among the child population must be understood against the background of the liberalization of the health sector. Before 1986, the government had started highly effective national programs of immunization and diarrhea control and had built a strong primary health care system down to the commune level.<sup>30</sup> In the mid-1980s, the government began to liberalize the health sector through the legalization of private health services, the establishment of a private pharmaceutical industry, and the introduction of user fees.<sup>31</sup> The liberalization of the health sector was intended to compensate for the government's chronic under-



funding of the health sector as well as to improve the quality of education and health services through financial incentives for customer-friendly service provision. Data on hospitals reveal the profound impact of this transition: revenues from user fees and health insurance accounted for only 10% of hospital budgets in 1991 — seven years later, external income made up more than 50% of the budget for central, provincial, and district hospitals.<sup>32</sup> According to the Ministry of Health, in 2001 there were more than 56,000 private health providers operating in Vietnam, mainly medical doctors (48%), followed by pharmacists (32%) and traditional medicine practitioners (17%).<sup>33</sup>

This policy was further boosted in 2002 by Government Decree No. 10, which allows public entities to raise revenues through user fees and to manage their incomes and expenditures more autonomously. The Decree is an instrument to move further away from centrally controlled budgets and give local staff more decision-making power over financial and human resources. This move was part of a broader state policy — called social mobilization — towards fee-based social services. State forecasts of financing requirements for social sectors until 2010 expect up to 15% of necessary resources to be raised from citizens through user fees and charity.<sup>34</sup>

The consequence of this private/public health care mix is that so-called out-of-pocket expenditures for health care became “by far the most important source of financing in Vietnam.”<sup>35</sup> Since only 13.5% of the Vietnamese population is covered by health insurance, the current structure of health care financing severely restricts the possibilities of poor families to access health care services of good quality. Data show that a single service contact of a person from the poorest quintile of the population costs more than 20% of the non-food consumption expenditure of the household; if the patient requires admission to a provincial hospital, the cost rises to 44% of the non-food budget of a poor household. In addition to formal user charges, informal payments to improve speed and quality of health care have become common. Such informal contributions can make up 36% of total hospital fees and have turned into an important income source for doctors and other health care staff. It should be noted also that some doctors recommend patients to

their (private) after-hour services for which, in some cases, they use public health care facilities.<sup>36</sup>

The World Bank pointed out that “Waivers and ceilings were introduced to protect the poor from user fees, but they have not led to the desired results in terms of free access to curative health care.” Furthermore, “There is evidence that many Vietnamese, and especially the poor, have dramatically switched away from professional health care to cheaper providers, such as drug vendors and traditional healers.”<sup>37</sup>

According to World Bank estimates, out-of-pocket spending for medical care has contributed significantly to poverty — approximately 2.6 million Vietnamese lived in extreme poverty in 1998, reportedly because of the health expenditures they had to incur.<sup>38</sup>

Other negative impacts of health sector liberalization and Decree No. 10 have been over-prescription of services to increase revenues for hospitals and priority treatment for high-income patients with small health problems over patients that require longer treatment and therapy but have lower incomes. “It is known that for-profit hospitals often admit patients who are relatively easy and profitable to treat and refer those patients with chronic and serious conditions to other hospitals, normally higher-level public hospitals. Consequently, the very sick and poor are often denied access. Anecdotal evidence from hospitals that have already implemented Decree No. 10 suggests an increase in the referral rate after the implementation of the decree.”<sup>39</sup>

Preliminary conclusions from existing research about the impact of user fees and health sector privatization indicate that these policies probably increased coverage and quality of health services for a part of the population in Vietnam but were detrimental to the poor. The introduction of user fees could have alleviated pressure on public health budgets and thus led to intensified investment in health care for the poorest parts of the population. Seemingly, however, this has not happened. Overall public investment in health care is one of the lowest in the world. The state spends less than US\$4 per capita (less than 1% of the gross national product in 2001) on health care for its citizens, and private households have to cover 80% of total health costs out of their own pockets.<sup>40</sup>

From a child rights perspective, existing evidence points

to the urgent need to revise this policy and to introduce better compensatory measures that will enable poor children to enjoy the same standard of health care as the majority of Vietnamese. At the same time, the body of research on the social impacts of this policy is still meager, and a comprehensive empirical study of the positive and negative results for children is not available. Therefore, a child impact assessment of Decree No. 10 is an urgent priority.

