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Health Sector Co-operation between Viet Nam and Sweden

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ĐỔI MỚI AND HEALTH

Evaluation of the Health Sector Co-operation Programme between Viet Nam and Sweden

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SIDA

Viet Nam


Thanh Hoa
Mekong
Hainan
bukten
VIENTIANE
Vinh
THAILAND
LAOS
Syd-
Hue
Da Nang
VIETNAM
kinesiska
Kontum
Pleiku
Qui Nhon
KAMPUCHEA
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Nha Trang
Da Lat
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PHNOM PENH
Ho Chi Minh-
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◇ biståndsprojektet Vinh Phu
väg
järnväg
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Contents

Acronyms

ARI	Acute Respiratory Infections
CDD	Control of Diarrhoeal Diseases
CFP	Central Fund Project
CHRH	Centre of Human Resources for Health
CHS	Commune Health Station
CHW	Commune Health Worker
CIDSE	Cooperation Internationale pour le Developpement et Solidarité
CLIP	Central Level Integration Project
CMTW	Central Medical Technical Workshop
CPC	Commune Peoples Committee
CPM	Centre for Preventive Medicine
CPV	Communist Party of Viet Nam
DAC	Development Assistance Committee of OECD
DCO	Development Co-operation Office, Swedish Embassy
DH	District Hospital
DHB	District Health Bureau
DHC	District Health Centre
DPC	District Peoples Committee
EPI	Expanded Programme of Immunisation
FAO	Food and Agriculture Organisation
FP	Family Planning
GDP	Gross Domestic Product
GMP	Good Manufacturing Practices
GTD	General Technical Department
H&A	Housing and Administration
ILO	International Labour Organisation
IMF	International Monetary Fund
IPCH	Institute for the Protection of Child Health
ISRMP	Institute for Scientific Research on Markets and Prices
IUD	Intra-Uterine Device
LTA	Long-Term Adviser
MCH	Mother and Child Health
MEP	Medical Equipment Project
MIF2	Medical Instrument Factory No. 2
MOFI	Ministry of Finance
MOH	Ministry of Health

MSEK	Million SEK
MTD	Medical Technical Department
MUSD	Million USD
MVDN	Million VDN
NGO	Non-Governmental Organisation
OCOM	Office of the Council of Ministers
OECD	Organisation for Economic Co-operation and Development
PC	Peoples Committee
PH	Provincial Hospital
PHB	Provincial Health Bureau
PHC I	Quang Ninh Primary Health Care Project
PHC II:1	Vinh Phu Primary Health Care Project
PHC II:2	Ha Tuyen Primary Health Care Project
PHC	Primary Health Care
POD	Provision of Drugs Project
RDF	Revolving Drugs Fund
SAREC	Swedish Agency for Research Co-operation with Developing Countries
SEK	Swedish Kronor
SIDA	Swedish International Development Authority
SMS	Secondary Medical School
SMTW	Southern Medical Technical Workshop
SPC	State Planning Committee
STA	Short-Term Adviser
TOR	Terms of Reference
TSSP	Training System Support Project
UBGH	Uong Bi General Hospital
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Childrens Fund
USD	US Dollars
VDN	Vietnamese Dong
WHO	World Health Organisation

Preface

On behalf of the Evaluation Team for the Viet Nam-Sweden Health Co-operation Programme 1986-1992, I would like to express our gratitude to all those people who made the study possible. The Ministry of Health, health people on provincial, district and commune levels, project staff, advisers, SIDA staff, InDevelop staff, as well as many others, have all contributed to the study in many different ways. Special thanks are also extended to the Resource Persons for their efforts to assist the Team.

The communication process between the Evaluation Team and the Ministry of Health, SIDA and the advisers, which was initiated by the study, has been rewarding for us. Our only fear is that we have not been able to render justice to all the comments forwarded to us.

The Evaluation Team has worked independently of the Ministry of Health and SIDA. Our conclusions and recommendations may be accepted or rejected by them.

In spite of the co-operation with all the above-mentioned persons, the Team remains solely responsible for the report. The last editing of the final report has been made by the Team Leader.

Stockholm August 28, 1992

Jan Valdelin

Executive summary

This report on an evaluation of the Viet Nam - Sweden Health Co-operation Programme 1986-1992 is presented by an independent evaluation team. The team members are Mrs. E. Michanek, evaluation analyst, Mr. H. Persson, pharmaceutical expert, Dr. Tran Thi Quê', economist, Mr. B. Simonsson, public health expert and Dr. J. Valdelin, evaluation economist. The study was carried out between March and August 1992. Independent Vietnamese experts were consulted as resource persons. They are Mr. Phan Quang Tue, management, Dr. Vu Manh Thien, health, Dr. Vu Tuan Anh, economics, and Mr. Pham Van Doanh, finance. Annexes present the terms of reference, people met and a list of references.

The introductory section of the report gives a brief picture of the health situation, the health facilities and the primary health care system of Viet Nam. These are then related to an analysis of the on-going economic reforms and their impact on the health sector, implying continued financial strains. The Viet Nam – Sweden Programme and its historical origins are also presented in the background section. From this section is has been concluded that the health sector remains an important sector for international aid and that Sweden should increase its assistance, or at least keep it on present levels. Another conclusion is that all Swedish aid should be subject to the criterion of its impact on the economic reform process: no funds should be used in a way that does not support the reform process. In an annex some of the recent changes in the organisation and finance of the public health system are described.

The evaluation study is presented briefly in the second section of the report. Emphasis is put on the difficulties to isolate programme impact from the effects of the social and economic changes resulting from the reforms. An annex gives the details of the evaluation methodology.

The section on the findings of the evaluation study presents the result project by project. The overall finding is that most projects have been strongly influenced by the reforms, most projects have increased their rate of progress from 1986 to 1992 and all projects together have produced a giant amount of training activities for the health sector.

In the final section the team presents its conclusions from the evaluation study and some recommendations for the future. The PHC projects, the hospitals and the training system support project are all recommended to continue, with some changes in terms of contents and the number of advisers. The regulatory control component of the provision of drugs project should also continue, while the production component and the supply of raw materials are recommended to be phased out. The medical equipment project, the central fund and the central level integration projects are also recommended to be phased

out as separate projects. Those components of those projects who may be selected for continued support should be merged with other projects or be replaced by financial support and advisers, without necessarily creating separate projects for those activities.

On the programme level the report has identified an opportunity to redesign the programme, in that it needs to be adapted to the new context in the country. By phasing out projects as recommended by the team, about 40% of the present programme budget is available for alternative uses. The programme should be simplified by the reduction of the number of projects and by adding a component of financial support. At the same time, the programme should be guided by an overall objective and more narrow targeting. In the redesign of the programme, the teams recommendations on selected themes should also be considered.

As regards organisation and management the team recommends a search for ways of reducing the administration costs of the programme. The Ministry of Health should keep its present management board and strengthen the central integrated leadership. The competence development components in the programme should be improved by better objectives, closer scrutiny of the needs for advisers and longer contract periods for adviser. It is recommended that SIDA considers to raise the knowledge of the Vietnamese language among expatriate advisers. The gender issues should be better analysed and integrated into the programme design. As far as the financial aspects of the programme go, it is recommended that the Ministry and SIDA analyse the future means of improving sector finance as a whole, but also to increase the role of the Ministry in the financial management of the Swedish aid funds. As regards procurement and advisers in this field, the study recommends that the support be phased out due to the competence level achieved in the country. In order to be able to improve cost-effectiveness of the programme it is recommended that the projects introduce performance targets and comparable cost indicators for monitoring.

Chapter 1
Background

Viet Nam and Sweden have co-operated for development in the health sector since the beginning of the 1970s. The first projects were the Swedish support to family planning and then to the construction of hospitals, to be followed by the Rural Health Project in Yen Hung[1] district, Quang Ninh province. Since the beginning of the 1980s, the Co-operation Programme has been focused on Primary Health Care (PHC). In 1992, the Programme disbursements had totalled approximately 600 MSEK, which constitutes roughly one tenth of the total Swedish development assistance to Viet Nam. The health sector share of SIDA disbursements has varied from around 12% before 1980 to around 8% in the first half of the 1980s, and increased up to more than 15% in the latter half of the last decade.

This is the report of an evaluation mission on the Swedish support to the Health Sector Co-operation Programme in Viet Nam. Previously, the PHC project was evaluated in 1985 and the Provisions of Drugs project (POD) in 1988. The present evaluation concerns the whole programme during 1986-1992. Conclusions and recommendations of the Mission have been made in the specific context currently prevailing in Viet Nam. This section presents a brief background to the report, where the current health situation, health services and the economic reform process are outlined, as well as the main ingredients of the Health Co-operation Programme of Viet Nam and Sweden.

The prevailing health situation is the indication of the general problems that the Programme, in the final analysis, should address, while the on-going economic reform process is an important factor in the Terms of Reference[2] for this evaluation. The reform process has a strong impact on the health services provided by public and private suppliers in Viet Nam. This evaluation is one element in a process to find out in what ways the Programme needs to be adapted to the new economic conditions of the country.

The reform process and its known and foreseen consequences, therefore, are reflected in many of the findings and conclusions in the evaluation. Other programmes and projects in the co-operation between Sweden and Viet Nam have been adjusted in several ways in order to adapt them to the new conditions in the country.

The reader should be aware that the introductory sections on the health situation and the economic reforms are intended only as a background to the evaluation work. Some

1. In accordance with Vietnamese practice in English texts, and due to the Teams general lack of knowledge of the Vietnamese language, this report transposes Vietnamese names and words using only the English alphabet and no accents.
2. Cf. **Annex 1.**

of the elements of the situation are therefore emphasised in these sections. But they are not intended to serve as a general reference on the subjects. Such material can be found in the References (Cf. Annex 3). The purpose of this report is limited to the presentation of the results of the evaluation study.

1.1 The Health Situation

The morbidity and mortality pattern of Viet Nam is similar that of other developing countries in South-East Asia. The leading causes of morbidity and mortality as of 1989-1990 are shown in table 1:1.

Table 1:1

	Morbidity No. of cases		**Mortality** No. of deaths
Malaria	1 060 000	Malaria	3340
Trachoma	650 000	Cerebral haemorrhage	882
Diarrhoea	199 434	Prenatal diseases	780
Salmonelosis	197 101	Pneumonia	689
Dysentery	120 450	Malnutrition	596
Influenza	113 108	Tuberculosis	454

Source: Health Statistics Data, MOH, 1992

It can be seen from the table that the main causes of both morbidity and mortality are preventable diseases that could be reduced by PHC. It is estimated that about 80% of all diseases that require medical attention can be treated at the Commune Health Stations (CHS).

However, it should be noted that the reported figures are of varying quality and it can be assumed that all the diseases are under-reported. This is especially true for diseases such as malaria, diarrhoea etc. Studies also show that there are groups of diseases where the level of under reporting is high. Gynaecological problems are one example which falls into this category[3].

The reported infant mortality rate has improved impressively during the last three decades: from about 156 per 1000 live births in 1960, to around 83 in 1979, 46 in 1990. The latter is an unusually low infant mortality rate compared to other countries with per capita income level similar to Viet Nam and is inconsistent with the severe malnutrition situation with a high proportion of stunted and underweight children. The situation differs, however, significantly in different parts of the country, with the highest levels of infant mortality and fertility in the mountainous areas of the North and the Central Highlands, while the lowest are found in the deltas of the Red River and the Mekong River[4]. These statistical inconsistencies may be an example of the difficulty of generating reliable statistics of, for example, child mortality.

3. For background statistical data, kindly see **Annex 7**.
4. Cf. World Bank 1992, UNICEF *Annual Report* 1991, Ministry of Health, *Health Statistics Data* 1992.

Many Vietnamese children suffer from malnutrition resulting in stunted growth and low weight. Here, treatment for malnutrition is administered at the Ha Noi Children's Hospital. Photo: Lasse Olsson/BAZAAR

In absolute terms, Viet Nams per capita health expenditure is low. According to the MOH, health spending per capita was 1.42 USD in 1990, to be compared with 1.52 USD in Ethiopia and 6.14 USD in Sri Lanka[5].

Relative to its per capita GNP and total government spending, government expenditures on health are also relatively low, constituting about 4% of total government expenditure in 1990 and around 0.8% of GNP. During the 1980s the lowest level of government expenditure on health was around 2% of the total government budget (1988).

In 1989, the Government introduced market oriented reforms into the health sector in order to stimulate cost recovery. A system of fees was introduced for district, provincial and national level hospitals. User fees, however, accounted for only 5,2 % of total health expenditure in 1990.

Experiments in health insurance have begun as a means of generating funds to sustain and revitalise the health system. Licensed private medical clinics are permitted, as well as private practices of doctors after office hours at public clinics.

A major concern is the low utilisation of health facilities in Viet Nam. Bed occupancy rates for hospitals average less than 50%. Annual per capita contact rates with the health services average between 0.3 and 0.5 for the overall population, with wide variations across provinces and regions. This means that a significant proportion of the Vietnamese population, especially in remote rural areas, rarely uses the health care system.

The main factors behind the low utilisation of health facilities are their poor quality and the long distances to the facilities in mountainous and remote areas. The problem is most acute in the rural areas, where a large number of health workers also engage in farming and other activities in order to increase their income. Health workers in commune health centres examine an average of one patient a day, while private practitioners and traditional healers attend to an average of 5-6 patients a day.

The number of physicians and nurses per thousand inhabitants in Viet Nam is higher than in most other countries at the same per capita income level. Retraining from curative to modern primary health care is, however, badly needed.

Another fact, which has often been emphasised, is that the *vertical* health programmes, such as the Expanded Programme of Immunisation (EPI), Control of Diarrhoeal Diseases (CDD), and the Acute Respiratory Infections Programme (ARI) are conducted without proper horizontal coordination. These programmes are often financially supported by external donors. They operate independently of each other and absorb time and resources from other aspects of primary health care, such as malaria control, basic sanitation and nutrition[6].

According to an analysis[7], which is supported also by other observers of the sector, Viet Nam has some relative advantages over comparable developing countries, which have contributed positively to the health status of the population:

- high literacy rates, particularly among women (above 83% in 1991)
- relatively few marginalised, homeless, landless or unemployed families

5. UN statistics, quoted in interview with MOH.
6. World Bank 1992, Kaufman & Sen 1991.
7. Allen 1992.

- the traditional role played by the family, village and commune in assisting members in times of hardship[8].

Several sources point at the following negative factors as being the most serious constraint for the amelioration of the health status of the Vietnamese population:

- extremely high malnutrition rates among children (45% of children under 5 in 1991)
- lack of potable water (proper use of safe water below 38% in 1991)
- lack of sanitary facilities (proper use of proper latrine less than 46% in 1991)

According to UNICEF, the most important factor for child mortality is poor maternal health. The proportion of low birth-weight children reflects malnutrition of pregnant women. In 1991, the rate was above 10% (acceptable rate, according to MOH, is 10%), with three regions having rates above that level.

It is evident that further analysis is necessary to determine where assistance to the health sector is most strategic. Without addressing the basic causes, the health situation will not improve rapidly. The MOH has given priority to the following five areas:

1. Control of infectious diseases
2. Nutrition
3. Family planning/maternal and child health
4. Protection of environment
5. Improvement of the quality of medical care[9].

1.1.2 Health Facilities and Services

The health care system in Viet Nam is organised at four levels. Each level has its own specific and well-defined duties.

The primary level is the Commune Health Station which serves a population of about 5000-10000 people living in the catchment area of the station. The station is intended to be the basic provider of health services covering a broad range of activities. These services are also known as the ten elements of PHC as stated in the National policy on PHC from 1972. This policy encompasses all the items of the Alma Ata declaration of 1978:

1. Health education
2. Nutrition
3. Safe water and environmental sanitation
4. Mother and child health with family planning
5. Immunisation
6. Prevention and control of endemic diseases

8. There are reasons to assume that some of the social security network systems may deteriorate as a consequence of the social and economic reforms. Cf. for example Quê 1992 and Leipziger 1991.
9. MOH Strategy 1992, p. 14.

7. Treatment of diseases and referral when needed
8. Supply and sale of drugs
9. Management of communicable diseases
10. Consolidation of basic health network

These various services are defined as a series of tasks on which the head of the CHS has to report to the next higher level of the health system on a regular basis.

The facilities and equipment available vary substantially from one commune to the other, as most of the facilities are provided by the communes themselves. The equipment can range from a fairly well equipped health station to a station with virtually nothing.

The staffing depends on the number of persons served and the resources of the commune. Lately, however, there has been a reduction of staff of about 30% at all levels of the health care system, mainly due to severe budget constraints. On the average, there are three to four commune health care workers in each CHS. As of 1991, there were 10046 communes in Viet Nam, out of which 8 940 had a health station. This is a reduction from 1990, when there were 9 024 health stations. There were 388 urban health stations[10] and more than 1 600 health stations under other Ministries.

Over 800 (1990) inter-communal polyclinics provide consultation and technical back-stopping for urban and community health stations.

The second level is the district level. In 1991 there were 550 districts. Each district serves a population of about 150 000 persons. The health service is organised by the District Health Bureau (DHB) that co-ordinates the work of the District Hospital (DH), a polyclinic and the Centre of Preventive Medicine. 505 of the hospitals were district hospitals with a catchment area of 100 000 to 150 000 people. There were a further 64 maternity hospitals at district level.

As with the Commune Health Stations, the facilities at district level vary significantly. On the average, each District Hospital has around 80-100 beds and is organised into different departments, such as surgery, medicine etc. Although there has been a marked reduction in the number of beds in recent years, the hospitals are still too many, or too large, with an average occupancy rate of 50-60%. The staffing is about one person per bed, including medical and support staff.

Other organisations, such as mining companies, have their own hospitals that serve as district hospitals although catering only for the company employees and their families.

The third level is the province. At present, there are 54 provinces in Viet Nam with an average population of less than one million, although several are larger with over 3 million inhabitants, for example Ho Chi Minh City. The health service is organised by the Provincial Health Bureau (PHB) which co-ordinates the work of the provincial hospital, specialist provincial services such as leprosariums, mental hospitals, etc. and the Provincial Preventive Services.

The provincial hospital is intended as a referral hospital which should deal mainly with cases referred by the districts. In practice, this seldom happens and the provincial hospital functions as a larger, better equipped and better staffed district hospital.

10. Health Statistics Data, 1992

The provinces carry the responsibility for the Secondary Medical Schools, where assistant doctors, second level nurses and midwifes, as well as some medical technicians and pharmacists, are trained.

The central level carries the overall responsibility for health. This responsibility is assumed by departments of the Ministry of Health, which formulate policies and plans and which partially manage the implementation of these plans.

There are central level health facilities, such as the National Institute of Hygiene and Epidemiology, the Institute of Nutrition, etc. These central institutes serve as national referral centres. They also have the responsibility for research, training and for advice to the Ministry of Health. The Ministry is also responsible for university level training of doctors, pharmacists and, as of recently, a limited number of nurses, midwifes and laboratory technicians. In 1991 there were 98 specialised hospitals and 678 general hospitals in the country, serving as referral hospitals.

The health sector manpower situation as of 1990, is illustrated in Table 1:2.

Table 1:2

Category	Number	Per thousand of pop.
Physicians	249347	38,7
Medical assistants	46412	7,2
Nurses/Midwifes	98288	15,0

Source: MOH 1992

The description above is that of the traditional organisation of the Vietnamese Health Care. This did not change during the early part of the period under evaluation. However from 1986 some fundamental changes have occurred within the structure of health services in Viet Nam.

Before 1986, the Commune Health Stations were funded and run by the agricultural co-operatives and they provided health care free of charge. The health workers, including brigade nurses, were paid on a work-point system by the agricultural co-operatives.

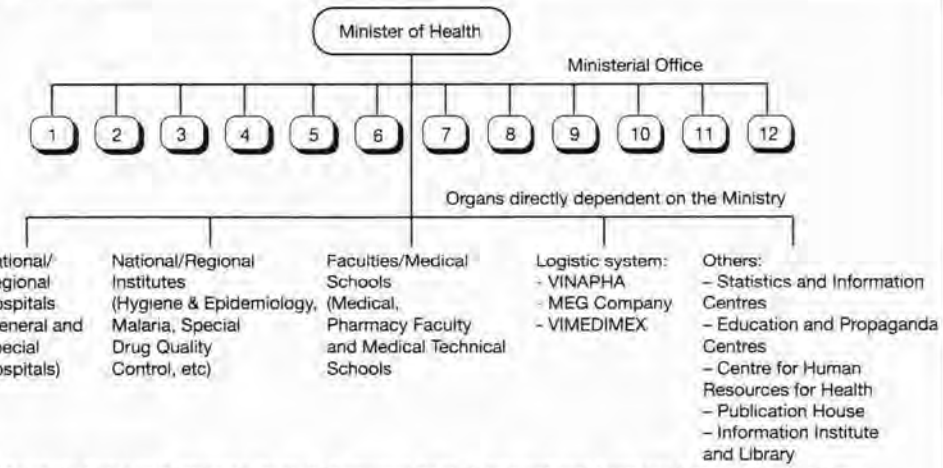
Between 1986 and 1988 the Communes took over management and funding of the Commune Health Stations and many brigade nurses returned to full time farming. This meant a decline in resources available to health services at the commune level and a parallel decline in the morale and motivation of health workers. Salaries were not paid regularly, and in kind supplements to the health workers were discontinued. Gradually, this led to falling attendance at health stations, polyclinics and hospitals.