### **WTO Accession**

Parallel to the process of internal liberalization of the health sector, Vietnam is intensifying its integration into the global economy, mainly through accession to the World Trade Organization (WTO), which it hopes to achieve by the end of 2006. Most likely, WTO accession will further accelerate liberalization of Vietnam's health sector and negatively affect the right of poor children to health care.

For example, under the Trade-Related Aspects of Intellectual Property Rights treaty of WTO (TRIPS), cheap generic drugs could be partly or totally substituted by more expensive branded drugs.<sup>41</sup> While Article 8 of TRIPS allows WTO members to "adopt measures necessary to protect public health and nutrition and to promote the public interest in sectors of vital importance to their socio-economic and technological development," and WTO has lifted restrictions on production of generics for export in 2003, there remains the possibility that WTO members will request Vietnam to comply with so-called TRIPS-plus provisions.<sup>42</sup> Such provisions could restrict the use of clinical trial data for five years by third parties, which could make it difficult for producers of generics to get approval for their drugs.<sup>43</sup> This would *de facto* stop the supply of low-cost generics in Vietnam for years and could directly affect children's right to health. Vietnamese households spend most of their health-related money on drugs. According to recent living standard surveys, drugs accounted for 69% of health expenditure for a single outpatient contact.<sup>44</sup> Children are very vulnerable to illness; therefore, their well-being is strongly dependent on access to affordable medicines. Hence, they will suffer the most from a reduced supply of cheap generic drugs.

Vietnam has confirmed that it will fully comply with

TRIPS.<sup>45</sup> However, the possible impact of TRIPS on generics in Vietnam has neither been researched nor widely discussed, and related comments from the government have been very cautious.<sup>46</sup> Given the potential threat of TRIPS to the access of poor children to affordable pharmaceuticals, it is imperative to assess the situation and prevent negative impacts on the right to health of poor children and families. With respect to the drugs necessary for HIV/AIDS treatment, all 22 anti-retroviral (ARV) drugs available for such treatment in Vietnam are patented or subject to patent.<sup>47</sup> Hence, "the fact that there are a significant number of patents and patent applications for HIV/AIDS drugs is limiting the possibilities for making use of low-priced generic versions of several important ARVs."<sup>48</sup> This issue came up during initial discussions between UNICEF and the Ministry of Health about the import of ARVs for the treatment of HIV/AIDS patients where UNICEF had to inform the government, "This means that UNICEF cannot supply generics, unless the Government invokes a clause in the TRIPS agreement/Doha Declaration to enable the country to legally import generic ARVs."<sup>49</sup>

Other examples of the impact of WTO accession on the right to health are in areas such as iodization of salt and promotion of breast-feeding. Salt is universally iodized in Vietnam, and this is an important public health achievement. Consumption of iodized salt protects children against goiters and mental retardation. Currently, iodization of salt is subsidized by the state. This has helped to protect millions of children from such diseases. Under the WTO, the state might have to stop subsidizing salt. In addition, non-subsidized salt from other countries will most likely enter the Vietnamese market. Since this salt may be cheaper than iodized salt, many poor families might switch to consumption of non-iodized salt with almost certain negative health impacts on babies and small children. Another example is the case of breast-feeding. Breast-feeding is promoted and protected through restrictions on the marketing of breast milk substitutes. However, WTO accession increases pressure to eliminate such regulations and restrictions and could lead to less breast-feeding, which would also negatively impact the health of babies and children.<sup>50</sup>

These examples illustrate some underlying key ques-

tions related to WTO accession from a child rights perspective. Will Vietnam be able to negotiate smooth accession that allows the country to protect children living in poor households from the negative impacts of market liberalization? Will Vietnam be pushed by WTO members towards a more abrupt and radical opening-up of its economy—with the subsequent risk of further deterioration of the living conditions of poor children? And, will Vietnam revise its current legislation and policies in time to mitigate any detrimental effects of WTO accession on the health of Vietnamese children?<sup>51</sup>

There are no clear answers to these questions. Despite widespread hopes and worries related to WTO accession, the evidence base for an assessment of potential positive and negative impacts of further economic liberalization through WTO agreements is limited. Beyond general conclusions, there is only random and scattered empirical data to assess WTO's potential impact on children. Hence, predictions on its impact on the right to health are mostly speculative. Research on the relationship between transitions towards market economy and rising inequalities suggests that future economic liberalization in Vietnam—while probably beneficial to the majority of the population—negatively impacts the human rights of very poor children and particularly children of ethnic minorities.<sup>52</sup> As in the case of Decree No. 10, it is urgent to assess the impact of WTO accession on children with particular emphasis on the right to health of poor children.