Between 1988 and 1992, the Government undertook to pay salaries for three health workers at every CHS, and for extra health workers, in proportion to the population, in large communes. The Commune Peoples Committees (CPC) remained responsible for buildings, maintenance, drugs and salaries for extra staff. Funds for paying health workers were channelled from the Province Peoples Committee (PPC) to the District Peoples Committee (DPC) and then to the CPC. There were many reasons for non-availability of money for e.g. salaries (delays, borrowing of money for other activities). Fees were introduced for users at hospitals and Commune Health Stations in an attempt to raise revenue for health care. At most stations this had little effect, due to the many

categories exempted from payment, and to the dramatically falling attendance at the clinics[11].

The Ministry of Health was reorganised in November 1988. According to the MOHs Planning Department the current organisation is depicted in chart 1:3.

Chart 1:3



1. Minister's Cabinet. 2. Planning Dept. 3. Personnel Dept. 4. International Relations Dept. 5. Finance Dept. 6. Pharmacy Dept. 7. Medical Equipment Dept. 10. Hygiene & Environment Dept. 11. Science & Training Dept. 12. Inspection. 13. Traditional Medicine Dept.

Source: Planning Dept. MOH, Jan 14 1992

1.1.3 Primary Health Care

Primary Health Care in Viet Nam has a long tradition and has been described in its present form as early as 1954[12]. The Vietnamese health care system was then, and still is, organised in a way that resembles the current recommendations of the World Health Organisation (WHO). The experiences of the Peoples Republic of China and Viet Nam were part of the conceptual framework for the Alma Ata declaration on PHC.

This position has been disputed lately[13], by the claim that the Vietnamese PHC concept is no more than a pure desk product. However, it is safe to say that this concept and the ideas of PHC have been present in the country since the early 1950s. The recent history of Vietnamese PHC remains to be written. This makes it more difficult to evaluate past performance as well as to appraise future plans[14]. The writing of the history of Vietnamese PHC is a task that should be pursued as early as possible for the benefit of the future development of practical PHC in Viet Nam.

11. From 1990 the organisation of province and district health services have been changed. Cf. Annex 4, where the management and funding of PHC since 1986 are described in charts.
12. According to Nguyen Khac Vien (ed.), 1972.
13. Vogel, 1987
14. One can only conjecture on what happened to the health sector in the past, since there is very little historical information on the functioning of the health system. *World Bank*, June 1992, p. 112.

1.1.4 National Health Policy

The following Vietnamese health sector priorities were adopted in the 1986-90 development plan:

- prevention and control of infectious diseases
- strengthening and development of the basic health services network at grassroots level
- reduction in the population growth rate
- development of the pharmaceutical industry
- promotion and integration of traditional medicine
- improvement of the environment

It may be noted that the expansion of services in 1986 included private clinics.

In the policy paper for health services, issued by the MOH in 1990, six national priority areas were selected in accordance with the WHO guide-lines. These included a consolidation of the health network for implementation of PHC, as well as promotion of family planning with mother and child health care. Expansion of consultation and treatment services should be made through Governmental, collective and private clinics. There should be a combination of modern and traditional medicine in the treatment of diseases. Implementation of EPI for all children under one year of age was emphasised, as well as malaria control, and provision of essential drugs and medical equipment.

In 1991 the results of the operational plan for 1990 were evaluated and led to a revised strategy that is still valid[15]. Within the WHO policy, the new strategy emphasises the following points:

1. Early prevention
2. Comprehensive health care
3. Full community participation
4. Planned health sector economics
5. Reorganisation of health services
6. Association of eastern with western medicine
7. Promotion of medical ethics
8. Inter-sectoral collaboration in health
9. Legislation and socialisation of public health actions

Some of the additional items in the above list could be taken as sign of adaptation to the changing economic and social environment. Community participation and reorganisation of health services, as well as planned health sector economics and intersectoral collaboration, indicate actions to be taken in order to bring the sector into line with the new situation.

15. *Strategy for health for all by the year 2000 and strategic health plan for the period 1990-1995 in Viet Nam*, MOH 1992.

1.2 The Economic Renovation – Doi Moi

According to a recent Vietnamese book[16] on the economy, experimental renovations of economic management mechanism started during the five-year-plan 1981-1985. The VI congress of the Vietnamese Communist Party (CPV) had taken a resolution on urgent tasks, where it was pointed out that planning activities were still based on central and bureaucratic mechanism, lacking realistic and scientific bases. It is argued that this resolution was the first significant step in the economic reform process. In October 1981, product contracts were introduced in agriculture, which is considered by some authors to be the first significant economic change[17]. During the years from 1980 to 1985 examples of piecemeal reform may be found, but the 1985 Central Committee Eighth Plenum was the real beginning of explicit reforms in that it actually started to take steps toward a market system and ordered the dismantling of the states wage and price bureaucracies[18].

The 1986 Party Congress is, however, a milestone in creating the political conditions for the economic reform process, ratifying several reforms and paving the way for radical changes in 1989-1990. During the last three years, economic change has been a continuing process, combined with administrative decentralisation and restructuring of state bureaucracy. The period of economic reforms since 1986 *coincides* with the time perspective of this evaluation, i.e. 1986-1992.

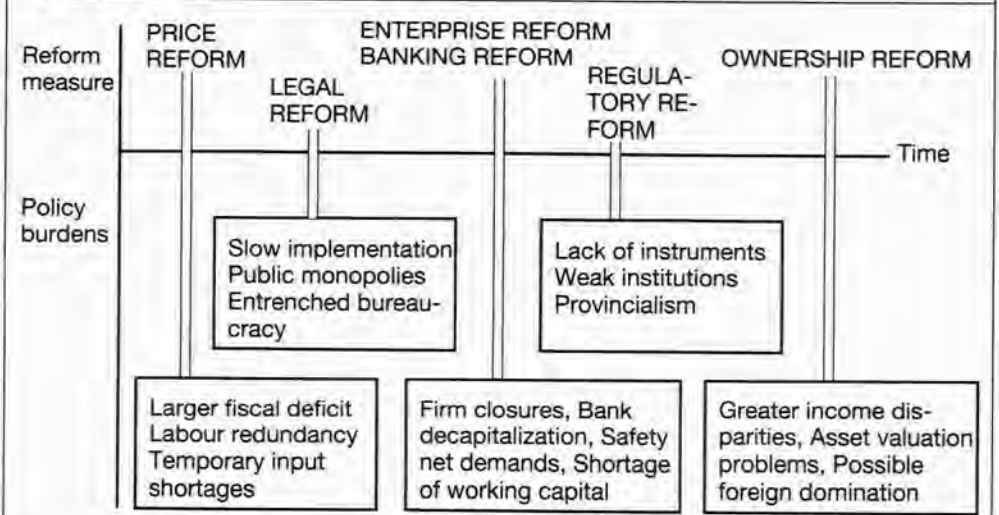
Doi moi applies not only to the economy. Political *doi moi*, for example, covers seven key areas[19]: bureaucracy, party organisation, media, elections, representative assemblies, mass associations and the legal order.

Articles on the reform process and the macroeconomic management of the economy are becoming abundant and this report cannot add anything significant[20]. It simply highlights some features of the economic reform process in order to enable the reader see the relevance of some of the conclusions in the report. However, the Mission has put emphasis on enterprises companies within the Health Sector Co-operation Programme and tried to verify empirically the consequences of *doi moi* in detail, particularly for the objectives of the Health Co-operation Programme as well as for the current overall objectives of the overall Viet Nam-Sweden development co-operation.

One method of conceptualising the reform process has been presented by Leipziger[21] in the way illustrated in chart 1:4.

16. Trang Hoang Kim 1992
17. Turley, 1991. But more precisely, it was the VIth Conference of the CPV Central Committee (September 1979) that may be said to have ushered in the period of reforms.
18. Turley, op. cit.
19. Turley, op. cit.
20. Cf. de Vylder and Fforde 1988 for the early years, and for example SPC/UNDP 1990, Fforde & de Vylder 1991, Dollar 1991, where further references to the rich sources of international comment and analysis may be found. There are also reports from the World Bank and IMF from 1991 and from the World Bank in 1992. For a short description of the steps taken in the economic reform process, see Van Arkadie & Vu Tat Boi 1992.
21. Leipziger, 1992

Chart 1:4

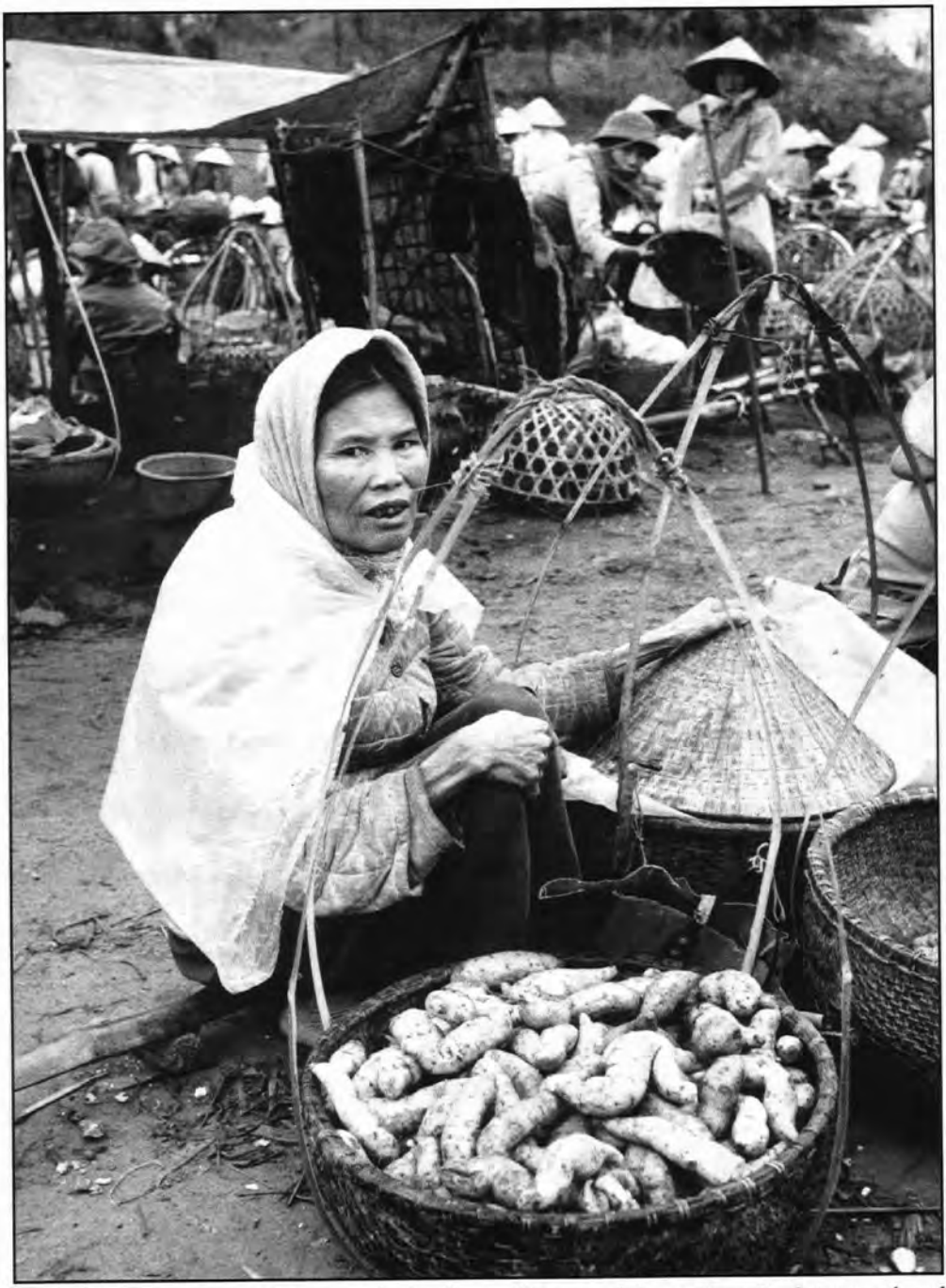


After the 1986 party congress, when *doi moi* was adopted, a major event that assisted the transition process was price reform. This included all important prices, i.e. those of labour, capital, foreign exchange and staple food, in a process that started in the early 1980s and was more or less completed in 1989. By then, internal and external trade had been liberalised and in 1988 farmers had gained the rights of long-term land occupancy. In 1991 the VII Party Congress decided to continue *doi moi*.

The impact of the reforms has varied for different sectors and individual companies and families over time, but according to our study its seems that 1989 could be taken as the period when the state enterprises were fully exposed to the new situation, i.e. what is called enterprise reform and banking reform in the chart above. By 1990, enterprises were fully exposed to higher interest rates, tighter credits, higher import prices and the necessity, and the right, to self-finance their operations. In agriculture, the impact of market prices and the shift to individual farming had already been felt for some years. In the health sector, all commercial units have been affected. Furthermore the sectors overall organisational structure, finance and patient attendance, have changed as a result of increased privatisation of sector activities.

Since early 1991, a number of basic measures have been taken by the Government in order to reform the state sector. All state enterprises have been registered as state business, with the introduction of Management Boards in such businesses. Some experiments with the change of state enterprises into share companies have been increasingly undertaken. The Government has also decided that interlocking and outstanding debts of state enterprises should be settled. This problem has affected the enterprises which are part of the hard ware projects of the Health Co-operation Programme.

As regards macroeconomic stability, measures were taken in 1989 in an effort to overcome the instability then prevailing, with hyper-inflation and balance of payments



Doi Moi is a transition process which affects all parts of the society. Both internal and external trade has been liberalised. Photo: Lasse Olsson/BAZAAR

deficits[22]: the Vietnamese Dong (VDN) was devalued, interest rates raised and credit growth reduced, while trade was liberalised. These policies were successful in 1989. However in 1990 the inflation started to rise again, the balance of payments deteriorated and Gross Domestic Product (GDP) growth slowed down from 7.1% to 4.5%. 1989 will remain a milestone in the reform process, because practically all prices were free, and subsidies and state credits to state enterprises ceased. In 1992 bankruptcy of state enterprises is an accepted and established concept.

Inflation in Viet Nam is mainly caused by a large state budget deficit. The most striking feature of Viet Nams fiscal situation is that revenue collection is very low. In 1988, only 10.0% of GDP was collected as government revenue, most of which was transfers from state enterprises[23]. In 1990 it had increased to 11.5%. Transfers from state enterprises declined, but were compensated by increased oil revenues.

But government revenues still do not cover even its current expenditures which represented 14% of GDP in 1990. The difference between revenues and current expenditure was 2.5% in 1990, while the governments capital expenditure was 3.6% of GDP. Hence the total deficit is exceeding 6% of GDP. *Dollar* points out that the bank financing of the overall deficit, at 3.5% in 1990, may have to be reduced to less than 1% of GDP to achieve price stability. In May 1992, it has been estimated that the current years deficit will be around 1%[24].

In 1989 and 1990 the total amount of foreign aid decreased rapidly due to the reduction of Soviet assistance, which was not compensated by marginal increases from the West. The budget deficit could not be financed by external resources under such circumstances. According to *Dollar*, macroeconomic stabilisation in 1992 would require an end to inflationary financing of the budget. Such an adjustment in turn will necessitate a very substantial restructuring of the public sector, both the civil service and state enterprises.

The challenge for Viet Nam is to reduce the budget deficit, at a time when the potential for revenue increases is limited, while at the same time reforming the state sector and increasing its investments in economic infrastructure and social services and meanwhile achieve macroeconomic stability.

For 1992 the government has undertaken to reduce state employment by 20%, after having reduced state sector employment from 4.1 million in 1988 to 3.5 million in 1990. It is unlikely that stabilisation policies will be supported by high private investment rates in the short term, creating sufficient economic growth to absorb lay-offs from the public sector. Thus, foreign investments or government access to international assistance or credits are necessary to reduce unemployment. An end to the US embargo is the single most important pre-requisite for such access. During the Missions visit to Viet Nam the US State Department, after establishment of telecommunication links with Viet Nam, announced that an easing of the economic embargo will take effect as part of a process for normalisation of relations with Viet Nam[25]. This decision partly resulted from the

22. Dollar, 1991
23. Dollar, op. cit.
24. Cf. Trinh Tien Dung, 1992, Paper by DCO, Hanoi. On the other hand, it may be that a large part of the reduction of the budget deficit has been achieved by a mounting credit by the banks to the formerly subsidised enterprises, in which case bank financing may have increased.
25. Viet Nam Investment Review. 2:31

increasing foreign investment interests in Viet Nam (Japan, Australia, Taiwan, Singapore, Thailand, etc.). From now on, US private non-profit organisations will be allowed to sell commodities to meet basic human needs and humanitarian projects.

It is well known that macroeconomic stabilisation will remain a general condition for Viet Nams access to credits in convertible currencies. In order to be able to finance necessary state economic undertakings such as economic infrastructure and social services, It would take a Herculean effort on the part of the state. Hence greater external support will almost certainly be necessary if the country is to achieve rapid socio-economic development[26].

Meanwhile, since 1986 Viet Nam has been demonstrating its willingness to undertake the necessary measures to reduce inflation and the balance of payment deficit: reduction of the public sector deficit, devaluation and liberalisation of foreign trade, i.e. a structural adjustment programme. If Viet Nam succeeds in creating a stable economic environment, the international donor community would normally be willing to assist in the Governments provision of public services in social sectors and infrastructure. International assistance targeted at these two areas can play an important role in generating satisfactory socio-economic development and some short-run financing of the balance of payments may be essential to the success of the overall structural adjustment programme[27].

This is a point of departure for the Mission: it has been convincingly demonstrated by Vietnamese and international analyses that the social sectors are going to be important areas for foreign assistance in the coming years, as well as balance of payment support. Swedish support to the Health Sector in Viet Nam will be a relevant area for the development of the country and for Swedish and Vietnamese co-operation objectives. The Mission therefore recommends that the total support from Sweden to the Health Sector in Viet Nam should not be reduced.

1.2.1 Economic Reform and Health Services

The economic and administrative reforms have affected the organisation and efficiency of public health services during the period under review. The reforms here also brought about a rapid growth of private health services. In this short review, we concentrate on problems facing the health workers and the Co-operation Programme[28].

In many areas, the growth of private health services and the increase of the supply of drugs and medical equipment, have led to improved quality of health services. This applies in particular to the urban centres. Meanwhile, this development has stimulated a rate of price increase for health service and drugs, which is higher than that of the incomes of the majority of the population. Price increases will also require higher allocations from the state budget for the Health Sector. The improved health services in urban centres are probably paralleled by reduced quality and quantity of the same services in mountainous and remote regions and for people living in the self-sufficient rural economic system. This implies increasing inequalities in the access to high-quality health services in the country.

26. Dollar, op. cit.
27. Dollar, op. cit.
28. This does not imply that all the effects of the reform on public health services are negative, especially not in the long run, nor that all the current problems originated with the reforms.

The current policy of user charges in many areas means that cost recovery efforts will also tend to increase in the health sector. Fees for users were introduced in hospitals and commune health stations over the last three to four years. This has not improved the situation of the public health system substantially, however, as exemptions are many and attendance has been reduced.

Simultaneously, the administrative reform of the public sector in general and the health sector in particular has been an on-going process since 1986. In general, the administrative decentralisation as part of the reform process has tended to be a disorderly decentralisation. This consequently, may lead to a weakening of the central power end, to the decentralisation of state power, even though the new decentralised system is not yet fully determined. A (temporarily) disorderly management may be a negative factor in the development of the public health services in the short run.

It has been demonstrated by surveys that the public health service attendance has decreased in recent years, and that a large proportion of sick people now go straight the market to buy drugs, without consultation. Hence, the increased and un-controlled supply of drugs constitutes a danger.

In addition the large reduction in the number of agricultural co-operatives has resulted in a huge reduction of the number of brigade nurses (commune level), who returned to agriculture. This has, again, had a negative impact on the quality and quantity of service in the rural areas.

Another development affecting public health services, is the reduction of the real wages of health workers. This has accelerated since 1990. It has aggravated the problem of absenteeism and low morale of health workers. In combination with lack of medical equipment and lack of drugs resulting from the budget constraints it has lead to a serious reduction of the quality of service, which in turn reduces consumer demand for the services.

Some of the structural problems of the sector are not new, such as the need for training and re-training and the need for improved, decentralised management systems, but these problems are harder to solve when addressed within the context of absenteeism and low morale.

The present economic developments also bring risks of destruction of the previous social security network[29]. Along with *doi moi*, a wave of privatisation is sweeping through Vietnamese society. This starts on a relative high level of aggregation, i.e. enterprises (the example of workers assisting laid off workers) and state organisations, markets, etc., but eventually trickles down to lower levels. At the end of market penetration into the economic system all economic units are privatised. Finally, the family is privatised and then it is only a matter of degree before society reaches the stage of the privatisation of individuals. Eventually, there is no longer a social security net for the citizens, who are reduced to economic objects in the markets.

The MOH has observed the relations between the economic reforms and health[30] and notes with respect to the users situation:

29. Cf. Que 1992.
30. MOH 1992, section 2.3.

The shifting from a subsidised to a socialist market economy has more negative than positive influences on health in Viet Nam. The increasing cost of medical care and drugs make them less affordable to the users. The differentiation between the rich and the poor is becoming more accentuated, increasing levels of poverty and exacerbating ill health and quality of services. Disregarding the needs of the poor, private physicians and private pharmacies compete only for the services to the rich. However, this competition also contributes to the improvement of medical care quality in general.

1.2.2 Health Sector Budgets

The *Strategy for Health for All* concludes that the main problem now is inadequate health budget in the transition period from a subsidised to a market economy oriented towards socialism[31]. The identification and mobilisation of sources of finance for public and private health expenditures will be a decisive sector during the next few years.

The total budget for the public health sector including capital expenditure (excluding business activities) was about 613 billion VDN in 1990. The budget had the composition and sources as shown in table 1:5.

Table 1:5

Health Budget 1990	**Billion VDN**	**%**
Current expenditure	328	54
Investment & primary equipment	51	8
Foreign Aid	150	24
Other sources	29	5
Communes contribution	55	9
Total	**613**	**100**

Source: MOH (rounded figures)

It may be noted that the aid contribution to the budget was almost a fourth of the total government health budget. The main sources were UNICEF, WHO, UNFPA, FAO, SIDA and Non-Governmental Organisations (NGOs). Most of the aid funds are used for current expenditure (including equipment). The communes contributed about 10%, while other sources, including user fees, still were no more than 5%.

A few important items in the health budget must be imported including almost all health equipment. Local production of drugs can meet about 30% of the needs[32]. The local drug production increased by a factor of two between 1986 and 1990, while consumption may have increased about several times more.

The economics of the health system will be affected by the rising import prices of drugs and equipment. The implicit costs of capital (buildings and equipment) will also increase together with costs of maintenance and repairs. Although we are not in a position to estimate the cost increases we foresee a rapid increase of the costs of both operation and maintenance of the public health facilities and the cost of capital in the sector.

31. MOH op. cit., p. 5.
32. MOH 1992, p.16.

At the commune level, communes (as has been witnessed during the Missions field visits) are now acting in various ways to raise funds locally, e.g. revolving drugs funds, health insurance systems and other local contributions in kind or in cash. Costs for treatment of people who are exempted from fees, for example, are often charged to the CPCs budget for social and cultural purposes. Hence, the quantity and quality of services of the Commune Health Stations will depend, not only on the provincial health allocation, but also on the relative political and local support in each commune.

The changes during the 1990s may be seen as part of the larger thrust towards decentralisation of the Vietnamese administrative system. If the above comments are valid, one consequence will be that the available funds for health services at the commune level will be heavily dependent on local resources. Mobilisation of local community involvement may be seen as a future necessity in order to generate sufficient finance. Health insurance should probably be part of such a system. It is of crucial importance that gender issues are carefully considered in such planning as the reproductive work load of women often tends to increase when local community mobilisation is based on free delivery of womens labour[33].

A tentative conclusion for the future is that the governments allocations and the donor contributions should be targeted in a more precise way, i.e. by strict target groups both in terms of socio-economics and in terms of regions, in order to support the MOH in its efforts to combat the increasing tendencies of reduced equity in health services.

1.3 The Viet Nam-Sweden Programme

Viet Nam and Sweden started development co-operation in the late 1960s after a period of Swedish humanitarian support to Viet Nam during the war. From the mid-sixties, Sweden was providing aid in the form of medical supplies and equipment, mainly through NGOs, the Swedish Save the Children and the Swedish Red Cross. In 1970 Sweden started to support the family planning programme in Viet Nam by commodity imports.

For a historical understanding of the development of the Viet Nam-Sweden Co-operation it is important to note two features distinguishing the origins from those of other countries. One is the strong role played by political relations and the other is Swedens lack of knowledge about Viet Nam. The political support during the war was not only a factor for confidence building in Viet Nam, but it also led to Swedish confidence in the Vietnamese administration. This confidence was not built on experience, because compared to other countries with which Sweden has co-operated Swedish experience of Viet Nam was very limited.

These two characteristics influenced the growth of the Health Sector Co-operation Programme. The selection of projects and programme components has been largely influenced by political considerations and Vietnamese priorities.

The humanitarian assistance during the war went to the health sector. The emphasis on hardware was also part of the activities from the start.

The first projects were for hospitals. The bombing of one hospital, leading to the decision about the childrens hospital (1974), as well as Vietnamese policy priorities, influenced these selections. The choice of Uong Bi (1975) was based, among other things,

33. This point is a general observation from experiences in other countries.

on Vietnamese domestic political considerations. The construction projects for the hospitals were later followed by agreements for continued support to operations and maintenance. The technology and equipment for the hospitals made it necessary to continue to import spare parts and equipment. It also turned out that the Vietnamese management needed technical assistance when the hospitals were handed over to the authorities.

In 1982, SIDA adopted a health policy for Swedish health assistance in line with the Alma Ata declaration on PHC of 1978. In 1983, partly as a response to public opinion in Sweden, criticising the hospital projects, the Yen Hung Rural Health Project was signed. It was in line with SIDAs 1982 sector policy, but the growing insight of the shortage of resources in the Vietnamese PHC system was also influential in the decision.

During some years, part of the import support had been used for imports of drugs and medical equipment. Sweden had tried to avoid the use of import support for projects, but some components were seen as needing more support than just imports. It became evident, for example, that the support to the pharmaceutical industry could not be limited to raw material, but needed training and technical assistance. In 1983, the Provision of Drugs (POD) became a project in the Health Programme, at about the time when funds for hospital construction were less needed. In a similar way, the Medical Equipment Project (ME) was started in 1986, justified by the need to service and repair imported medical equipment and to develop the competence in the country in all aspects of medical engineering. Although the original intention of this latter project was to limit its duration to three years and hand it over to a UN organisation, the project is still a part of the Health Programme. From the Vietnamese side, there was an interest to standardise the donors medical equipment supplies through one unit. Upon the advice of consultants the ME was later split into two projects, Central Technical Workshop and Medical Equipment Production, when a small production unit for simple equipment was getting support.

In the 1986 agreement the Central Fund (CF) Project was included in the Programme as a way of handling management support and the administration of the advisers, as well as to manage training and fellowships outside Viet Nam. But the CF was also, from July 1990, a way of accommodating a Vietnamese request for material support to a number of Central Institutions in need of spare parts and physical rehabilitation.

The 1986 agreement also marks the point where the Yen Hung project was changed into the Quang Ninh PHC Project (PHC I), whereby the emphasis was switched from material support and delivery of PHC services to material support and support to the development of management systems for delivery of PHC services. This project has later been paralleled by assistance in Ha Tuyen and Vinh Phu, both locations selected because of other Swedish projects in the areas. One element of the PHC I, that was added to the agreement in 1990 is the rehabilitation of district hospitals. This project actually started in 1989 in Han Yien as a side activity based in the Uong Bi camp.

The present agreement from 1990 also includes the Central Level Integration Project (CLIP) and the Training System Support Project (TSSP), both of them situated at the MOH and both of them intended to support central functions, i.e. management integration and training system development, respectively. The objectives of the TSSP are to strengthen the capacity of the training system for health workers and to enable the

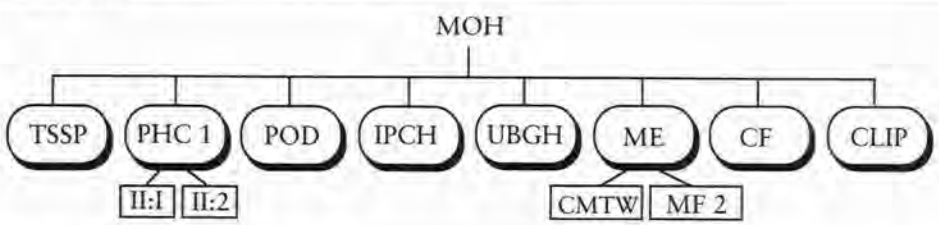
MOH to plan for the future manpower needs. The CLIP, however, was expected to create an effective coordination of the activities to ensure an integrated delivery of the PHC programme. The CLIP also involved a compromise solution to some requests for support to research, that SIDA did not want to support, given the division of labour between SAREC and SIDA.

The above description illustrates how the projects were born out of different considerations, rather than resulting from a single programme design, based on overall co-ordinated objectives. It also illustrates how compromise solution and coincidence have played their respective roles in creating the present bundle of 11 projects, constituting the Programme.

But the development of the contents of the Programme also illustrates the developments of the total Swedish co-operation with Viet Nam. The origin was imports of hardware. The gradual change to transfer of knowledge and institutional development took place in the 1980s. Currently, competence development[34], enabling and policy dialogue are key words, and they are all reflected in the current Health Co-operation Programme documents.

In 1992 the Programme contains the 11 Projects illustrated in chart 1:11 (The Medical Equipment Project is regarded as one project with two components, while the PHC II:1 and PHC II:2 are regarded as separate projects, the criteria being the appointment of a Head of Project).

Chart 1:11



34. The term competence development is not approved of by British people we have discussed with. It is used here because of its use in the project documents.

Chapter 2
The evaluation study

The evaluation covers the period from July 1986 to 1992, i.e. up to and including the latest data available to the Mission. The choice of this time period is related to the fact that the previous evaluation of the programme was carried out in 1985. In July 1986, an agreement for a new period was signed. The present agreement started on July 1, 1990.

The fact that two different agreements have been in force during the period to be evaluated means in this case that the Programme objectives as well as its projects have changed in the course of the period.

The object of study for the evaluation is the Health Co-operation Programme, i.e. it is not only its individual components, but rather the unified programme, that has been evaluated. According to SIDAs methodological guide-lines[35] a programme consists of several projects that are linked to each other and *are related to the same objective.* A project is a system of activities, delimited in time and space, intended to produce a precise outcome.

This implies that the evaluation of the separate impacts of individual projects will not suffice to evaluate the impact of the Programme. In order to evaluate the Programme, the combined impact of all its components must be evaluated. On the other hand, SIDAs guide-lines state that cost-effectiveness is normally applicable only to project objectives or partial objectives, not to sectorial objectives[36].

The purpose of the evaluation is to create new information: by evaluating the past performance of the programme in relation to its objectives, lessons will be learned. These lessons may then be applied in recommendations for future re-designs of the programme. First of all we want to know whether the intended results have been achieved. Second, we want to distinguish what went wrong from what was workable in the past programme. Third, we want to use this new information as an input to the future co-operation between Viet Nam and Sweden in the health sector. It should be noted that the long-term impact of a programme or project may only be assessed several years after the completion of a project[37], i.e. the present evaluation cannot measure long-term impact of the latest years of implementation, only short-term impact.

The time period to be evaluated has been delimited by the dates of agreements between Sweden and Viet Nam. It coincides with a period of dynamic changes in Viet Nam. 1986-1992 is therefore a period when many of the given parameters of previous years were changed and where few things that were valid in the earlier years were still true. The

35. Cf. Metodhandbok 90, SIDA, 1990, p. 134 (our translation and emphasis).
36. SIDA, op. cit. p. 116.
37. SIDA, op. cit. p. 114.

changes in Viet Nams economic system are also an important reason for carrying out the evaluation of the Programme at this point of time. Before the end of the present agreement in June 1993, the MOH and SIDA want to know what impact the reforms have had on the Health Co-operation Programme.

The Swedish Team members were Mrs. Elisabeth Michanek, evaluation analyst from the Evaluation Unit of SIDA, Mr. Hans Persson, pharmaceutical expert, Mr. Bo Simonsson, public health expert, and Dr. Jan Valdelin, evaluation economist, who also acted as Team Leader. The Vietnamese Team member was Dr. Tran Thi Quê', economist and researcher at the National Centre for Social Sciences of Viet Nam, Institute of Economics.

The Swedish members of the Team started preparations in Sweden in March 1992. Considerable efforts were made by SIDA and the Team members to identify and collect all relevant documents on the Health Co-operation Programme between 1986 and 1992 (Cf. **Annex 3**, References). Documents were studied during March and April 1992. A final work meeting before the departure for Viet Nam was held on April 24.

On April 27, the Swedish Team members arrived in Ha Noi. The field visit lasted 25 days, during which interviews were held with responsible officers in Ha Noi, Quang Ninh, Vinh Phu, Ha Tuyen and Ho Chi Minh City (Cf. **Annex 2**, People Met). The Team received a number of prepared documents with data on the on-going projects from the Vietnamese side. Before departure from Viet Nam, the Team debriefed to the MOH and the Development Co-operation Office (DCO) of the Swedish Embassy on the preliminary findings and conclusions.

During work in Viet Nam, the Team established a Resource Group, consisting of independent Vietnamese experts. The members of the Resource Group were Mr. Phan Quang Tue, Institute of Management, Dr. Vu Manh Thien, Institute of Nutrition, Dr. Vu Tuan Anh, Institute of Economics and Mr. Pham Van Doanh, Finance expert. The Resource Group has served as a discussion partner for reading and commenting upon drafts and ideas proposed by the Team.

After the work in Viet Nam, the Mission carried out interviews with the staff of InDevelop in Uppsala as well as with the Senior Consultants of the Programme. Some other follow-up interviews were also made with SIDA officials and short-term consultants (cf. Annex 2).

The Team is independent from the Ministry and SIDA, who will accept or reject our conclusions and recommendations.

The final item to be brought to the readers attention as both a constraint and a resource, is the methodology applied in the Evaluation Study. In **Annex 5**, Evaluation Methodology, the interested reader will find a presentation of the Missions methods and the evaluation criteria applied. SIDAs established evaluation criteria have been used, i.e. *achievement of objectives, cost-effectiveness, relevance and sustainability.*

A word of caution regarding the impact of *doi moi* on the evaluation work undertaken in the period of transition in Viet Nam is necessary.

The economic reform process in Viet Nam is influencing all tenets of social and economic life. The overriding theme of Swedish development co-operation with Viet Nam during this process is that Swedish assistance should support the reform process. The implication of this is that all Swedish co-operation should be investigated and

monitored in terms of its impact on the reform process: no funds should be made available for projects or activities which are counter-productive in terms of doi moi.

An obvious principle following from the overriding objective of Swedish assistance is that no Swedish funds should be used for purposes where commercial or productive units are subsidised, i.e. no bailing out of commercial units should be permitted by Swedish funds.

This means that any on-going projects in the Swedish-Vietnamese programme of co-operation must be scrutinised by the application of the principles of the economic reform programme[38], regardless of whether the project in other respects is very well implemented. The application of the principles of doi moi may result in the rejection of an on-going project without anybody having committed any errors in implementation. The project may have to be halted just because of the changing conditions of society. It is important that readers of this report take this consequence of the economic reform process into account. All recommendations of the Mission are submitted to this criteria: the present objectives of the Sweden-Viet Nam co-operation agreements are to support the reform process and this will carry implications for our recommendations regardless of the other possible intrinsic values in the past or presently of any given project.

Finally, it should be pointed out that the simple use of the term doi moi, thus implying the economic reform process, must not hide the fact that the present transformation of Vietnam from a subsidy economy to a market economy implies a transformation of all areas of activity, such as ways of thinking, organisation, management, work relations, etc. The influence on the Health Co-operation Programme is consequently not limited to market factors, but includes all those social factors that in a mutually dependent system of relations create the present situation in Viet Nam. Although the Team may not be able to incorporate all such factors in the analysis, it is evident that the impact of the reform process must be considered as a combination of economic, social and other factors.

38. This process of scrutiny has been going on for some time with the DCO as one of the driving forces and in close collaboration with the respective Vietnamese authorities for planning of the co-operation. The health sector has, however, so far been excluded from this process. This means that the present evaluation also represents the starting point of the process of adaptation.

During the 1986-1990 agreement period, the two hospitals consumed about 20% of the Programme budget. In the current period, their joint share is about 21%.

The first two periods were also characterised by a strong Swedish presence. There were advisers in virtually all areas of the operations of the hospitals. During the period up to the end of 1985, the two hospitals started to develop modern medical, technical and administrative routines.

The number of Swedish advisers was gradually reduced from a peak of about 30 for the two hospitals, to five for each hospital in the end of 1985.

The objectives of the various projects have never been spelt out in the project documents, with the exception of the latest addition, i.e. the TSSP. Instead, the project documents have listed a number of activities that could lead to implicit targets. This shortcoming is partly due to the conceptual difficulty of separating ends and means, but partly also to the lack of comprehensive overall policy for the Viet Nam-Sweden Health Co-operation.

Therefore, for most of the projects, the evaluation is based on the activities performed and not on a precise objective. The absence of performance indicators, however, makes also this type of evaluation cumbersome.

One implicit target in the hospital projects, at least on the Swedish side, has been to reduce the number of expatriate advisers. The reduction from 30 to five advisers is a successful achievement of this objective.

3.2.1 Co-operation with the PHC I

Since the re-orientation of the Swedish Health Support to Viet Nam in the early 1980s, both hospitals have started to conduct outreach activities and to provide support to the PHC programmes in their respective areas of co-operation. For Uong Bi hospital this has been primarily in the district where the hospital is located. But the hospital has also provided support through training courses for health care workers from all the other districts in the province. It has also provided the commune health stations with medical assistance in their day-to-day work.

The courses have mainly been for the six national programmes, but with greater integration than is normally achieved in Viet Nam.

The IPCH has started Social Paediatric Activities in ten provinces. One commune in each of the 10 provinces serves as pilot area in order to gain experience and practical knowledge. The work has consisted of the establishment of a system of health education of mothers and provision of basic preventive measures, such as immunisation of children with the six EPI antigens and the introduction of weight monitoring and weaning advice on a regular basis. The results of these activities are said to be good, although no proper assessment or evaluation of them has been undertaken. However, there is no reason to doubt that the outreach activities have benefitted the communes.

The fact that both hospitals have been able to establish a good co-operation with the PHC programmes in their respective areas is valuable since it increases their understanding of the problems occurring in the peripheral areas. In the long run this may also change the training provided to nurses and medical students and make it more PHC-oriented. This is an activity that should be replicated all over Viet Nam, especially where a medical

teaching institute is located, in order to provide the students with a good practical base.

3.2.2 Hospital Training Activities

At the IPCH the first specialised paediatric nurse training course has been developed. This course is a very important development for nurses, as it provides the opportunity for them to get a more in-depth education in paediatrics. If possible, this kind of activity should be expanded with the co-operation of the Training System Support Project at the Ministry of Health. In the beginning, the length of the training course was nine months, but later it was found to be too long and was shortened to three months.

The first regular training course was held in 1984 and up to the present the following courses have been conducted at IPCH:

Ten training courses for paediatric nurses: a total of 150 nurses have been trained in this first specialised nurse course. The Institute has also run four seminars for paediatric nurses with a duration of one week each and a total of 288 participants.

The MOH has not made any decision regarding specialist training for nurses. Therefore, this undertaking of training of paediatric nurses should temporarily be scaled down to include only in-service training at the hospitals, until a decision regarding the contents and scope of the training has been made.

The UBGH has conducted several Head Nurse courses to which other provinces have been invited to send participants. All hospitals in Quang Ninh Province have had nurses trained at this course. The experience gained by the hospital in conducting these courses should be retained and other similar courses should be conducted in Uong Bi.

Other training activities conducted in both Uong Bi and Ha Noi include the retraining of nursing staff and the training of newly recruited staff on both hospital and treatment routines. Retraining is a new concept in the sector, which has never before been implemented. The result that could be noted was a more uniform nursing care in the hospitals as all staff knew the procedures and methods to be used. This practice has been in place since 1984, but it is only in recent years that the result could be observed.

3.2.3 Nursing

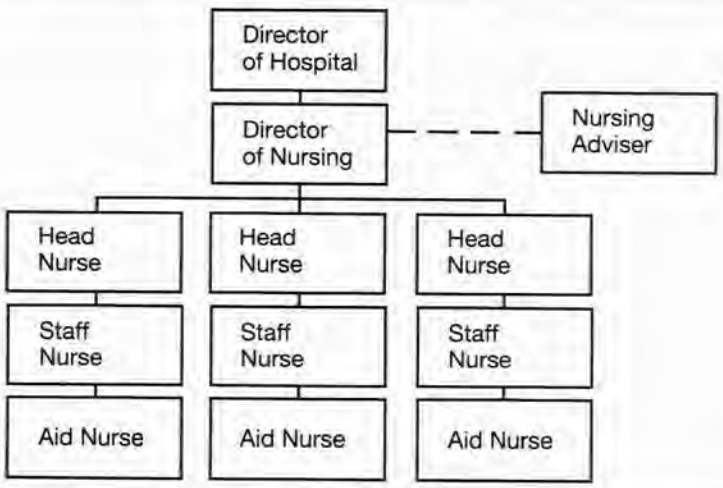
The Vietnamese nurse is traditionally completely dependent on the medical doctor and has little or no medical responsibility, except for basic care of patients. For many years, the training of nurses has been very old-fashioned with a minimum of practical work on the wards. The concept of nursing in its more specific sense was not heard of in the north of Viet Nam. With the return of the first Vietnamese nurses trained in Sweden in 1979-1980, this new idea was discussed among the nurses. However, it was not well received by the medical doctors as they saw the possibility that their responsibilities could be delegated to the nurses.