## **Policy Options**

The studies reviewed for this article have shown that the first decades of transition towards a market economy have been highly beneficial for the majority of Vietnamese children and their families. This pattern of pro-poor growth cannot be taken for granted in the coming years. The next decade of liberalization in Vietnam will be characterized by stronger internal and external liberalization that is risky for the poor and may contribute to further social disparities. As mentioned, there is only limited research to assess possible social impacts of increasing the speed of liberalization. Nevertheless, even without such a body of research, it is possible to state that a private/public mix in health care need not have a negative im-

pact on the poor; nor does trade liberalization necessarily lead to increased marginalization and worsened health conditions. The state, however, must create a social policy environment in which a public/private mix minimizes disparities and ensures access of poor children to social services of good quality.

### ***Budget Allocations for Health Care***

The previous analysis of the impact of user fees and a private/public mix in provision of social services has pointed to the need to increase and reallocate public expenditures for health care towards the poorest children. Vietnam has recognized this shortfall, and in 2005 the National Assembly approved a health budget of approximately US\$803 million, an increase of nearly 17%. Furthermore, the Parliament decided to increase state spending for the health sector to 10%-12% before the year 2010 as proposed by the Ministry of Health.<sup>53</sup>

### ***Health Insurance***

In addition to increasing the state budget for public health, the government is introducing a number of compensatory measures to address the marked inequalities in the health sector and thereby ensure the right to health for the whole population. In the long run, the establishment of a national health insurance program is a priority. Currently, health insurance reaches only 9% of the poorest quintile of the population.<sup>54</sup> The government is experimenting with different models, but it also is struggling to find viable mechanisms to implement them.

To improve health insurance coverage for the poor, the government introduced the Health Care Fund for the Poor in 2002. As a result, nearly 4 million people received health insurance cards with another 4.5 million receiving exemption cards.<sup>55</sup> However, this fund has not had its intended effect. Poor provinces, in particular those that should cover about 20% of the fund from their budgets, have found it difficult to finance, and overall reimbursement rates have been low. Such experiences indicate that a key requirement for the successful implementation of such programs is allocation of national funds rather than reliance on sub-national funding sources.

The decision to ensure free access to health care for children under six years is another important policy measure.

This policy is a consequence of the revised Law on Care, Protection, and Education for Children (2004), which states “Children under six years are entitled to primary health care and free medical examination and treatment at public medical establishments.”<sup>56</sup> According to a recent assessment by the Ministry of Health and UNICEF, hospitals provide only a small amount of free services to children under six years.<sup>57</sup> The value of these services is currently less than 5% of overall hospital budgets and covers almost exclusively medical consultation. Fees for diagnostics and analysis, therapy, and drugs need to be paid by the patients. If all health care services were cost-free for children under six, then current budget allocations would only be sufficient to cover two months of services. Given the huge budget implications, several proposals for providing free health care for children have been discussed.

In the end, the government has decided to issue health cards to all new babies, resulting in coverage for about 1.5 million babies each year. To obtain a health card, parents or legal guardians have to show the child’s birth certificate. If the child does not have a birth certificate, his/her parents or legal guardians must register the child immediately at the commune’s committee for the card. With health cards, they can enjoy free health care services at public health care centers.<sup>58</sup>

### ***Compensatory Poverty Reduction Programs***

National targeted programs for poverty reduction are another important public policy instrument to provide social protection for the poor.<sup>59</sup> In Vietnam, the reform and implementation of a national program called the Hunger Eradication, Poverty Reduction and Job Creation Program (HEPR) merits special attention because large sums from this program are invested in social services, including health care for the poor.