During the first years of operation, the nursing advisers mostly spent their time with the counterparts in discussing and conducting hands-on training in running the hospitals, which included care of patients and cleaning of the wards. The basic knowledge regarding hygiene was not there. During this time, the level of the nursing care was raised compared to other hospitals in Viet Nam.

The department of nursing was established at both hospitals in the beginning of 1984

with the duty to oversee the nursing care of the hospitals and ensure that routines and procedures were being practised. Additional functions were subsequently included. These additional responsibilities of the nurses made it necessary to increase the nursing organisation. At present the organisation of nursing may be illustrated as in chart 3:1.

Chart 3:1



The main duties are:

1. Nursing care management
2. Health education (for patients and relatives)
3. In-service training (for nurses and cleaners)
4. Manpower management
5. Material management

This change, from a completely subordinate status to a position with more responsibilities and specific duties, is a revolution in the Vietnamese health care system. It could not have been achieved without the support and pressure from the Swedish Nursing Advisers.

The nursing component will even be further strengthened when the new nursing curriculum is adopted by the Secondary Medical Schools. The curriculum has been developed by the TSSP although it is surprising that the TSSP did not contact IPCH, but only UBGH, during the drafting of the new curriculum. The nursing departments of the two hospitals could have provided considerable advice and suggestions.

The responsibility given to the nurses for manpower and material management can only benefit the hospitals as the nurses are more involved than the doctors in the usage

of consumables in the day-to-day work. The nurses are also more affected by staff shortages and problems. However, some sort of control mechanism has to be developed to ensure that mismanagement does not occur.

One of the big difficulties in evaluating this component is that there are no indicators that are easily available for comparison. However, the establishment of the nursing office and the development of routines, in-service training and other items as described above, clearly indicates that a major development has occurred.

At the present stage of the development of the hospitals, the nursing advisers might have completed their roles in the hospitals, as the Vietnamese head nurses can perform the duties on their own without the help of the Swedish advisers. Therefore, the advisers should be transferred to a more central level, where they can assist in the development of nursing organisations at other major hospitals. At present, about 60% of all hospitals have nursing departments, but their functions and duties are not standardised and in some cases they do not have any real influence on patient care.

The Swedish nursing advisers can play an important role in the training of trainers at the Secondary Medical Schools and also in developing hygiene routines at all levels.

It is encouraging that the 90 000 nurses have organised themselves in a National Nursing Organisation.

3.2.4 Operations of the Hospitals

The two hospitals have both began the task given by the MOH to be model hospitals. This is a great honour and requires that the hospitals have a high standard of performance.

Since the beginning, both hospitals have developed the treatment of patients in their respective fields. The IPCH has become the most important centre for paediatrics in Viet Nam and Uong Bi is considered the leading centre for hospital management.

Since 1980, when IPCH was established in its new premises, the hospital has gone through a period of rapid development.

At the beginning, there were just two medical advisers. They worked in very specialised fields, such as X-ray and anaesthesiology. Later, in 1983, the medical adviser post was changed into a paediatrics post with an overall duty of assisting in developing treatment procedures and guide-lines. The hospital Director was the counterpart.

There are indications that IPCH ran into some rather severe managerial problems in 1984-1985, when the requirements on the hospital started to increase with a larger number of both out- and in-patients. At that time there were also some rearrangements of the senior staff and there was a reduction of Swedish support to the IPCH.

The post at the IPCH was cancelled in the end of January 1990, as it was felt that the Vietnamese could carry out the medical work without a permanent adviser. This phasing-out of the adviser came at a time when the hospital board was capable of providing all the medical needs of the hospital.

It is now felt that the hospital does not need a new adviser on paediatrics. However, the need for short-term advisers in specialised fields cannot be ruled out.

The Uong Bi General Hospital still has a medical adviser who is working half-time with the hospital and half-time with the PHC project. This arrangement provides a good link between the hospital and the PHC work in the district. This arrangement should be

preserved as it will give the project the opportunity to be a testing ground for other centrally placed projects.

The important role of the hospitals in developing health care in Viet Nam is beyond doubt. IPCH, being the leading paediatric hospital, has made good progress in the treatment of patients, which can be seen from the mortality statistics in table 3:2.

Table 3:2 Mortality in percentage of in-patients at IPCH

	Before 1980	1990-1991
Severe malnutrition	32	9
Acute diarrhoea	1,2	0,8
Rheumatic heart disease	12	2,3
Encephalitis	25	15
Pneumonia	5,5	2,1
Hemorrhagic fever	10	1

Source: IPCH, April 1992

Similar trends have not been seen in other hospitals, except at the UBGH. Although there is a downward trend elsewhere too, it is less significant. This gives an indication of a better functioning hospital as the number of in-patients increases every year: from about 2000 per year in 1980-1985 to 10 000 per year as of 1991.

The state of maintenance of buildings and equipment at the two hospitals is very different. The UBGH does not need any major repairs at present. The hospital is still very well preserved, suggesting good maintenance. All areas are kept clean and faults found are repaired at once. On the order from the hospital board, the General Technical Department (GTD) has established a system of periodic preventive maintenance of all buildings and major equipment. This has prevented major damage from occurring. The GTD seems to function well, with well-trained and dedicated staff. However, there is a need for the replacement of some major equipment such as coal-loaders for the boilers. A special study should be conducted to prepare a plan for the future, including maintenance and repairs of the hospital.

The Medical Technical Department (MTD) perform their duties in an acceptable way, although the standard is not as high as at the GTD. During the next few years, the department will need support in the form of spare parts and some minor equipment.

By contrast the IPCH has suffered some major damage to its buildings. B building has been repaired. The X-ray equipment has been reinstalled by the MTD of IPCH. Due to the location of the hospital and the large number of patients frequenting the facilities, the hospital has a more run-down appearance than that of the UBGH. There is still a need for additional repairs of some of the buildings as well as a need for improved general maintenance of the buildings. Such maintenance has been neglected, mainly due to lack of funds.

One of the major problems at the IPCH is the water shortage. There are days when there is no water at the hospital. This has to be solved urgently, as the care of the patients is suffering. Nor is there any hot water in the hospital. This is as serious a problem as the

water shortage, but needs to be looked into in order for the appropriate action to be taken as soon as possible.

The IPCH has a similar problem with the coal-loader for the boilers as the UBGH. This should be replaced urgently. Although this represents a major capital investment, it will be the most cost-effective solution in the long run.

The sewage treatment plants of both the UBGH and the IPCH have never functioned properly. The raw untreated sewage is currently flowing strait into two small lakes. This is not acceptable, as the transmission of waterborne diseases is increased. This may have a major negative impact on the health status of the people living close to the lake and taking its water from it.

The GTD of IPCH should be able to perform the routine duties without expatriate advisers. However, there will be a need for a joint long-term adviser for the two hospitals, during the time needed to solve the problems of the sewage plants and the equipment for the boilers. The Swedish support to the two hospitals should concentrate on the maintenance of the buildings and equipment provided. This also includes some replacement of obsolete equipment.

The MTD at IPCH is of a very high standard and there is no need for an adviser to this department. The support should, as at UBGH, be concentrated on spare parts and replacement of equipment and tools.

3.3 The Primary Health Care Projects

The primary health care project commenced operations in 1984, when it started as the Yen Hung Rural Health Project, with emphasis on training of health care workers on technical aspects of immunisation, control of diarrhoea and other related fields. The objective was to provide better health services to the population, especially women of childbearing age and to children under five years of age.

The project introduced several new concepts, such as growth monitoring, standardised treatment of acute respiratory infections and oral rehydration therapy for treating dehydration during diarrhoea. This was done by means of the training courses that were held in the first year of the project. There was a strong feeling that the subjects taught during the courses should be appropriate to the local situation and therefore considerable energy was spent on finding local solutions to the various problems occurring. However, little attempt was made to merge the contents of the courses taught in order to reduce the time spent on courses and formal training.

During that first year there was little Vietnamese involvement in the formulation of policies and content of the project, and there was a feeling of being by-passed among the leaders of the Provincial Health Bureau. This partially explains the slow implementation of the new project, as will be described below.

3.3.1 The 1985 Evaluation

The operational report of 1985 identified four main problems:

a) material shortages,

b) poor management system,

c) no integration of vertical programmes,

d) lack of community involvement.

The subsequent change in the design of the PHC project, following the evaluation, was made with the intention to address these four main problems.

The main objective of the programme was to assist the provincial health service with the following:

1. to develop the technical and managerial aspects of individual PHC programmes from the provincial level downwards (vertical management)
2. to develop the integrated performance of the health service at each level and promote effective two-way relationship between the levels (horizontal management)
3. to improve the training of health workers in primary care through courses and continuous on-the-job training, using teaching material derived from the management system and employing appropriate pedagogical methods
4. to provide equipment, essential drugs, and other material and consumables necessary for the implementation of the management and training objectives

The same orientation of the project still prevails. With the four main goals formulated at the onset of the project in 1986, the project tried to reach the main target groups, i.e. the rural population of Quang Ninh Province. Attention was also given to the PHC of industrial workers and their families as well as to the sanitary condition in the workers housing areas.

During the formulation of the new project document, several meetings were held with the Provincial Health Bureau to promote participation from the Bureau. However, it can be concluded that although there were meetings held, the level of participation from the Provincial Health Bureau was not as high as would have been desired. The reason being that the concept of PHC was not fully understood by the Bureau at that time. This understanding is now very apparent, resulting in the full participation of the PHB.

The low initial participation was another factor contributing to the slow implementation of the project during the first years.

3.3.2 Recent Developments of PHC

Before presenting the evaluation of the project it is necessary to give a brief description of recent developments and changes in the health care system in Viet Nam. The reader is referred to Section 1 and Annex 4 for this information. It should be noted that the effects of the recent developments in the society on the PHC system are difficult to assess. This constitutes a special problem for the evaluation as it is hard to distinguish the impact of the project itself from the consequences of the reforms.

3.3.3 The PHC I

The project in its new form started in mid-1986. It has been virtually impossible to find reports or other documents that can provide an insight as to whether any progress was

made during the first year. A number of training courses were held on subjects such as EPI (Expanded Programme on Immunisation) and CDD (Control of Diarrhoeal Diseases) as well as others among the six National Programmes. The previous mistake was again repeated, no integration or merging of courses. The courses were based on the WHO training modules and not on the local situation. The experience gained during the first year of the Yen Hung rural health project was not utilised. Another shortcoming was that several courses were conducted for the same category of staff. This forced the CHWs to absent themselves several times from work thereby hampering the service delivery in the CHS.

It seems that no real community diagnosis was undertaken before or at the beginning of the project. A community diagnosis not only includes health data, but also information regarding the economy, sociology, agriculture, water and sanitation, meteorology etc. This has to some extent been rectified during the operation of the project. If such a diagnosis had been performed, it would have demonstrated that areas other than the ones included in the PHC project should have been included. Examples of this are womens health, health education, water and sanitation as well as population activities, such as family planning and vector control.

It is surprising to find that the two largest health problems in Viet Nam are not explicitly addressed in the project. With an annual population growth of about 2.3%, or 2 million surviving new-born per year, and a great need for family planning, the situation is getting more and more difficult. The projected decrease in annual population growth by the year 2000 to 1.26%, is not a real decrease in number of new-born but rather an increase in death rate as the population grows older. The number of new-born will increase to 2.1 million per annum by the year 2000.

It is estimated that about 50% of all couples in Viet Nam are without proper family planning. Abortion is frequently used as a family planning method. This cannot continue due to the health risks for the women and also due to the strain it puts on the health services. In one ongoing study in Quang Ninh it was found that every forth women of fertile age goes through an abortion or menstrual regulation every year.

Activities for the reduction of the population growth rate are a high priority in Viet Nam and should be supported by SIDA.

The other area that should have been included from the onset of the project is vector control. About 61% of the population are living in malaria endemic areas. This is based on official figures that often tend to be underestimated. There are cheap and effective methods available for controlling the common vectors, such as malathion impregnated mosquito nets.

It can be concluded that the PHC project would have had a different emphasis if these two areas had been included, and the impact on the health situation in the project areas would have been greater.

In 1986, each health station in the province was supplied with a standardised set of equipment. Most of the equipment was appropriate for the work at the Commune Health Stations. However, most health centres visited during the evaluation requested more gynaecological equipment and also some additional tools for minor surgery. In addition the Maternity, Paediatrics, Infections and Laboratory departments at the four district

hospitals in Quang Ninh Province were provided with medical equipment. Sixteen polyclinics and other health facilities were also supplied. The cost for all the equipment has been calculated at a mere USD 0.15 per inhabitant for the province of Quang Ninh, which is well below the internationally recommended USD 0.25 per inhabitant. The supply of equipment met the first priority of the Vietnamese government for the project and one of the objectives of the project. The cost of equipment, if kept at the same level, would not be prohibiting factor for a wider expansion of the PHC project.

A Provincial PHC Committee was established to advise the Provincial Peoples Committee on PHC policy and implementation. The committees work has been to formulate goals and work practices, including the formulation of quarterly work plans and targets. Two of the specific tasks of the committee are to support the implementation of the Swedish-Vietnamese PHC project and to find the best ways to involve UBGH in the PHC work. With the establishment of this PHC committee, the project formed a direct link with the political leadership of the province, which has turned out to be vital for the implementation of the project.

However, it was found that while the PHC committee has done a lot of good work, much remains do be done. The PHC project has not been institutionalised by structural organisation and development of policies. The committee is composed of many different participants such as Womens Union, Education services, Financial services, Red Cross etc. Their duties and responsibilities are not well defined and therefore their participation is of low quality and is ineffective. The functions and duties of the different members should be clarified.

The project started to change shape at the end of 1987, after several months of delays, mainly due to the factors described earlier, i.e. lack of trust and confidence in the project due to low participation in the early stages. Secondly, incomplete understanding of the objectives and scope of the project also hampered progress. Thirdly, there appears to have been several organisational problems due to the reorientation of the health care system of Viet Nam. The new direction of the project was more oriented towards managerial development of the Provincial Health Bureau and, later, district level management. The rationalisation, as described earlier, of the provincial health institutions, including merging of several of these institutions into one, gave the right opportunity and climate for this change of direction.

Quang Ninh was one of the first provinces that undertook this organisational change through-out the health care system. It is clear that the PHC project contributed to paving the way for the merger of institutions at district level, and thus to mobilising and utilising the resources needed to address the problems of the district.

The project has developed work guidelines and job descriptions for the CHWs at the Commune Health Stations. Other activities have included the development of ante-natal cards, supervisory check-lists, etc. All of those activities required a lot of time and were initially carried out in a haphazard manner, with some elements developed, not in sequence, but depending on the personal preferences and interests of the expatriate medical advisers. It was not until the end of the period under evaluation that a clear and logical system could be seen in the development of the project.

However, many of the activities undertaken by the project could be considered to be

tasks for a higher organisational level than the Provincial. But the experiences gained during the recent years has to some extent been utilised by CLIP in developing supervisory check-lists and job descriptions for district level managers.

One of the goals of the project is to develop both the vertical and horizontal management of the PHC in the province. This integration can be seen at two levels. Firstly, between central and provincial levels and, secondly, between provincial and district. The first level of integration requires more responsibility for the province. With the present reforms it is inevitable that this will come in the near future. However, to date, little progress has been made at this level, mainly due to the fact that the present regulations do not make the necessary provisions. At the second level, considerable development has occurred as the province, under the present system of financing, can put a lot of pressure on the districts to implement the PHC in an integrated manner.

The role of the expatriate medical advisers has been discussed at length during the evaluation mission. It has been stated by the Vietnamese authorities that the development of the project is closely linked to the advisers. It has also been observed that when advisers with little or no experience from developing comprehensive PHC programmes have been involved the level of progress is low compared to the expected outcome. At the beginning of the project, there was also a low understanding among the Swedish advisers about the objective of the programme. This might have been the single most important factor causing the slow progress during the first years. However, this problem has been solved with the selection of very experienced advisers who have occupied the posts during the last three years.

To enable the programme to progress in a way that will enable its targets and goals to be achieved it is necessary that some primary health experts are provided as medical advisers in the future. It is therefore important that the number of advisers should not be reduced and that one or two PHC nursing advisers are included in the PHC team. This will strengthen the support to the lower levels of the PHC project. The preferred division of duties will be as follows: one medical adviser to the PHB, one medical adviser to the district level managers, and one nurse adviser to the Secondary Medical School. Although the school has received assistance from Swedish Nursing advisers the need for additional support is apparent. The remaining nursing adviser should develop the practical working routines of the District Health Centres and Commune Health Stations.

Primary Health Care requires Community Participation to succeed and to reach the people most in need of its services. The project has not yet been able to mobilise the community as it does not fully meet the needs and demands of the people. This is demonstrated by the increasing number of patients visiting private practitioners and the declining attendance at the different health facilities.

A lot of training activities have been undertaken during the period and the level of technical knowledge is quite high compared with other areas of Viet Nam. The next step will be to train the district level staff in management as this has not been done to the extent necessary for the provincial wide implementation of the management system which has been developed.

One of the main problems to be solved in the near future is how to lift the morale and enthusiasm of the health care workers. To expect that underpaid and frustrated staff will

do a good job is unrealistic. The project must for a transitional period, try to find ways to alleviate the burden of the community health workers.

Several of the six national programmes have made good progress in Quang Ninh province, with EPI as the leader. The immunisation coverage has increased from around 25% in 1985 to 87% in 1991. This is an impressive gain, although no attempt has been made to evaluate the quality of the EPI (including cold chain, sterilisation, etc.). A similar increase in coverage has been seen in other parts of Viet Nam. It is clear that the PHC project had some impact on the coverage, how much is difficult to say. It should be borne in mind that the Ministry of Health has set a national target of 90% coverage by 1995.

The low level of sanitation among the inhabitants at the beginning of the project has been addressed. Cement has been provided to the province. This has subsequently been provided to the people needing it. However, the cement provided has only amounted to about 10% of the requirements for building a toilet or a cemented well. This has been a sufficient incentive for the people to raise the additional funds needed to build the toilet or well. This is one of the areas were community participation is easily established, as it clearly contributes to the betterment of the living conditions of the people.

The impact on the health situation in the communes resulting from this provision of cement has to be studied. It is said that in one commune where all inhabitants have access to clean water the level of diarrhoeal diseases have decreased. However, this is a premature conclusion as diarrhoeal diseases have a seasonal pattern.

The PHC project should continue as in the recent past but with the shortcomings pointed out pointed out above rectified in the next phase of the project. One of the major undertakings in the near future must be a national conference on PHC with participants from all the provinces that have ongoing PHC projects in order to share experiences and to discuss future development and policies of PHC in Viet Nam.

3.3.4 The PHC II

In 1988 the PHC project was expanded to include Vinh Phu and Ha Tuyen Provinces. One district in each province was selected to participate in the project. The selection criterion was that each of the districts already had other ongoing Swedish forestry projects. This expansion was made in order to find out if the so called Quang Ninh model would be replicable to other areas of Viet Nam. However, the same mistake of not conducting a proper community diagnosis was made again. If done it would have shown that the main problem in Ha Tuyen Province is the lack of potable water. According to the PHB in the province about 50% of all health problems can be attributed to insufficient access to water. Secondly, both these provinces are major lumber producing areas with endemic malaria. Neither of these problems have been addressed.

There is also unfortunately, some confusion regarding the level of involvement of the project into the PHC work in these two provinces. In 1988 the DCO felt that Sweden should withdraw completely from these two provinces, but for internal political reasons the Vietnamese Government felt that the projects should continue. Therefore, there has been little direct involvement, only a few training courses have been conducted and some equipment provided to the Commune Health Stations in the two districts involved.

This expansion should either be discontinued or a full-scale PHC project should be

developed because a half-hearted project does not serve any purpose. The best thing would be to develop individual PHC projects in the two provinces, as a direct duplication is unlikely to work in three such different provinces. It is also clear that the expansion of the Quang Ninh project was done, as usual, in a hurry. The Quang Ninh PHC project is lacking experiences and knowledge from other PHC projects in other provinces of Viet Nam.

3.4 Provision of Drugs

The Provision of Drugs project is the single largest project of the Health Programme. It was evaluated in 1988 and is therefore a part of the Programme which has been the most recently evaluated. During the 1986-1990 agreement period, the POD constituted about 40% of the Programme costs, a share that was slightly reduced to about 36% in the present period. In this Section the Provision of Drugs Project (POD) is analysed, starting with a review of the Teams findings regarding the new market trends in Viet Nam. Another sub-section deals with the regulatory functions necessary for the improvement of the situation. Subsequently, the development of the project and its component parts is described and analysed.

3.4.1 New Market Trends for Pharmaceuticals

In the POD project document from 1986 it is said:

> *Lack of foreign currency limits the supply of essential drugs to the country. Today Viet Nam is spending less than half a dollar per capita per year on drugs.*

In 1992, the annual per capita consumption had increased by approximately 6 times[42]. This figure does not include pharmaceuticals sent by private mail from relatives living abroad, nor products brought into the country by travellers or illegal imports. The value of these imports is not known, but it is believed to be quite substantial, particularly in Ho Chi Minh City.

This represents a tremendous increase in the consumption of pharmaceuticals over six years. In spite of this the POD Plan of Operation for January 1992 to June 1993[43] states that:

> *There is a shortage of finished essential drugs in primary health care and of raw materials for domestic production of essential drugs. The distribution network for drugs is unable to effectively supply the primary health care with sufficient amounts of drugs.*

The Evaluation Team has during its Mission to Viet Nam in May 1992 obtained a different impression of the situation in the country. The primary health care facilities

42. The Ministry of Health estimates the import of pharmaceutical products to be 85 million US dollar. Out of this amount about 50% is imported as finished products and the remaining amount as pharmaceutical raw materials. When considering that the processing of the raw materials to finished products increases the value by about 2.5 times, the total value of finished products before distribution is about 150 million USD. Assuming that the mark-up in the distribution chain is about 30%, the total market value of pharmaceuticals in Viet Nam in 1992 is about 200 million USD, which corresponds to a per capita consumption of about 3 USD, i.e. six times more than the estimate from 1986.
43. Approved in November 1991.

The number of registered pharmacies in the country has increased from about 2 000 in 1989 to more than 6 000 in 1992. Photo: Heldur Netocny/BAZAAR

visited did not have a shortage of pharmaceuticals. The central factories visited had an excess of raw materials for the production of essential drugs. They complained that they were facing problems in selling essential drugs, because of the stiff competition from imported products.

According to the MOH the number of pharmacies in the country had increased from about 2000 in 1989 to more than 6000 registered pharmacies after the Government had allowed the establishment of private pharmacies. The number of unregistered pharmacies is not known, but it is believed to be substantial. It is reported[44] that pharmaceuticals are sold also by doctors and nurses. Health authorities that the Mission met confirmed that the drug market is out of the authorities control. Many unauthorised salesmen are selling pharmaceuticals on the streets.

The National Quality Control Institutes in Ha Noi and Ho Chi Minh City complained about the large number of substandard and counterfeit products on the market.

In 1986, the main problem on the pharmaceutical market was a shortage of drugs. Today, the market has developed in an uncontrolled way, totally inconsistent with the 1986 objective of the rational use of drugs. This is particularly true in Ho Chi Minh City, where the annual consumption of pharmaceuticals is estimated by the MOH to be about 10 USD per capita. The big cities of Viet Nam are now facing the following problems in the market for pharmaceuticals:

- over-consumption (wrong consumption, unnecessary consumption)
- use of expensive products

44. Prag 1991.

- sale of unnecessarily expensive presentation forms
- sale of not registered products
- sale of counterfeit products
- self-medication
- wrong prescription

When the international companies increase their marketing campaigns, there is a considerable risk that a similar market situation will develop in the countryside to the one currently prevailing in the large cities. Unless the Vietnamese authorities take strong measures to control the market very soon, many Vietnamese citizens, particularly the poor and ill-informed parts of the population, may suffer from their consumption of pharmaceuticals.

The uncontrolled import of pharmaceuticals by mailed parcels to private persons is unfortunately accepted by the Government[45]. This is demoralising the pharmaceutical sector in Viet Nam and contributes to its disorder. It also constitutes a threat to the health and safety of the people. According to the MOH steps are being prepared to ban this business. However, this phenomena was also addressed by a WHO Mission in September 1989[46] and the reply by the MOH at that time was the same as to this Mission in May 1992.

3.4.2 Legislation and the Role of the Authority

The Mission does not have a clear picture of Vietnamese legislation in the pharmaceutical field[47]. Therefore, this presentation is based on the incomplete information we succeeded in collecting.

Viet Nam has legislation on the registration of pharmaceuticals[48]. As far as we can see, the regulation does not deal with any penalty for a company or a person who sells drugs in Viet Nam without having them registered. It should be observed that the Circular of 1990 is only concerned with imported drugs and not with drugs manufactured in the country.

The current law allows private pharmacies to sell pharmaceuticals. A condition is that the owner has a pharmaceutical university degree and five years of professional experience. The registration of a pharmacy (= giving permission to sell pharmaceuticals) is made by the provincial authorities. Most private pharmacies are not registered. The reason is that very few of them have applied for a registration.

Many Commune Health Stations have opened separate shops for pharmaceuticals in the villages. Sales are normally conducted by a nurse.

Inspection of manufacturers and Provincial pharmacies is made by the Ministry of Health. The MOH currently has *one* governmental drug inspector. Inspection of District

45. These products are not registered by the authorities and their quality and suitability have not been evaluated.
46. Darmansjah & Fabricant, 1989.
47. No report in English was available about the legislation, in spite of the fact that the POD project has had a separate sub-project called Drug Regulatory Control during the whole period now being evaluated
48. The discussion in this paragraph is based on the MOH Circular, December 1990 about the implementation of the regulations concerning the registration of imported drugs.

are made, how money is transferred, what the driving forces are, what the causes and the effects are or how the sector is connected to other parts of the society.

Vietnamese society is very complicated with decision-making at many different levels and with a combination of subsidised and market economy. It seems that everybody involved from the Swedish side, SIDA Stockholm, SIDA Ha Noi and the consultant InDevelop, has been living with a home-made picture of how the centrally planned economy of Viet Nam functioned. Stemming from the close co-operation with the MOH, the Swedish view seems to have been limited to the domains of the Ministry, although the pharmaceutical sector is much bigger. A UNDP report from 1987[50] was the first small attempt to grasp the complexity of the pharmaceutical sector in Viet Nam. SIDA, who is a dominant donor in Viet Nam, did not go further in analysing its area of concern until October 1991, when it commissioned a study on the sector[51]. With so much money and so many experts involved for so many years, such an analysis at an earlier stage might have contributed to a more efficient use of the resources, and to making the co-operation with the Vietnamese partner easier and more fruitful.

3.4.5 The Project Components

The POD is a large and very complex project with a range of many different activities and in many different fields. It has been divided into three sub-projects: Drug Regulatory Control, Drug Production and Drug Procurement. This report does not intend to describe the details of the project as the space involved would not be justified. Instead it concentrates on analysis and evaluation[52].

The POD project has from the beginning of 1986 to the end of 1991 utilised 142.6 MSEK plus the costs of advisers and training activities (experts, courses, seminars, study trips etc.) for which funds have been taken from the Central Fund for all projects of the Health Sector. These costs are estimated to be about another 15 MSEK.

3.4.6 Financial Support for Procurement of Raw Materials

By far the largest cost component of POD, has been the financial support for imports of raw materials. During 986 to 1991 expenditure totalled 111.2 MSEK, which is about three quarters of the whole budget of the project.

The consumption of pharmaceuticals and the availability of pharmaceuticals at different health facilities have increased during the evaluation period, particularly during the last two years. However, it has not been possible for the Mission to confirm whether the financial support from SIDA for the purchase of raw materials has contributed to the increased availability of drugs or not. According to the Missions findings the volume of pharmaceuticals produced in accordance with the central plan made by VINAPHA (the production planning department within the MOH) has not increased during the evaluation period[53]. Since the introduction of the market oriented economy, the central

50. Persson, Chari & Csizar 1987.
51. ISRMP, 1991.
52. For the reader interested in more details, a study of Gille, G., Johansson, S., & Persson, H., 1988 may be recommended. Also the Report to the Evaluation Team by the POD project (1992) and the Report to the Evaluation Team made by VINAPHA (1992) give a good background to the evaluation.
53. ISRMP, 1991, Table 1.

pharmaceutical factories have more than tripled their production and at the same time have reduced their staff by almost 50%. Only about 20% of their production is in accordance with the MOH plan. About 40% of the capacity used is allocated to the manufacture of their own products for which they buy raw materials through their own channels. These products are sold on the free market. The remaining 40% of their production capacity is used for manufacturing under contract where the other contract parties deliver the raw materials.

It has been confirmed that the SIDA raw material support has resulted in an increased volume of raw materials being purchased from Western countries for Governmental production. However, the Mission believes that the purchase of raw materials from the Eastern Bloc countries has been reduced by a similar volume.

The total annual import of pharmaceutical raw materials is about 42 MUSD. About 50% of this[54] (21 MUSD) is used in the provincial factories in Ho Chi Minh City. The remaining 50% is used in the Governmental factories. Out of these 50%, the VINAPHA plan constitutes about 20%, i.e. 4 MUSD. The SIDA funding of raw material imports is about 3 MUSD per year. From this it can be concluded that almost the whole budget for raw materials for MOH production of essential drugs is currently financed by SIDA.

The consultants examined the production subsidy system. Favourable artificial exchange rates were previously applied when pricing the raw materials bought by the pharmaceutical industry. At the same time, the sales prices of the finished products were fixed by the Government. The intention of the system was that consumers should get cheaper drugs. However, due to the complexity of the subsidy system and the high inflation rate, in combination with the short stay of the Mission in Viet Nam, it has not been possible to verify whether the consumers really did get cheaper drugs or whether the system has just subsidised the inefficiency of the pharmaceutical industry[55].

There seems to be a misconception in some reports about the drug supply in Viet Nam, i.e. that pharmaceuticals are free of charge. This was the policy in the past. However since 1986, the general policy has been that patients should pay for drugs (since the end of 1989 without subsidy). Certain exceptions exist. Drugs for social diseases (malaria, leprosy, diabetes, goitre, mental diseases and respiratory infections in children under 5 years of age) and epidemic diseases are supplied free of charge. Governmental employees, handicapped people and the poorest are exempted from payment. In these cases, funds are supplied by the Government and by the Peoples Committees at the corresponding provincial, district or commune levels.

Hence the increased availability of drugs in the country partially reflects an increased buying power. It can also be the result of an increased flexibility in supply caused by the free market mechanism. A consequence of availability being related to utility to pay is that the availability of drugs in remote and poor areas is still low, in spite of the rapidly increasing drug consumption in the country.

The raw material project component has also included procurement training. A short-term consultant has been to Viet Nam three times for training of the staff at the Governmental import organisation Vimedimex. The purchasing procedure has been the

54. ISRMP, op. cit., Table 2

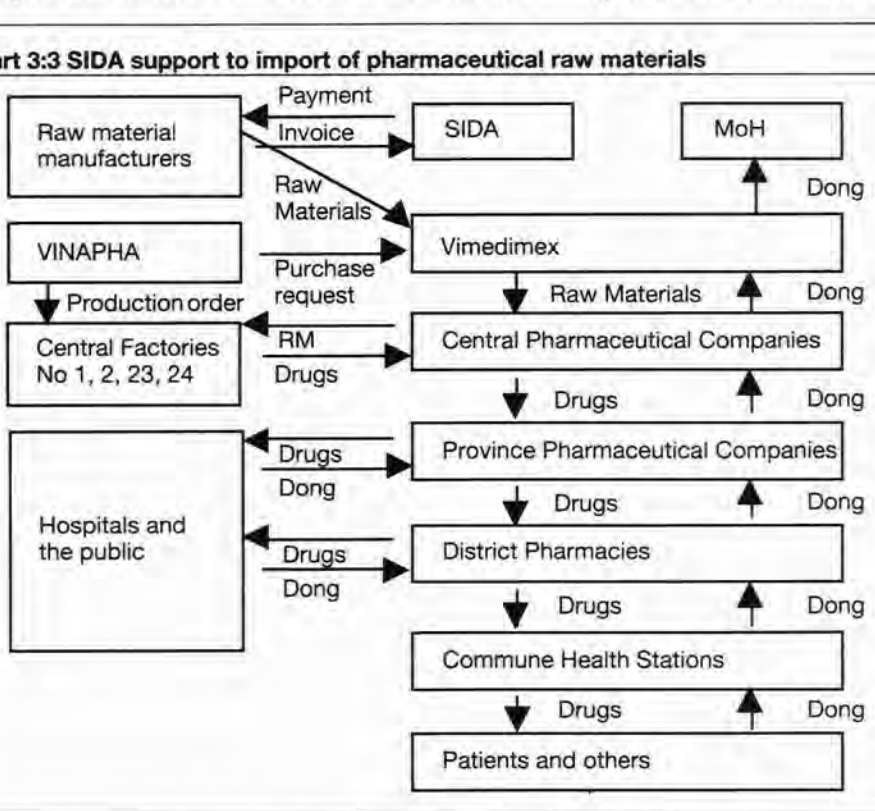
55. After abandonment of the subsidy system, the industry has increased its efficiency by 500% and also reduced its quality defects.

tender procedure with closed bidding. The company offering its materials of specified quality at the lowest price is supposed to be awarded the contracts[56]. SIDAs procurement division has performed an audit in 1991[57], in which it commented on non-compliance with the established procurement policy (for example: prices had been reduced through negotiations after the bidding). Most of the procurement has been made by Vimedimex in Ha Noi. In 1989 and 1991 Vimedimex in Ho Chi Minh City applied the same tender procedure for procurement of raw materials for the factories in southern Vietnam (For further analysis of the procurement issues, cf. Section 3.15).

The money transfer procedure should also be analysed. As previously mentioned, it is rather complicated and has over the years been somewhat simplified compared with what is described in the project document. A simplified general description is as follows:

VINAPHA makes an annual production plan. The raw materials are specified and a purchase request is sent to Vimedimex which orders the materials and sends the bill to SIDA, which pays the suppliers. The raw materials arrive at Vimedimex, which sells the materials to the Central Pharmaceutical Company and transfers the money to the Ministry of Health. The further flow of material and money is described in chart 3:3.

Chart 3:3 SIDA support to import of pharmaceutical raw materials



56. The whole procurement procedure, including checkpoints by InDevelop and SIDA, is presented as an annex to the project document for POD, 1986.
57. SIDA, Purchasing Division, Memo RN. 42/91.

The end result of the SIDA payment and the transactions in Viet Nam is thus an income at the Ministry of Health. Originally, the money was transferred from Vimedimex directly to the Ministry of Finance (e.g. through the national budget). After this routine was changed the end result remained the same, because when the Ministry of Finance allocated funds to MOH it took into account the money already received from SIDA. The allocation of funds to MOH thus depends on the Governments priorities to other ministries. Due to fungibility of donor funds the final use depends on the priorities of the MOH, whatever different channels are used for the money. However, it can be concluded that the transfer of SIDA funds for procurement of raw materials could be simplified by an annual direct transfer to the MOH of the agreed amount. The advantages should be:

- no delay in payments on which complaints have been forwarded by the Vietnamese side
- expensive, qualified Swedish staff now involved in this process could be made available for more productive assignments.

3.4.7 Financing of Hardware and Rehabilitation of Factory No 1

SIDA has during the evaluation period financed imports of equipment, instruments, tools and spare parts for 13.1 MSEK. This has in most cases contributed to the introduction of modern techniques in manufacturing and quality control of pharmaceuticals, thereby laying a foundation for future technical and economic development.

The largest individual cost item has been the rehabilitation of the dry ampoule line for manufacturing of penicillin for injection at Factory No 1 in Ha Noi. The total costs of the project were 4 MSEK. The total expenditure and the time consumed were four times greater than planned. This shows that SIDA has been working under difficult conditions in Viet Nam. By using the services of a pharmaceutical industrial consultant, instead of giving the responsibility for the project to pharmaceutical adviser[58] and the managers of Factory No. 1, the time consumed and the total costs for the project might have been reduced.

The observation has been made that the SIDA support for production facilities for the manufacturing of injections seems to be in contradiction to the SIDA sponsored Essential Drugs Programme. This opposes the excess use of expensive preparations for injection. Penicillin for injection is in fact an essential drug, although it can in many cases be replaced by cheaper and safer oral preparations.

What should be questioned is the feasibility of upgrading a factory that from industrial and economic points of view had reached the end of its useful life. Particularly when that there already existed two factories in the country which were equipped with modern machinery for the manufacture of penicillin for injections. They could have had a capacity sufficient to meet the countrys needs and on ability to compete with imports.

When the Mission visited Factory No 1, the dry ampoule line had been out of operation for several months, due to an insufficient supply from the factory resulting from a delay in the procurement of raw material. This had resulted in major imports that were currently flooding the market.

58. Who did not have any experience of industrial projects.

3.4.8 Long-term Pharmaceutical Advisers

During the evaluation period, the POD project has spent 11.5 MSEK on long-term advisers. One long-term adviser has been stationed in Ha Noi during the whole period, working in close co-operation with the MOH. A second long-term adviser has been stationed in the Quang Ninh province for three years, co-operating with the PHB in connection with the PHC I. During part of the period, a Vietnamese assistant adviser has been stationed in Ha Noi and co-operated with the Swedish long-term adviser.

The objectives of the provision of long-term pharmaceutical advisers are the same as those of the POD project as a whole:

- To support the implementation of the essential drugs concept in the country.
- To promote safe and rational use of drugs, ensure their quality and proper distribution in the PHC.
- To improve the quality of Vietnamese drug production, especially concerning processing of raw materials supplied from Swedish funds.
- To supply raw materials for a small number of essential drugs used in PHC and processed in a limited number of factories.

A long-term pharmaceutical adviser is necessary for as long as SIDA is involved in the pharmaceutical sector. The area of concern is so complex and difficult that a professional expert is vital. In addition to fulfilling the advisory role, be should closely follow the development within the pharmaceutical field in the country and in so doing also act as an adviser to SIDA.

The employment of a Vietnamese assistant adviser was an excellent decision, as such a person acts as a link between successive Swedish advisers. Such a person should always be an highly qualified industrial pharmacist with experience from the MOH.

The decision to employ a long-term pharmaceutical adviser in Quang Ninh was a good decision. SIDA should always have a long-term expert in place when entering a new area of support. It is very important to get a professional view of the situation in order to plan the support in an efficient way. It was also a correct decision to terminate that post, when sufficient information about the area had been gathered and the foundation for the support strategy had been laid down. The long-term adviser stationed at the MOH should be able to manage the future follow-up. It was also a very good decision to use the former long term adviser for the short term follow up mission in Quang Ninh. Such an assignment is not easy for someone who is new in the area.

The degree to which the objectives have been met by the POD project cannot be charged to the record of the long-term advisers. They are not responsible for policy making. Their tasks have been to work within the allotted areas of responsibility, keeping in mind the stated objectives of the project. Based on this criterion the Mission is of the opinion that they all have done a very good job.

In the project document for the period of July 1990 to June 1995 it is said:

A second advisory position is foreseen for procurement advice and training till July 1991.

This post was still contracted at the time of the evaluation. Based on the above argument on the financial support for procurement of pharmaceutical raw materials, it is the opinion of the Mission that there is no need for such a position in the POD project, particularly when the current Procurement Adviser is not accepted as an adviser to Vimedimex. The long-term pharmaceutical adviser, supported by the assistant, should be able to provide the advice concerning procurement of equipment and instruments. This takes into account the expected decrease of this type of support because of the low priority currently given to it by the pharmaceutical industry.

3.4.9 Additional Drugs to PHC I and Revolving Drug Funds

SIDA has, during the evaluation period, contributed 2.6 MSEK for additional drugs to the Quang Ninh Province.

The objectives were according to the 1986 project document as follows:

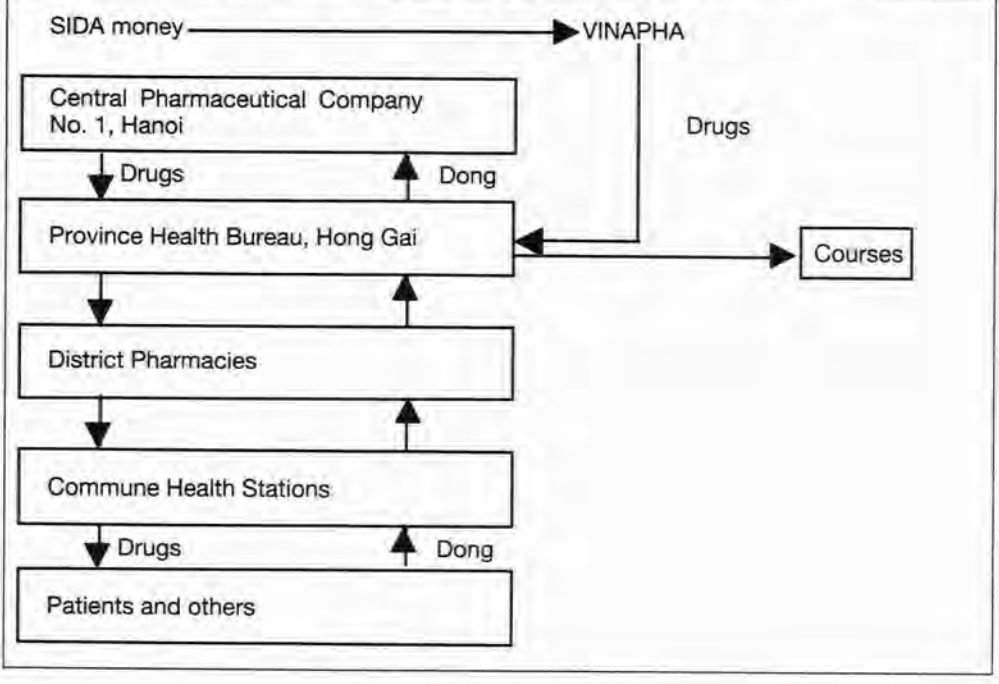
- *To ensure good quality of drugs supplied to the Quang Ninh province, these should be procured from the factories supported by Sweden in the form of larger quotas from the central level.*
- *Pilot districts will be supplied with increased quantities of essential drugs to allow the PHC and training programme to be implemented. This will be combined with training courses in the districts and the use of drugs will be carefully monitored.*

In the Prag report[59] the same subject is mentioned: *The courses have been financed with money paid by the district pharmacies for the Swedish additional supplies of drugs.[...] Finally the Swedish programme collapsed when the amount of drugs was big enough through the regular channels at the same or lower prices.*

These observations made the Mission examine the connection between drugs and training courses. Chart 3:4 illustrates the flow of money and drugs.