HEPR is one of the biggest public poverty alleviation programs in the developing world. It was initiated in 1998 in combination with a targeted program for the poorest 1,000 communes in Vietnam — most of them inhabited by ethnic minorities. Between 2001 and 2005, nearly US\$800 million was invested to alleviate poverty. A joint evaluation by the Vietnamese government and the United Nations Development Program (UNDP) showed that — although overall cov-

erage of poor families was limited — extremely poor families were being reached fairly well.<sup>60</sup> Based on the positive experiences of the first five years, the government has decided to continue HEPR until the year 2010 and to increase its budget nearly three-fold to US\$2.2 billion.<sup>61</sup>

### ***Ethnic Minority Policies and Programs***

Children from ethnic minorities are the most likely to be denied the right to health in Vietnam. Therefore, specific policies and programs are needed to protect their rights in the process of economic transition and beyond. Vietnam has ratified the Convention on the Rights of the Child. This ratification obligates the state to design specific programs and policies, as pointed out to the Vietnamese government on several occasions by the Committee on the Rights of the Child.<sup>62</sup> The design of culturally appropriate programs for ethnic minorities will not only determine the ability of the public health system to reach ethnic minority children but will also improve their survival and development. Such programs will also support non-discriminatory implementation of the MDGs.

Significant efforts have been undertaken by Vietnam to improve the living conditions of ethnic minorities. A study by the Committee for Ethnic Minorities (CEM) and UNICEF on the impact of health care policies and programs in ethnic minority communes found good coverage of immunization campaigns.<sup>63</sup> At the same time, many programs face challenges. For example, reproductive health programs are insufficient, and ethnic minorities make limited use of available public health facilities. The latter seems to be connected to local cultural practices and beliefs that limit the demands of these families for formal health care services. Also, many services and related information about them were not made available in local languages; hence, people did not know about them. Such findings indicate that reaching ethnic minority children with basic social services is not just a matter of the physical availability of services. Their use also depends on whether such services are designed taking local language and customs into account.<sup>64</sup>

Therefore, the most important question is whether HEPR, Program 135, and other programs for ethnic minorities will be designed in culturally sensitive and participatory



ways or whether assistance to ethnic minorities will follow a vertical, “one size fits all” assimilatory approach. Culturally sensitive strategic approaches do not yet appear to be on the horizon of Vietnam’s development planners. Despite the visible willingness of the government to invest in remote areas and to support the social development of ethnic children and families, current strategies concentrate on increased infrastructure investment and do not take sufficiently into account the specific cultural characteristics of different ethnic groups. This became obvious during the design process of Program 135 (2006-2010), which is the most important national program for ethnic minorities. It includes only limited investments in basic social services for ethnic minorities—around 4% of the total draft budget of US\$808 million.<sup>65</sup> The overwhelming majority of funds will still be devoted to infrastructure investments. The plans for basic social services do mention occasionally that cultural factors should be taken into account for the delivery of these services. For example, health care services should “provide incentives to encourage engagement of traditional doctors in public health care, especially by using traditional herbs.” But such culture-specific factors are mentioned only exceptionally and do not form part of a strategic approach to reach children and families from ethnic minorities more effectively.<sup>66</sup>

Such developments and experiences illustrate that it will take more time, advocacy, and technical assistance to reform the policies for ethnic minorities in Vietnam. To reach ethnic minorities with culturally appropriate services of good quality is a big challenge. According to UNICEF’s experience, effective strategies to meet this challenge include the following:

1. In health—to study and assess local health practices; train ethnic persons as health workers to work with traditional healers and birth attendants; and improve access to quality health services in distant and remote locations.
2. In gaining access to free health care—to take steps to overcome obstacles to birth registration.
3. In education—to develop pre-school education programs; offer bilingual education with strong emphasis on teaching in the local language, especially during the

first few years of schooling when children are not fully fluent in the majority language.

4. In participation—to empower ethnic minority children to participate in community, national, and international discussions.<sup>67</sup>

### ***International Co-responsibilities: WTO Negotiation***

As described above, the process of liberalization of Vietnam's health sector will receive an additional push through accession to WTO. The nature and impact of this push on the right of the child to health will depend on the final conditions for Vietnam's accession.