59. Prag 1991, p.3 and 5.

Chart 3:4 SIDA support for extra drug supply to Quang Ninh province



SIDA has been paying SEK to VINAPHA. The equivalent amount in VDN has been transferred to the PHB in Quang Ninh. With these funds the PHB has bought drugs from the Central Pharmaceutical Company in Ha Noi. The drugs have been sold to the district pharmacies and the income from this business has been used to cover costs that the Bureau incurred in arranging courses in the province. The end result is thus that SIDA paid for courses. The primary objective was, however, to supply additional drugs to the PHC facilities in the Quang Ninh province. It has not been proven whether this in fact has occurred, as the quantities sold before the project started were not measured. When the project started nobody knew exactly how the normal business was going on in the Province and the belief was that with additional funds the prevailing disequilibrium in the distribution system could be altered. The use of the extra income by the PHB for courses seems to be based on an agreement made at a later stage, when it was discovered that the SIDA money for additional drugs in fact ended up at the Health Bureau.

This suggests that SIDA should not involve itself in complicated business arrangements over which it does not have sufficient control. If it is decided to sponsor courses the scope and price should be agreed upon, and the money be transferred directly to the course arranger.

The latest mechanism for increasing the availability of drugs at the commune health stations is to arrange Revolving Drug Funds. This has been tested by the MOH in some districts. The principle is that the CHS is given a working capital to buy drugs from the district pharmacy, to be sold in the commune. It has been decided to use funds from SIDA

(allocated for additional drug supply to Quang Ninh province) for disbursement to commune health stations as Revolving Drug Funds. In a CHS visited by the Mission the profit from selling drugs was divided in the following way: half the profit was used to increase the capital in the fund to make up for the depreciation caused by inflation, and the other half was used as an extra income for the staff. Such arrangements have resulted in the sale of expensive non-essential drugs in order to increase profit[60].

Before SIDA becomes further involved in this business, more studies should be made in order to ensure that it is not contradicting its objective of rational use of essential drugs.

3.4.10 Finished Drugs to Central Hospitals

1.5 million SEK of the POD funds were used for the procurement of finished products for supply to central hospitals[61]. This has been done in accordance with the project document 1990-1995. However, the Mission is of the opinion that this use of funds does not comply with the objectives of the POD project. Costs for the supply of drugs to the central hospitals should therefore be charged to the corresponding hospital projects.

3.4.11 Training and Competence Development in the POD

The most encouraging and fruitful components in the POD project are those related to training. A wide range of different training arrangements in the forms of courses, seminars, short-term consultants etc. in Viet Nam, as well as study trips both to Sweden and other countries, have given good results. Some examples of particular interest are analysed in this report.

SIDA has been particularly active in the transfer of knowledge for GMP. In the evaluation report of the POD project of 1988 it is said:

> • *Some VINAPHA staff, both from the headquarters and from the factories, have been to Sweden for training. These activities have been very valuable for the understanding of the GMP, Quality Assurance and Quality Control concepts. It has also resulted in GMP courses in Viet Nam conducted by some of the participants in the Swedish courses.*
>
> • *So, from a theoretical point of view these activities have been successful. But, when looking into the practical results in the fields of GMP and Quality Control not much has been achieved.*

Although these comments were not very encouraging, SIDA has continued its support during the last three years. However the stress has been more on quality control than on GMP. Today, the situation is quite different from that which was described in the 1988 evaluation report. The factories have paid considerable attention to GMP, by the introduction of Batch Records, In-process Controls, raw material and finished product testing, Release Certificates etc. Also considerable investments have been made in GMP for upgrading of the production facilities. International standards have not yet been achieved and many problems still remain concerning material handling and reduction of the risks. But the change in attitude and the ambition to improve is very encouraging.

60. According to Svante Prag.
61. POD 1992.

Hence the transfer of knowledge has lead to increased local competence.

The change from a subsidised economy to a semi-market economy has created competition between the different manufacturers of pharmaceuticals and has probably contributed to an increased interest in GMP. This works in two ways:

- As a major part of production capacity is used for manufacturing under contract, every manufacturer wants to convince the contract customers that his factory is the best from a GMP point of view and is able to deliver products of good quality.
- Another major part of the production is sold directly on the free market and every manufacturer wants to boost his image as a leading manufacturer of quality products which compare well with the foreign products entering the market.

Other good examples of competence development were found in the areas of product formulation and process development. A Swedish expert had been to Viet Nam three times to train staff in the central factories on these subjects. In the last evaluation of the POD project few results could be seen. But now several factories have developed their own products based on the know-how they had gained from the Swedish expert. Furthermore, one factory reported that they had saved 35 MVDN on one product last year by improving the manufacturing process resulting in fewer quality defects. These examples of competence development are in part the result of the change in the economic system which has created a concern about results and profits.

It should also be mentioned that in the new economic environment the factories are very interested in receiving SIDA assistance for training and the transfer of knowledge, particularly in the areas of management and technical know-how. Raw materials and equipment are given a low priority compared with transfer of knowledge. This is understandable as the factories pay the full price in VDN for raw materials and equipment resulting in an income only for the MOH. Previously, a certain advantage could be gained by the factories when receiving equipment, because a favourable exchange rate was applied when paying the counter value in VDN to the MOH.

3.5 Central Fund

The Central Fund Project (CF) was originally established as a compromise solution between the MOH and SIDA. The MOH felt a strong need to continue to distribute material support to a number of its institutions, while SIDA had identified a need to strengthen the central management of the Programme. The outcome of the negotiations was the CF. Since 1986, this fund has financed the central activities of the Programme such as training abroad, scientific research and printing of documents for the Programme, as well as management of the Programme and support to institutions.

During the 86/90 agreement period, the CF was allocated 7% of the total Programme budget, while the share during the current period is 6%. The CF is a relatively small share of the Programme, but vested with one very important role, i.e. Programme Management, as well as the role of material support to institutions, which is marginal to the remainder of the Programme.

The underlying cause of the need for strengthening of the Programme Management was the apparent verticality of the Co-operation Programme, i.e. a problem similar to that of the vertical PHC programmes at the national level. The Chiefs of Projects of the

Programme tend to become vertically isolated. This weakness was addressed by the CF. Unfortunately, the problem of verticality and lack of coordination within the Viet Nam-Sweden Health Co-operation Programme has not yet been overcome[62]. In this sense, one of the two main problems addressed by the Project, has not been resolved, i.e. the hidden objective has not been achieved.

As regards the other hidden objective, the CF reports satisfactory progress, given the budgetary restriction. The implementation of the support to institutions and hospitals is not being monitored by SIDA and has not been followed-up by the Mission.

In the current agreement period, the CF functions are reduced to the strengthening of management capacity of the MOH and the Steering Committee, and to supporting a number of institutions and hospitals (currently nine) with materials. These are institutions which are outside the rest of the Viet Nam-Sweden co-operation.

The budget for the 1990-93 agreement period totals 11 MSEK, 28% for Programme Management and 72% for institutional support. During the first 18 months a total of approximately 5 MSEK has been divided as follows: 66% for equipment, 28% for training, and 6% for adviser services.

It is interesting, in terms of the history of the Programme, that the current objectives[63] include the following: Putting, from step to step, the Gender issue into the projects activities, into the medical services as well. No achievements have been reported yet by the Project on this score.

For the current agreement period, the CF has reported different levels of progress in relation to its other objectives. However there are no ways to measure this in terms of achievement of objectives. Similarly, it is not possible to measure the extent to which the weaknesses of the project implementation retard.

In the Missions view, the Health Insurance Commission is a strategic part of the activities, partly funded by CF. In the context of the on-going reforms on health finance, the development of a health insurance system is an urgent task.

3.6 Central Level Integration Project

The Central Level Integration Project (CLIP) was started under the current agreement of co-operation. The purpose of starting yet another project in the Programme was to find ways to achieve integrated planning and provision of health services. The CLIP constitutes about 2% of the current budget for the Programme.

The lack of integration and the need for action had been amply demonstrated[64] by 1990. A total of more than 60 health programmes and projects were then being implemented[65] and their lack of integration caused duplications, increase of health workers work loads and inconveniences for the served population. The Minister of Health emphasised on the problem, in a paper in 1990, adding the need for integration of state management and programme management[66].

62. MOH interview.
63. Central Fund 1992.
64. Cf. for example Segall April 1991.
65. National programmes, national support programmes as well as internationally-aided programmes or projects (WHO, UNICEF, SIDA, UNFPA)
66. *Segall, op. cit.*

The idea of a central integration project was to promote understanding of the need and support for integration at central level in the MOH, while the actual integration should be achieved at the lower levels in the planning and provision of services. The project was related to the experiences from Quang Ninh PHC Project and it was intended to use that project as a base of data and experience during its implementation, as reported by the CF, are important or not..

The projects organisational set-up is rather complex, with the involvement of staff from the MOH, one national institute and the university. The Steering Committee involves the National Centre for Human Resources for Health, the MOH Department of Organisation and Management and a Director of MOH Cabinet. There is also a Secretariat, an Advisory Board and a Working Group. Some of the staff are involved in parallel research projects in Quang Ninh, financed by SAREC and the EEC. Many of the staff are only engaged on a contract basis, i.e. the CLIP hires resources to be used for implementation of activities.

The project was slow to start, this seems to have been due to the organisation of the project, as well as to the vagueness of its purpose as perceived by the participants. While the people involved may have known that the key was a change of attitudes in the MOH combined with a change of power relations, the relation between these factors and the project activities may have been rather blurred.

The project has carried out studies and worked out a draft set of National Guide-lines for PHC services. The latter will currently be reviewed and tested in Quang Ninh. It is generally agreed that the guide-lines in their present form are academic and lengthy, i.e. impossible to use in their present form. The studies are part of the working method of health systems action-research. The Mission has not been able to study whether the on-going research is appropriate to the projects objectives or not.

3.7 Medical Equipment Project

The Medical Equipment Project (ME) has been part of the Programme during the whole evaluation period. During the first agreement period it received about 2% of the Programmes allocations, while during the second period this share has increased to about 3%.

The existence of a project for support for equipment is entirely logical in a Programme where the roots are equipment intense. The technology levels of the hospitals supported by Sweden and the equipment delivered to the system mean that there is a need for continued material support in the form of spare parts and maintenance.

The ME is divided into three sub-projects. One is the Central Medical Technical Workshop (CMTW), the second is the Medical Instrument Factory No. 2 (MIF2) and the third, from the latest agreement period, is Southern Medical Technical Workshop (SMTW).

The support has had two components, one being short-term consultants for advice and training, the other being financial support for purchase of spare parts and raw materials for repairs, maintenance and production of medical equipment.

The funding of the project and its utilisation is illustrated by table 3:5[67].

67. From ME report, May 1992.

Table 3:5 ME funding and utilisation

000 SEK	1986	1987	1988	1/89-06/90	07/90-12/91
CMTW					
Allocation	838	500	500	672	660
Utilised for repairs	730	383	359	500	0
Utilised for production				538	600
Remaining	108	225	366	0	60
Total funds available	838	608	725	1038	660
Quantity of ME repaired	300	350	350	400	439
Incomes repairs	233	180	230	225	245
Incomes production				600	660
MIF 2					
Allocation	1000	100	527	0	680
Utilised for production	915	193	29	489	687
Remaining	86	-8	498	9	-7
Total funds available	1000	186	527	498	680
Income production	200	250	510	540	720
SMTW					
Allocation					700
Utilised for repairs					450
Remaining					200
Total funds available					700

Source: ME

The allocation of funds to production units and their utilisation does not convey the extent to which the units have been successful in their economic activities. The income figures in the above summary do not reflect income related to the activities of period in question. The expenditures are also shown as per day of payment, not related to activities[68]. In some years, for example, large amounts may have been spent on production, while the sales of the products may have been made during the following year. A simple addition of utilised funds and incomes demonstrates, however, that total income during the whole period does not get even close to the total funds utilised: 22% of the utilised funds have not been earned as income.

The Swedish support for Medical Equipment has had the purpose of facilitating the provision of services in hospitals and other health facilities by supplying equipment and spares. The indirect way of supporting this, i.e. through the imports of parts, raw material and advisers, has turned out to be counter-productive. This can be demonstrated by the flow of funds and equipment and all the conditions necessary for the system to work. Chart 3:6 illustrates the flows, with CMTW as an example.

68. In terms of accounting, this simply means that the table shows incomes and expenditures, but not revenues and costs.

Chart 3:6 Situation up to 1991

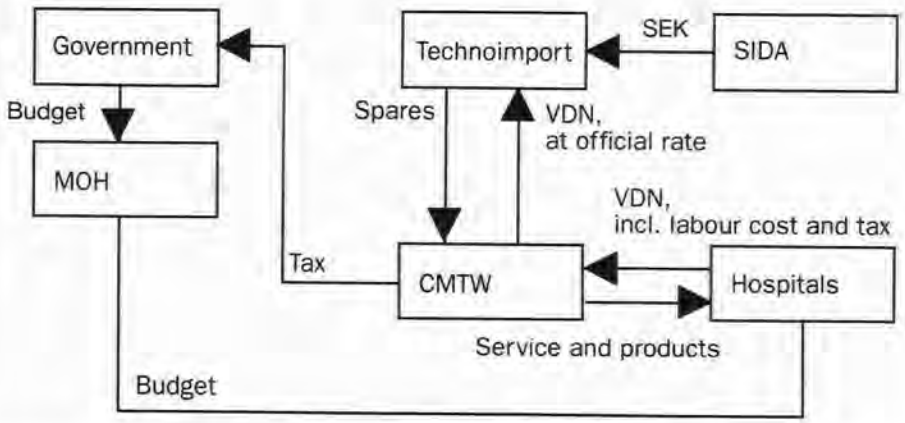


Chart 3:6 illustrates how the support to ME was supposed to function in the Vietnamese system prevailing until 1991. The first thing to note, is that the two main effects on the system, apart from medical equipment or services reaching the hospitals, are that the money ends up in the MOH and that the CMTW receives a subsidy as soon as the official VDN exchange rate contains a subsidy (up to 1989). But the critical link in this system is the hospitals payment to CMTW: it has been very difficult for CMTW to get payment. When the system breaks down because of non-payment, the end result is that the flow of spare parts is stored at CMTW and no deliveries to the hospitals take place. This is what has happened over recent years, when hospitals did not want to pay or were unable to pay. Capacity utilisation at the workshop went down below 50% and the spares remained in the stores. As can be seen in the above table the CMTW stopped purchasing spares.

In 1992, according to CMTW, the Minister of Health has decided that the hospitals should no longer pay for the spare parts. The consequences of this may be that the spares are given to the hospitals. This would increase capacity utilisation at the workshop, create access to spare parts for the hospitals and if the CMTW can generate a surplus on its labour costs it would create income for the company. In the Missions opinion this change would imply setting up a new system of subsidy.

It can be concluded that the ME Project may have contributed to the improvement of the equipment situation in the health facilities in the beginning of the period of evaluation. However the economic reform process gradually, and to an increasing extent, made the Project concept redundant as it was designed for the old subsidy system. In 1991 the Project was no longer workable. In the meantime, the cost-effectiveness of the Project has been reduced. It is providing subsidies to production units. The impact of short-term advisers and training will be lost to the Health Programme unless the companies survive in a competitive environment and continue to serve the hospitals.

The Mission recommends that support for equipment in the Health Programme be given, if it is considered a priority, by financial support, advisers and short-term consultants within the Projects of the Programme, but that the ME Project in its present form be phased out.

3.8 Training System Support Project

The Training System Support Project was officially initiated on July 1st, 1990. Some activities of the project commenced at that time, but it took until April 1991, when the revised Project Document was agreed, for the project became fully operational.

The overall purpose of the project is to support the MOH in strengthening the capacity of the training system for health workers and to support the implementation of the Health Manpower Development Plan. One of the continuing tasks of the TSSP will be to support the annual revision of the Health Manpower Plan and to establish competence (in terms of individual skills and organisational capacity) to complete this task. For the present discussion on quality instead of quantity, and retraining instead of training, this kind of manpower data is of great importance.

The project has been working towards the establishment of Provincial Continuing Education Boards, responsible for retraining, as well as for the development of teaching methods in the provinces. Fourteen such boards have been established.

The TSSP has been instrumental in the preparation of a new National Second Level Nursing Curriculum that is about to be completed. This curriculum incorporates a modern approach to teaching with the active participation of the students. The updated training will provide the nurses with a new set of skills and knowledge.

The TSSP has also translated basic PHC books from English to Vietnamese and printed them with a professional layout. This material has been supplied to fourteen schools in the first phase and it will gradually be supplied to other schools.

The TSSP has also worked towards the establishment of relationships with projects funded by other donors in the field of health workers training. Assistance has been given to provinces to assist them in applying for funds from NGOs and other donors for courses and other training activities.

The project employs six full-time staff and two on a part-time basis. It is assisted by one short-term senior consultant who has visited the project four times since its inception. An expatriate long-term adviser has been working at TSSP for the last year.

The project has a more advanced design than other parts of the Health Co-operation Programme. Objectives, strategies, activities and performance indicators have been defined from the beginning. The prerequisites for good monitoring of the project seem to be there.

The TSSP is situated within the Training Department of the MOH and the activities are implemented through the Department of Training. The project has, however, its own budget, its own Plan of Operation and its own Advisers, and in many ways operates independently from the Department. The project is better integrated in the structure of MOH than other projects in the programme. It has the explicit aim of strengthening the capacity of the Training Department to fulfil its duties more effectively and works according to a PlanOp carefully designed to achieve this aim. The question is whether this

Traditionally, the vietnamese nurse is completely dependent on the doctor for instructions and has little or no medical responsibility. The Vietnam-Sweden Co-operation Programme altered this role. The nurses are now responsible for manpower and material management in the IPCH and UBGH hospitals. Photo: Paul Rimmerfors/BAZAAR

process of integration can go further, in making TSSP less of a project and more of a regular activity of one department of the MOH.

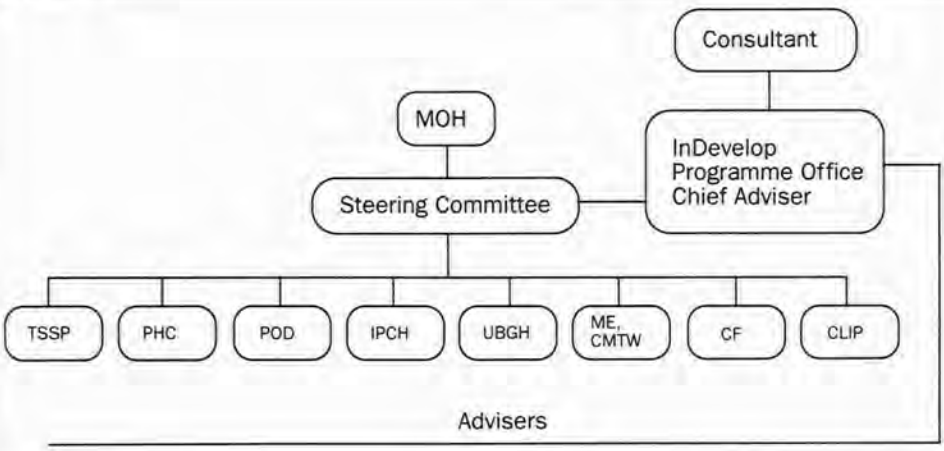
3.9 Organisation and Management

The organisation and management of the Co-operation Programme is a joint undertaking of the three major actors: the Ministry of Health, SIDA and the consultant, presently InDevelop. These three are briefly presented here, while at the same time a few issues concerning the management are discussed.

The Ministry of Health has the overall responsibility for the co-operation with Sweden in the field of health. The organisation of the MOH was illustrated in chart 1:3 above. In the Specific Agreements on Health Co-operation signed in 1986 and 1990, detailed plans and budgets for each project in the co-operation programme are agreed upon between the MOH and SIDA annually.

Between 1986 and 1989 the Viet Nam-Sweden Programme was supervised by a Committee comprising two representatives of the MOH and all Heads of Projects within the Programme. This organisation is illustrated in chart 3:7. The major problem with that type of organisation was the verticality of the Programme, caused by the influence of the Heads of Projects. This reflected the historical trends of the Programme growth, where a large emphasis was always given to projects. Funds were, for example, channelled to the projects, not to the Ministry during that period, as mentioned earlier. With the efforts to achieve integration, i.e. reduction of the verticality of programmes in general and the Viet Nam-Sweden Programmes in particular, this organisation became outdated.

Chart 3:7

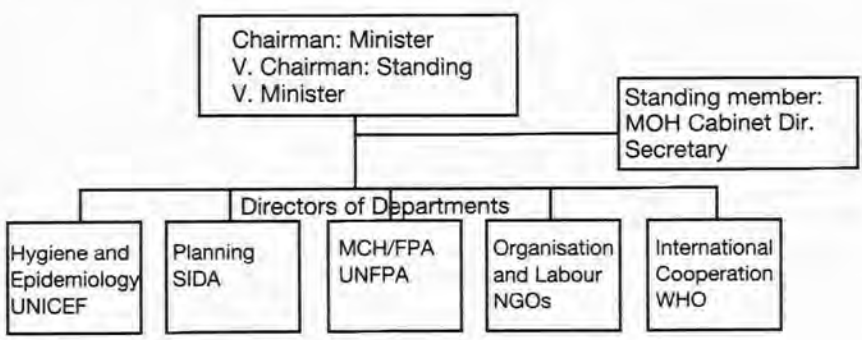


Source: Job description 1990, chief adviser

In 1989 when a Programme Management Group for the Viet Nam-Sweden Programme was formed within the Department of Planning of the MOH. The Management Group consists of six persons and is chaired by the Assistant Minister. This change implies an improvement of the opportunities for guiding the Programme by general policies in an integrated way.

In the same way, the MOH has formed a Steering Committee to co-ordinate all projects supported by foreign donors. The organisation within the MOH to deal with donors is described in chart 3:8.

Chart 3:8 The Steering Committee of the Health Programmes



Under each department assigned for a particular donor there are several projects. In the future, the requirements in terms of donor co-ordination on the part of the MOH will be increasing at a rate corresponding to the increase of donor support to Viet Nam. The responsibility for this co-ordination is now vested with the Steering Committee of Health Programmes. In case the function of donor co-ordination needs to be reinforced by adviser services, it is recommended that SIDA approves of such support.

The Swedish International Development Authority represents Sweden in the Co-operation Programme. SIDA is represented in Ha Noi by the Development Co-operation Office of the Swedish Embassy.

SIDAs Health Division in Stockholm is the operational unit within SIDA, responsible for the outline and follow-up of the Co-operation Programme. The original major Swedish consultant involvement in the Programme started with the planning and construction of the two hospitals. Hifab AB was then leading those projects. This task led to a broader engagement when Hifab also assisted in recruiting advisers. Around 1983, a unit of the University of Uppsala, ICH, was engaged for the medical expertise services.

InDevelop Uppsala AB (International Development Consultant Services) is an independent Swedish consulting company, providing technical assistance and project management in health care. It was established in 1985, jointly by the University of Uppsala and Hifab AB, Stockholm, with the health programme in Viet Nam as the main rationale behind the establishment of the company. InDevelop has since 1986 been commissioned by SIDA to administer the Swedish support to the health sector in Viet Nam. InDevelop is responsible to the MOH and SIDA in accordance with a contract between SIDA and InDevelop[69].

The companys annual turn-over is around 13,5 MSEK, 70% of which is generated by the Viet Nam programme. The remaining 30% consists of a contract with NORAD for a Nordic Clinic in Tanzania and consulting services for other organisations. The core staff in the Head Office in Uppsala consists of 6.6 persons (1992), of which 6 persons are involved in the administration of the programme in Viet Nam. The Uppsala staff dealing with Viet Nam are the following: Director, Finance and Personnel Manager, Project Co-ordinator, Finance Officer, Training and Recruitment Officer and a Secretary.

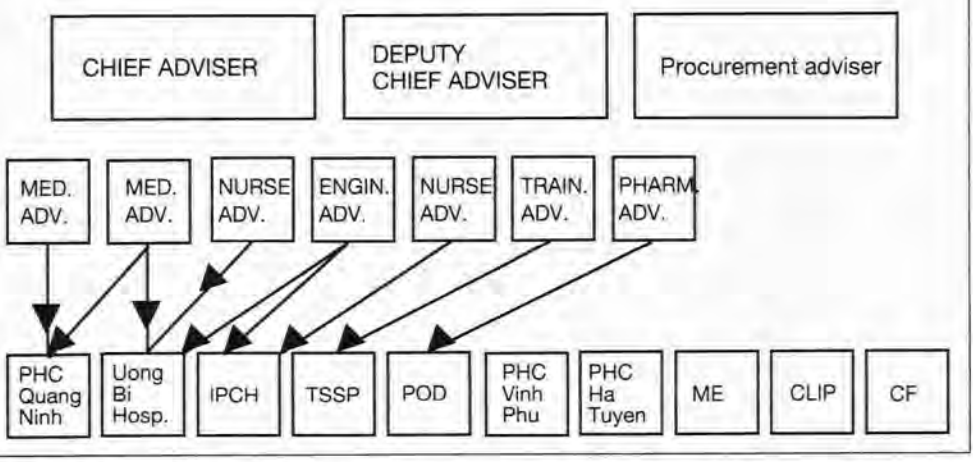
These six staff members are not fully occupied with the Viet Nam programme, especially the Director, who has overall responsibility for all InDevelops activities. It is not possible to get exact figures on how much time each employee devotes to the Viet Nam programme. It varies over time. However with the Viet Nam programme representing 70% of the companies turn-over it is clear that, with the exception of the Director, Viet Nam is the main activity of the above listed staff.

The administrative set-up with six persons in Uppsala and seven in Ha Noi dealing with the management and administration of the programme seems top heavy and costly. The functions of the two offices should be further investigated with the aim of merging posts and reducing the costs of administration. It should for example be possible to run the Ha Noi office with only one Chief Adviser, who should absorb the duties of the Assistant Chief Adviser.

69. Terms of Reference for Consulting Services, Health Co-operation Sweden-Viet Nam, 1990. InDevelop was awarded the contract after competitive bidding.

The projects and the long-term advisers in Viet Nam are co-operating in the way shown in chart 3:9 (1992).

Chart 3:9 Project and long term advisers



InDevelops interpretation of its role as consultant has changed over the years. In the beginning of the evaluation period, they acted in a more interventionist way, with active involvement from the Ha Noi office in the different projects. Gradually, that office has reduced its interference in the different projects. At present the role of adviser to the MOH and of administering the programme is emphasised. Their role is seen as giving advice, and encouraging the MOH to act rather than to take action themselves. This emphasis is also manifested in the manning of the Ha Noi office, with a gradual change from medical professionals to professional administrators. The office has also moved to the premises of MOH. Recently there has been a gradual Vietnamisation of the InDevelop Ha Noi office, which now has two Vietnamese Assistant Programme Officers and one Vietnamese clerk, a secretary and an interpreter[70].

InDevelop has gradually taken over administrative tasks from the SIDA office in Ha Noi. Re-allocations between projects are formally decided by the SIDA office based upon proposal from MOH and InDevelop, but SIDA very rarely opposes the advice of InDevelop.

It may be observed that the division of roles between the MOH, SIDA and the Consultant is a key factor in the organisation and management of the Programme. Over the years these roles have shifted. From an initial situation where the Consultant had an executive role and SIDA carried a large share of the responsibility of monitoring, the role division has shifted to the current situation where the MOH carries the overall responsibility, the Consultant is only adviser and where a lot of the administration on the Swedish side is handled by the Consultant. The present division of roles has recently developed at a quick rate, particularly after 1990.

The Mission has found the present division of roles to be the most conducive to

70. As of July 1992, the camp administration has been taken out of the Health Programme, which is a positive development.

development of the health sector. Although the responsibilities are shared between the three actors also in the sense that no single one of the actors may be blamed for a particular aspect of the programme organisation or management we have noted that a main factor behind the present division of roles has been SIDAs explicit effort to assign a purely advisory role to the Consultant in connection with the emphasis given to competence development in the Programme.

3.10 Competence Development

The concept of Competence Development needs to be defined as there are many different interpretations of the term. Many other names have been used for the same thing, e.g. transfer of knowledge or exchange of knowledge. One of the reasons for using the term competence development instead of transfer of knowledge is the conviction that the development of competence is a two-way process, where advice and knowledge have to be requested, accepted, understood and relevant in their context.

Competence development takes place, in this case, at three different levels. The first level is the staff that has to be trained in order to obtain the necessary skills to perform their tasks. This training can take place in different ways and can either be formal training of different skills or on-the-job training. The next step in this process is to make use of the better trained staff in an appropriate way. They must be trusted with tasks in accordance with their new skills and given remuneration in the form of career development and better salaries for having acquired more skills and higher competence.

The third level is the development of competence in the system itself, which is similar to organisational development. This requires a long time perspective. The management training in Quang Ninh is one example of efforts to improve the organisation of PHC.

Competence development has in different ways been part of the programme throughout the evaluation period, but has been given increased emphasis over the years. A weakness has been the lack of definition of what it actually means in the different projects. Sometimes it is more clearer to talk about training or retraining, when that is what is needed. In other cases a discussion of competence development within an organisation might have resulted in other ways of attacking the problem, e.g. increased co-operation between Swedish and Vietnamese institutions. It might also have led to the conclusion that in some cases financial or organisational changes are prerequisites for increased competence by an institution or a part of the system.

Throughout the programme, advisers have been considered to be the main vehicle for transfer of knowledge or competence development. Between the years 1986-93, 68 expatriate (mainly Swedish) long-term advisers have been employed in the programme.

In table 3:10 the length of the contract periods for long-term advisers is illustrated. It shows that contract periods have generally been short, especially for the medical advisers, where the average contract period has been only 17,4 months. Taking the costs for recruitment, preparatory training, travels and installation into account, this period is too short to be cost-effective. The average contract period in most SIDA-programmes is three years. It is known also from other studies[71], that longer contract periods generally increase the effectiveness of this type of assistance.

71. Cf. Forss et. al., 1988

Table 3:10

Projects (incl. HSO/IPO)

	Contract period (months)	Number of persons
Medical advisers (PHC, IPCH, UBGH)	17,4	14
Nurse Tutor	28,6	12
Training Adviser	24	1
Pharmaceutical advisers	23,2	5
Engineer Adviser	37	2
Procurement adviser	26,7	3
Interpreter	35	1
Chief Adviser (and Assistant Chief Adviser)	24,9	8
Average LTA	23,5	46
Camp Administration, Clinic, School		
Secretary	14	4
Administrator (Camp)	16,3	4
Camp Technician	28,3	7
Staff Physician	20	4
Teacher	32	3
Overall average	23,6	68

(Locally recruited personnel, e.g. camp masters, are excluded.)

Three reasons for the high turn-over of technical assistance personnel have been suggested: the career possibilities in Sweden, the difficulty for accompanying family members to get employment in Viet Nam during the period evaluated and the timing of contract periods between SIDA and InDevelop. The contracts for advisers have sometimes been shorter than planned because InDevelop has not known whether they will be in charge after their present contract with SIDA has come to an end. This was the case in 1990 and is the situation right now: the contract between SIDA and InDevelop expires in July 1993.

Quantifiable indicators for competence development are rarely used. Some efforts have been made in the PHC project in Quang Ninh, but generally there are no ways of measuring the impact of the work of the foreign advisers. The general attitude towards the advisers is positive, but the reasons for this vary. In some cases the adviser is the bridge to hardware or to important contacts needed. To get frank answers about the need for an adviser is always difficult. In some cases it is quite evident that change is taking place as a result of the input from an adviser, but in many cases it can be argued that the impact can only be seen in a longer perspective.

Efforts must be made to better define the need for an adviser. The job descriptions for

the present advisers have no phase-out plans and have few indicators for measuring the competence development that is supposed to take place as a result of the work of the adviser. This should be changed and the possibility of recruiting a Vietnamese expert if additional funds are made available should be discussed in all cases where requests for foreign advisers are made. If such an analysis is made in all cases where there are Swedish advisers today, it is likely that some of the posts could now be Vietnamised. It should also, in some cases, be advantaged to make use of former long-term advisers, with good knowledge of the Programme, as short-term advisers, instead of recruiting new long-term advisers.

Another problem observed in this context is related to the incentives for the consultant to work for a rapid Vietnamisation of the programme. In the present contract between SIDA and InDevelop, based on the Standard Conditions for Consulting Services, costs for the consultants administration in Sweden are mainly based on a percentage of the fee for the advisers. The monthly fees for advisers are agreed upon between SIDA and InDevelop and costs for administration and project coordination are parts of that fee.

A rapid Vietnamisation of the programme resulting in the employment of lower cost advisers would immediately reduce the funding for InDevelops overheads

Even if this is the normal procedure when hiring consulting companies, it has clear disadvantages in the current situation, as it could be a disincentive for Vietnamisation and the withdrawal of Swedish advisers. SIDA should examine alternative ways of financing the administration, based on an analysis of the necessary administrative resources to run an operation of this size.

The importance of the question of language became very apparent to the team during the evaluation. The discussions through interpreters or using a mixture of English, French and translated Vietnamese gave a very clear picture of the problem of being an adviser without having a knowledge of Vietnamese. An enormous effort is made on the part of the Vietnamese to learn English. This often has many advantages, but sometimes it was doubtful whether learning English was really relevant at that point in time. In some cases it might be better for the adviser to learn Vietnamese before taking up the assignment in Viet Nam. In the recruitment of advisers to the Programme, knowledge of Vietnamese should be a key selection criterion.

A problem frequently mentioned was the fact that the reports of short-term advisers are often translated months after the visit of the adviser, which makes it very difficult to make proper use of the advice given.

3.11 Gender Aspects

Although, gender analysis has been omitted from the Health Co-operation Programme, the Mission has been requested in the TOR to look into the question. This section gives a brief description of the situation in Viet Nam and the Programme.

3.11.1 Gender Awareness in Viet Nam

The concept of gender aspects of activities is new in Viet Nam. Most Vietnamese confuse the issues of gender with those of sex[72]. When gender issues are discussed, people anticipate that feminists will argue for improved status and protection of women and in

general give women equal rights with men. In other words, women should have the rights that men have, and women should do the things men do. Often, people are blind to the economic effectiveness of female participation in various activities.

There is limited knowledge about gender questions in general, and a particular lack of awareness about gender interests and gender needs. Potentials and constraints of men and women, especially poor men and women, affecting their participation in social activities, are not considered when projects are planned and implemented.

At present, the situation in Viet Nam is the following:

- On one hand, the basic idea is that women and men have different roles in the family and in the society. Women deliver children, take care of them and the other members of the family. They cook, wash and clean the house. Men earn money, manage the family and the society; in other words, carry out productive activities. This set of ideas have their origin in Confucianism and feudalism as both these ideologies stress the differences between women and men, giving women a subordinate status.
- On the other hand, after Independence in 1945, the Government of Ho Chi Minh paid much attention to the improvement of the role of women in all social activities. As stated in laws, decisions, and rules, women and men are equal. In some cases, State rules even favour women in comparison to men, such as in education, in the allocation of houses, and in political work, particularly in the 1960s and 70s and in the beginning of the 80s.

Because of the State policy that encourages women to take part in production and also because of the poverty in Viet Nam, women have engaged very actively in production and are now of key importance as a productive force. This situation, which is easily observed in the society, has led many Vietnamese to believe that women are quite equal to men in society and that they even have higher priority in some respects. Thus there are no gender problems in Viet Nam. Regrettably, this perception is false; Viet Nam has indeed many gender problems. Confucian and feudal beliefs are still widespread and may stage a comeback if the situation is favourable.

3.11.2 Gender Issues in the Programme

There is a general lack of gender awareness in the Vietnamese-Swedish Health Cooperation Programme[73]. Among all the project documents, gender issues are mentioned only once, in one of the objectives for the Central Fund Project. In the text related to project implementation, there is no mention about gender. It is thus impossible for the Team to evaluate gender-related achievements in relation to targets set in the documents.

Through interviews during field visits, however, the Team has understood that project

72. In this report we try to apply the concept of gender as defined by SIDAs gender courses, i.e. as for example in a handout in the course given in Sigtuna 15-17 June 1992: Sex identifies the biological differences between women and men. Gender identifies the social relationship between women and men. It therefore refers not to women or men but to the relationship between them, and the way this is socially constructed. Gender relations are contextually specific and often change in response to altering economic circumstances.

73. It is surprising that a study of gender issues related to health in Viet Nam has never been carried out in the framework of the Programme. In the 1985 report by Segall (Segall 1985) such a study was suggested, i.e. the same year as SIDA adopted its present position on how the role of women in development should be considered in SIDA-supported activities.

Vietnamese women on their way to the market. Just one part of their hard working day. Photo: Paul Rimmerfors/BAZAAR

staff look for ways to introduce gender issues both in the overall programme and at the project level. In comparison with the situation before 1986, there is at present a much better understanding of the need to integrate gender issues into the programme. The lack of knowledge about gender issues and the complete lack of implementation of any gender-specific activities in the programme is, however, still conspicuous.

The low standards of food, sanitation, and environment, as well as the heavy workload with few opportunities for rest, have a negative influence on health, particularly for women and children. Under nourishment affects about 42% of the children under five years of age and about half of all pregnant women in rural areas. Many women have persistent, often untreated, gynaecological problems, because of poor hygiene. In poor areas, particularly among ethnic minorities, there is a general lack of sanitary facilities and clean water. Ponds and lakes, rather than wells, provide water for cooking and other household uses for approximately 40% of all farm households. In poor areas, the proportion is even higher; many people use untreated water even for cooking.

The economic problems faced during recent years have also affected health services. Only few drugs and very little equipment are available in communal health stations and local hospitals. Poorly trained and poorly supervised health workers work under difficult conditions and with low salaries. This erodes morale and make it essential for them to have other sources of income. Although there is a health station in every commune,

nominally providing primary health care, because of the problems outlined above, there is very little ante natal care for pregnant women. Babies may be delivered by inadequately trained staff or by relatives at home. In many places, women have to travel to the district hospital for advice on procedures related to family planning. Particularly in remote areas, there may be no drugs in the health station for acute conditions. In order to solve some of these problems, charges have been introduced for health services. This may however cause additional problems for women, while at the same time not necessarily improving the available health care. Private practices by state health workers are now allowed and provide another option, particularly for urban women, but the poor and many rural families will not have that choice. Health services provided in state enterprises (for example in forestry) are often of a better standard, as they are better funded. If health services do not receive external support, they are likely to deteriorate rapidly, especially in remote areas.

Family planning is a problem area within the health co-operation programme, which merits serious attention. It is, at present, a major national issue in Viet Nam. Most family planning methods focus on women, thus giving women an additional major responsibility. The high rates of abortion indicate the seriousness of the problem. Many women have abortions already after the first child is born and many more after the second. Many women have several abortions during their fertile period. Nevertheless, very little attention has been paid to this problem.

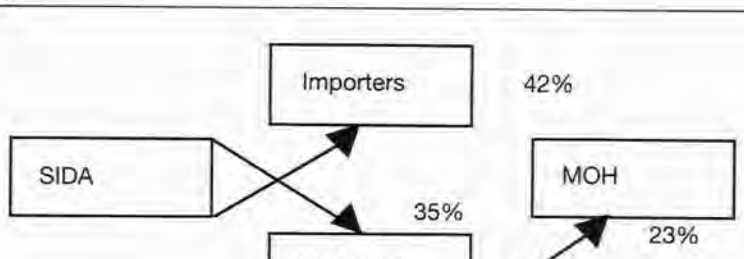
The poor health services at the communal level have a particular influence here. IUDs are the main method for preventing pregnancies. Only few communal health stations have, however, the ability to insert IUDs properly. Women can go to district hospitals, but will then lose much time in travelling and cause problems in their families by their absence. Instead, most wait for the district family planning team to come to their commune. These teams come to the commune about once a month or once every few months. Some communes are not visited at all. In the communes, facilities are not good. The lack of clean water is a particular problem. Many women also have problems using the IUDs, particularly in the beginning. Some become ill, and because they are not given proper attention or supervision by health workers, serious cases may develop.

As in most countries, women have been singled out for particular attention in the health strategies in Viet Nam, both in terms of their needs and their responsibilities. Integration of gender issues into programme and project documents and the subsequent implementation in the field are urgent priorities for the Vietnamese-Swedish Co-operation in the Health Sector.

3.12 Financial Management

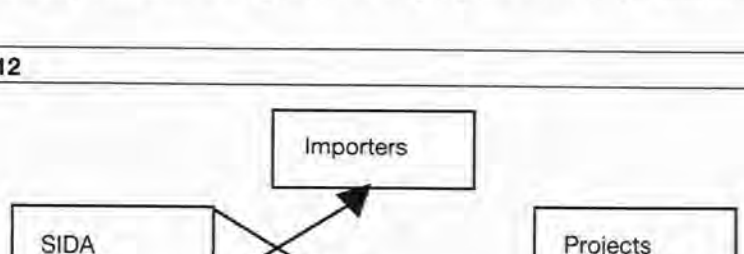
The financial management of the health co-operation programme currently involves three financial flows: one is from SIDA to the Consultant, another one from SIDA to Vietnamese companies, and the third one is from SIDA to the Consultant and further on to the Ministry of Health. Each flow represents various items of software and hardware, local costs or foreign exchange costs. This can be illustrated as in chart 3:11, where the percentages, (based on 90/91 budgets), indicate the respective shares of the total flow.