Vietnam has asked the WTO to consider it as a Least Developed Country (LDC) with a per capita income around US\$400 and thus to be allowed an extended transition period.<sup>68</sup> Theoretically, WTO allows for such considerations. The overall goal of WTO is "to improve the welfare of the people of the member states," which is a perspective that extends beyond trade and economics. In addition, WTO member states have discussed and in principle acknowledged the need to consider the fragile economic situation of the poorest countries within the process of WTO accession. This helps establish a conceptual link between international trade and social and human development, and from there towards fulfillment of human rights. However, this is legally not robust, since one also has to recognize that WTO provisions for non-economic considerations are meant to be exceptions with extremely limited scope, subject to very restrictive interpretation.

The practical question is whether Vietnam will be able to negotiate terms for its accession to WTO that will not jeopardize its aim to maintain equitable and sustainable development. A study by Oxfam described in detail the recent negotiation process.<sup>69</sup> For example, the US, Australia, and New Zealand asked Vietnam to further reduce its farm subsidies, which are mostly directed to small and poor farmer families in remote areas. The same nations that propagate fulfillment of the Millennium Development Goals by 2015 and related poverty reduction strategies seem to pursue a tough position when it comes to trade and economics—such positions do not help create favorable conditions for countries like Vietnam to develop in an equitable way. A more coherent

approach towards development and trade policies of WTO member states would be desirable, such as agreed by all states in MDG 8: “Develop further an open, rule-based, predictable, non-discriminatory trading and financial system including a commitment to good governance, development, and poverty reduction — both nationally and internationally.”<sup>70</sup>

### Some Conclusions and Recommendations

The combined impact of internal liberalization and WTO accession on the Vietnamese health sector is difficult to predict and may be different for various groups at different development stages of society. However, the data and literature on the implementation of MDGs and the fulfillment of the right of the child to health care suggest that the poorest and most marginalized groups in society benefit least from the liberalization of health care and are at the highest risk of suffering further deterioration of their living conditions and health status.

Vietnam and its international development partners should pay full attention to these factors and social risks and provide appropriate legal and social policy measures to protect children from possible adverse impacts of liberalization on their health and nutrition. The following policy measures are recommended:

1. **Health Budget:** significantly increase the public health budget to ensure free health care for children under six years old.
2. **Social Safety Nets:** rapidly introduce social safety nets, including health insurance programs, reform and expansion of the National Targeted Program for Hunger Eradication, Poverty Reduction and Job Creation with improved transparency and financial management and wider opportunities for participation of beneficiaries with results-based monitoring mechanisms.
3. **Ethnic Minority Policies:** provide diversified health services of good quality for poor ethnic minority children and families that are developed in a participatory way. These should include, for example, culturally appropriate reproductive health care services for ethnic minority women and access to information in their local language.

4. **Impact Research on Children:** undertake an empirical assessment of the impact of user fees (Decree No. 10) on the ability of poor children to access health care services and conduct a child impact assessment of WTO accession with particular focus on the health sector.
5. **WTO Negotiation:** WTO member states should support Vietnam's accession to WTO in the spirit of MDG 8. Given the extraordinary achievements of Vietnam in child survival and development, WTO member states should allow sufficient time and appropriate conditions to enable the government of Vietnam to minimize the risks of trade liberalization on the needs and rights of poor children. In this context, it is urgent to develop a social impact assessment of WTO accession with particular emphasis on the health sector. This is necessary to stimulate discussions and decisions to mitigate the negative impacts of health policies and introduce social safety nets in Vietnam.

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4. Convention on the Rights of the Child, G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 (1989), Article 24.1.
5. Ibid.
6. Committee on the Rights of the Child, General Comment No. 4,

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20. However, one has to take into account that the Gini-coefficient is calculated from successive rounds of Vietnam Living Standards Surveys. These surveys have been quite useful for calculating the poverty line, but less useful for the Gini, since they tend to exclude the very rich and the very poor (namely no registered migrants, people living in substandard housing, and people living in institutional housing including worker dormitories). Hence, it would be very surprising if these surveys did pick up much change in the Gini.

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24. World Bank, *Vietnam Development Report 2004 for Consultative Group Meeting* (Hanoi: World Bank, December 2003).
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Children under 6 (June 10, 2005).

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62. The Convention on the Rights of the Child stipulates that states in which ethnic, religious, or linguistic minorities live should fulfill the right of the child “to enjoy his or her own culture, to profess and practice his or her own religion, or to use his or her own language” (CRC, Article 30). All children should be educated in a spirit of respect and “friendship among all people, ethnic, national, and religious groups and persons of indigenous origin” (CRC, Article 29).

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