Chart 3:11



Before 1990, the situation was different in that the MOH did not monitor any of the flow. During the period from 1986 to 1990 all foreign exchange costs as well as local costs were paid, either by SIDA to the Vietnamese companies (Technoimport for equipment, Vimedimex for chemicals and drugs) or from SIDA to the Consultant. In this system the Consultant paid funds for local costs direct to the projects. This meant that the MOH was not involved in any financial management of the programme funds, as illustrated in chart 3:12.

Chart 3:12



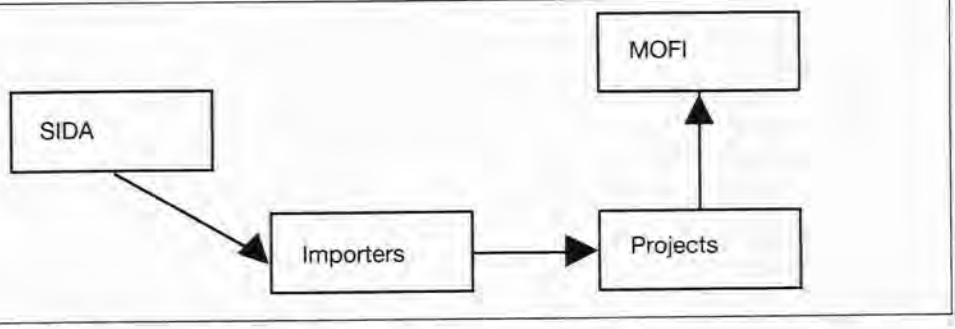
In 1992, a new model was introduced, wherein the local costs are paid from the Consultant to the MOH, instead of to the projects. This model was presented and discussed during 1991, and has been implemented during the first quarter of 1992. In this model the MOH disburses, monitors and follows-up the funds for each project.

In practice financial monitoring is the responsibility of the Consultant: 1) the Procurement Adviser still has to approve all purchases, imports as well as local goods, although there is no written regulation to this effect; 2) all the other foreign exchange costs can only be monitored by the Consultant, not by the MOH. SIDAs role in the monitoring of costs is very limited, as it basically relies on the Consultant.

The only funds that came to a Vietnamese ministry during 1986 to 1989 were funds generated by the sales of products in Viet Nam, which ended up in the Ministry of Finance

(MOFI), until Decree 114 was passed by the Council of Ministers in 1989, after which these funds were received by the MOH. Chart 3:13 illustrates the situation before 1989.

Chart 3:13



After Decree 114 was passed the MOH became final recipient of funds used for purchases of hardware to be sold in Viet Nam. This situation, currently valid, is different from the above chart only in the final destination of the funds, i.e. MOFI is replaced by MOH as the recipient.

The Mission has been informed by the MOH among others about the on-going discussion between the concerned Ministries, regarding the effects of Decree 114. Without having any firm view on the details of the consequences of various arrangements, the Mission believes that a solution, in which the SIDA funds are allocated and monitored by the MOFI, would be more in line with the overall efforts to support the reform process.

A matter that should be considered is the entry point of SIDA funds into the Vietnamese financial system. As was illustrated above, there have been different entry points in the history of the Programme: the projects and the MOH. There have also been two different end recipients for part of the flows, MOFI and MOH. In order to clarify the roles and responsibilities along the lines of the co-operation between the two countries, the Mission suggests that only one entry point should be used for Swedish support. This point ideally should be the Ministry of Finance. The responsibility for the transfer of funds and financial monitoring, as well as for financial reporting to SIDA, would then be vested with that Ministry, while the Ministry of Health in turn would monitor the programmes in the health sector and report to the MOFI. Due to the on-going discussions in Viet Nam and due to the Missions limited knowledge as to the present capacity of the MOFI it would be premature, however, to make a firm recommendation on this issue at this point.

3.13 Replication of Experience

The question of the extent to which experience from PHC I may be replicated in other provinces is important. However the Mission has found that the Quang Ninh model (in terms of management and organisation of PHC) does not exist for any practical purpose: it is not clear what exactly would constitute the model.

In the present process of change in Viet Nam a great number of models may be

invented and tried and some of them may be replicated by others at the same level, be it commune, district or province. Due to the varying conditions in the country, many models will be needed.

On another level, experience from the Health Co-operation Programme may of course be transferred to other areas: i.e. curricula, guide-lines, etc. that have been developed in the Projects.

3.14 Culture and Communication

In spite of the fact that the Mission does not possess any formal background in the fields of culture and communication, our experience from Viet Nam and Sweden merits some comments. In less than four weeks we have witnessed a number of problems of misunderstandings and non-communication between intelligent people who are sincerely struggling to understand and to be understood. It is impossible to be certain about a given answer in many interview or discussion situations, unless one patiently verifies it over and over again.

The reasons for this situation are many, but they are certainly related more to differences in culture and language than to anything else. It seems there is a filter between the two sides: this filter tends to distort messages between two individuals trying to communicate.

The question is: from what is this filter made. One component may be the cultural differences between Viet Nam and Sweden. Those differences may be traced back to Confucius and Luther, but also to climate and degree of industrialisation. Such differences can of course be overcome, but it takes time and hard work. A second component is the simple issue of language: the official language between Viet Nam and Sweden is English, a language foreign to both sides. When Viet Nam and Sweden started to co-operate in the Health Sector, English was not spoken by many Vietnamese people. Sweden opted not to train its officials and experts in Vietnamese, which is exceptional in Swedish international development assistance. It should therefore not be a surprise that it has taken a long time for the communication between Vietnamese and Swedes to develop, and it is still not fluent. A third component of the communication filter has certainly been the mixture of different political systems and a political fraternity stemming from the Swedish support to Viet Nam during the war: the Vietnamese side has been more secretive than would otherwise be the case and the Swedish side has been more accepting and less demanding. A fourth component has probably been a genuine lack of understanding of each others social and political system. The Swedes could not grasp how the Vietnamese system worked unless they spent a long time in the country, and the Vietnamese could not understand how the Swedish system of grants for development aid worked in terms of conditionality and degrees of freedom for the recipient country.

Over time the filter will create less and less distortions of the communications between Vietnamese and Swedes. The Vietnamese side is now investing in English language training and is rapidly improving the quantity and quality of its English speaking professionals and interpreters. We are convinced, however, that in the past the communication problems have influenced considerably the Health Sector Co-operation between the two countries. There are reasons to believe that the slow start of the PHC Project was partly caused by the communication problems.

As previously mentioned in the section on Competence Development, the Mission recommends that SIDA should reconsider its policy of not requiring of long-term experts to learn Vietnamese. The Australian and US policies on this issue should be noted

3.15 Procurement

For a Programme where the current common denominator between Projects is competence development, the share of costs for hardware in the Health Co-operation Programme is high, i.e. above 55% in the current period. It has been demonstrated in this report that this is part of the historical heritage of a Programme, originally strongly influenced by the idea of material shortages in the Vietnamese system. The large proportion of the budget which is used for equipment and materials suggests that procurement is an important area for analysis in any evaluation of the Programme.

Some aspects of procurement were discussed in the above Sections on Projects. This Section presents some general comments are presented on the subject.

The Programme has always had advisers for procurement (since 1980). In the current period, the Procurement Adviser has a central position without being attached to any specific project. The adviser participates in all purchasing, at least at the final approval stage, although there is no written instruction to this end. In fact, even the Head of the DCO is still, unwillingly, signing procurement documents in spite of the fact that this should not be his role. The involvement of the Procurement Adviser at Vimedimex is reduced to none, while it is still strong at Technoimport and the Projects.

The present distribution (budget 90/91) of actual purchases is as follows: InDevelop accounts for 44% of the budget in the form of materials, while the MOH accounts for roughly 10% of the total budget in this form. The actual material purchases are divided between Technoimport (about 17% of total budget), Vimedimex (around 27%) and the Projects (less than 10%). Almost 80% of the local purchases are to made by Projects, the rest by Technoimport.

Technoimport is presently undergoing changes as a result of the reform process. There is a growing cost-consciousness in the company. Its previous commission on SIDA purchasing (1.54%) does not cover its costs, including the office in Stockholm. Since the MOFI has terminated the payment of commission, the Projects are charged with this function, but they have no means to do so. Technoimport is therefore trying to identify other ways of recovering its costs incurred when purchasing with SIDA funds.

The introduction of new tender procedures at Vimedimex is recent. When questioned by the Mission as to the new procedure had resulted in lower prices, the two offices of Vimedimex gave different replies. The Ha Noi office whose earlier experience was based on purchases from the Eastern Bloc countries could not make a comparison. The Ho Chi Minh City office which had long experience from trade with Western countries said that the prices were the same as when applying their normal purchasing procedure. They were familiar with the different manufacturers on the world market of the materials concerned. After asking for quotations and negotiating the prices they placed their orders. They found the SIDA procedure very complicated and time consuming. The Mission concludes that the tender procedure has very limited advantage.

It was surprising, when so much expertise has been involved from the Swedish side,

to find that the Vimedimex procurement was still arranged as annual orders of fixed quantities with one large delivery in most cases. This in spite of the fact that most pharmaceutical raw materials are sensitive to heat and humidity and that their quality deteriorates over time. (Viet Nam has a very hot and humid climate). When buying large annual quantities, large storage facilities are required by the recipient. The loss of interest on their working capital, required for raw materials, does not seem to have been considered. Placing orders based on fixed annual quantities also involves a considerable risk since demand can change. This is just what happened when the Government liberalised import regulations and the central factories had to face competition from foreign manufacturers. Large quantities of raw materials for the production of essential drugs are now stored in Viet Nam because imported finished products are available at prices which the governmental factories cannot match, if they are to cover their costs.

The present changes affecting those companies which have been importing for the Health Sector Co-operation Programme impinge upon all aspects of their activities: revenues, credits, costs, etc. The procurement procedures are an important element, but until the transition of the companies has been completed, there is no need to focus on procurement and the provision of a Swedish adviser for this task is unnecessary.

3.16 Cost-effectiveness

It has not been possible to measure cost-effectiveness in a quantitative, comparable way at project level. No such indicators have been established in the projects and no suitable comparative figures have been available. **Annex 6** illustrates what is meant by cost-effectiveness analysis. In this sub-section we simply present some alternative ideas and questions on the performance of the various components of the Programme.

It is a well known[74] observation that the first years (1986-1989) of the PHC I witnessed very slow progress, implying that the costs for the produced results were unnecessarily high. A number of reasons may be identified for this, and we suggest that they probably include:

- lacking of a common understanding of the project concept
- communication problems
- inappropriate recruitment of advisers
- too short duration of long-term advisers presence
- too many changes of the Vietnamese leadership
- insufficient professional back-stopping to the advisers

All of the above hypotheses have their defenders. Without being able to know which ones have the greatest explanatory value, it may still be noted that cost-effectiveness was unsatisfactory during that phase of the PHC I. It seems to have improved during the present agreement period.

The costs for the Viet Nam-Sweden Health Co-operation Programme from July 1986 to December 1991 are shown in table 3:14 (thousand SEK):

74. Cf. observations by the Project, the MOH as well as Senior Advisers and SIDA officials.

Table 3:14

	1986	1987	1988	1989	1990	1991
LTA	4.855	9.837	9.340	10.232	7.619	7.320
STA	663	2.153	2.310	866	1.867	1.858
H&A	2.000	5.700	5.751	5.179	4.519	5.532
Total programme costs	18.641	50.519	31.198	64.376	37.125	59.196
HSO/IPO (incl. above)	1.138	2.562	2.583	2.683	2.064	1.915

Notes: LTA = Long-term advisers, STA = Short-term advisers, H&A = Housing and Administration; HSO/IPO is the InDevelop office in Ha Noi and the figure includes costs for Chief adviser and Ass. Chief Adviser. Source: InDevelop

Total programme costs include advisers, training, equipment, upgrading of institutions, and raw material for drugs. Advisers account for an important proportion of programme costs. Together with the costs for the Ha Noi office, which is to a large extent dealing with the advisers, the costs for advisers in percent of the total programme costs are shown in table 3:15. It may be noted that the share has been varying from a high of 55% in 1988 to a low of 24% in 1991.

Table 3:15

1986	1987	1988	1989	1990	1991
40%	35%	55%	25%	37%	24%

The number of advisers in the programme has decreased as shown in table 3:16. This may be interpreted as an indication of progress in terms of competence development. It is hardly quantifiable, but the implicit target of reducing the number of expatriate adviser has been reached. On the other hand, in a programme where competence development by means of expatriate advisers is an overall objective, the relatively large share of hardware costs, may be discussed.

Table 3:16

	1986	1987	1988	1989	1990	1991
LTA (years)						
Projects	14,7	15,7	15,3	14,2	10,8	9,7
Others	7,0	6,9	6,6	5,2	4,7	3,5
Total LTA	21,7	22,6	21,9	19,4	15,5	13,2
STA (months)	11,0	24,8	25,5	11,8	17,3	18,0

Others include camp masters, camp technicians and teacher.

The costs for long-term advisers in the projects, including personnel at the InDevelop Ha Noi office, expressed as thousand SEK per expert year (excluding housing), are shown in table 3:17.

These costs may be compared to the standard unit cost for a medical adviser in Ha Noi

as estimated by SIDAs Personnel Division for 1992, thereby offering an opportunity of cost-effectiveness analysis. The standard unit cost is 856 thousand SEK for a medical doctor and 583 thousand SEK for a head nurse[75]. In order to make an exact comparison we would have to calculate with the precise distribution of medical doctors and nurses, while eliminating other advisers. Instead, we just note that the costs for advisers in the Programme seem to be well in line with SIDAs standard unit costs.

Table 3:17

Thousand SEK

	1986	1987	1988	1989	1990	1991
Cost per expert year	330*	626	610	720	705	755

* The figure for 1986 is only from July 1st.

The costs for H&A and for the operations of the InDevelop office in Ha Noi are relatively large in relation to the costs for advisers. Throughout the evaluation period these costs amount to between 68% and 81% of the costs for the long-term and short-term advisers and they have increased by 12% between 1990 and 1991, when they reached their highest share. Cf. table 3:18.

These relative shares for overheads in terms of housing, administration and the Ha Noi office are high, particularly if the advisers in the InDevelop Ha Noi office are regarded as administrative inputs. Even if the Chief Adviser and the Assistant Chief Adviser also have a role as long-term advisers to the MOH, their main tasks is to be management advisers to the projects.

Assuming that a certain proportion of the housing and the administrative costs are overhead, not related to the number of advisers, it seems logical that the share of administrative and housing costs increases, when the number of advisers is reduced. The costs for camp administration, for example, would probably remain about the same, regardless of the number of advisers actually using the camps. In July 1992, the housing and administrative costs should be considerably reduced as a share of adviser costs, due to the handing over of the camps to an independent company outside of the Health Programme.

Table 3:18

Thousand SEK

	1987	1988	1989	1990	1991
H&A + IPO	8262	8334	7862	6583	7447
LTA + STA	11990	11650	11098	9486	9178
Percentage H&A + IPO	68	71	70	69	81

It may be interesting to note an example of opportunity costs in the Programme. All such examples may be seen as unfair, when they cannot be related directly to objectives, but this should not stop us from bringing out a few of them.

75. In both cases the costs are estimated under the assumption of one accompanying adult and two children of less then twelve years of age.

The low salaries of health workers is an important negative factor influencing the health services. Therefore, it may be interesting to compare the costs of expatriate advisers to those of the health workers in the country and analyse the consequences of different alternatives. In Example 1 it is demonstrated that, under given assumptions, the cost of one long-term adviser corresponds to the personnel costs of one complete hospital. The question to analyse is then in which of the two alternative uses of the funds the largest benefit is created. We cannot answer that question without being able to compare the benefits of the two alternatives. And further, the benefits should be compared over a given period of time, e.g. short-term or long-term benefits.

Example 1.

Using the example of the UBGH and assuming that the cost of living for each inhabitant in the area is 150 000 VDN per month, the cost of keeping all the staff and their dependants fully paid can be estimated. The total number of staff is 500 persons. Assuming that the average number of dependants is two, the total cost per employee per month would be 450 000 VDN. The total cost for all staff would then be 225 MVDN per month, representing an annual cost of 2700 MVDN. At the May 1992 exchange rate, this amounts to around 207 000 USD or 1.2 MSEK per year. Under the given assumptions the cost of keeping the whole staff of UBGH for one year is about the same as the cost of one long-term adviser, including housing and administration.

In the POD and ME projects cost-effectiveness may have been low due to the role that the funds have played in subsidising inefficient production and commercial units. The objectives of those projects may have been achieved at a lower cost, had the funds been channelled directly to the final purposes, such as the pharmaceuticals or spare parts.

As was demonstrated earlier in the report other projects are not conducive to cost-effectiveness analysis.

Chapter 4
Conclusions and recommendations

This Section presents the conclusions of the evaluation study and the recommendations for future planning.

First, we present a few points which serve partly as points of departure of the evaluation study and partly as evaluation criteria. Then we summarise our conclusions and recommendations regarding the projects, the selected themes and the overall programme.

The overall objective of Swedish development co-operation with Viet Nam to support the economic reform process should serve as an evaluation criterion when deciding whether or not a given project should be continued. This means that any project deemed to be out of line with the economic reform process must be terminated or modified so that it conforms to the objectives of the reform process regardless of the past merits of the project.

It follows from this that no Swedish funds should be used for purposes where commercial or productive units are subsidised.

The evaluation period has coincided with a period of dynamic change in the Vietnamese economy with far-reaching consequences for the health sector. Some of the changes may be beneficial for the future development of the Health Sector Co-operation Programme, but it has been concluded that those changes have also caused temporary problems in the execution of, for example, PHC programmes, i.e. they may have adversely affected some projects in the Programme. It is beyond the capacity and scope of this evaluation to separate the effects of the on-going projects from the effects of the economic reforms. Limited project progress may have been due in part to the impact of reforms. Conversely some of the benefits of the later years may be due to the positive effects of the reforms.

It is recommended that future programme and project design should incorporate the recent changes in the health care system in Viet Nam in order to adapt on-going and future activities to the new situation. It is also recommended that MOH and SIDA commission a study on the recent history of the Vietnamese PHC, which could serve as basis for planning.

From the analysis of the Background section it has been concluded that the health sector will need considerable international support during the nest few years. It should therefore remain a priority in the Swedish development co-operation with Viet Nam.

The Mission therefore recommends that the total support from Sweden to the Health Sector in Viet Nam rather than being reduced, should actually be increased.

Due to the foreseen increased donor activity in the health sector, it has been concluded

that donor co-ordination will be of utmost importance for the future of the sector. In the past, the MOH has avoided donor co-ordination. This has probably been counterproductive in terms of the total benefits of foreign aid. In the future MOH must act to ensure donor co-ordination, otherwise the donors efforts to implement their own strategies would be counterproductive, while any attempts to establish their own co-ordination system would have limited benefits.

It is therefore recommended that the MOH changes its policy and establishes a system for MOH donor co-ordination. SIDA should strongly support such an initiative and be prepared to play a leading support role, if requested to do so. This task is urgent.

For donor co-ordination to be effective, a guiding National Health Policy must be established so that donor initiatives can be evaluated against the Policy. This means that it has to be clear and specific in terms of international co-ordination.

It is recommended that a clearly defined policy for Health Co-operation should be developed by MOH, based on the Vietnamese National Health Policy. It is further recommended that SIDA should support such a development and subsequently apply the resulting policy to the Viet Nam-Sweden Health Co-operation Programme. It is hoped that such an initiative by Viet Nam and Sweden would serve as an example for the co-operation with other donors and reinforce the required co-ordination of donors by the MOH.

4.1 The PHC Projects and the Hospitals

During the first years of the PHC I project, implementation was slow, partly due to internal project factors, but also to the changes in the Vietnamese health care system. It is difficult to determine which of these factors was the more important cause of the limited progress. Since 1990, the project has improved considerably in terms of rate of implementation of activities and its conceptual development.

The PHC I and the hospital projects have affected one major achievement in that they have together undertaken a massive training effort resulting in the training of many course participants. The results of those courses cannot be evaluated in detail, but it can be assumed that the technical knowledge of the health workers has been improved. It is also difficult to assess to what extent previous course participants have left the health care system as a result of the on-going changes of that system.

It is recommended that the PHC I project should continue to be supported in the future, either as an individual project or as part of a larger PHC project.

There are several factors in the Vietnamese health situation which have not been addressed by the project, for example, the lack of water, particular aspects of womens health, vector control and health education. Some of these are discussed below in connection with the future Programme design.

There is a huge demand for family planning. Population activities are a priority area for Viet Nam. However, the Swedish bilateral contribution in this field is small and should be increased.

The equipment provided has been appropriate and of good quality. However, there are a few additional items that could be supplied.

The establishment of PHC committees has been useful for the implementation of the

project. However, the roles and duties of the different participants should be spelled out more clearly and specifically.

The development of managerial skills of the staff at all levels of the Quang Ninh provincial health care system has been hampered by a lack of clear targets and objectives. The basic idea of improved health management is a sound one and the training in this field should be given proper attention, but not at the expense of actual service delivery.

The development of working guidelines and job-descriptions has helped in making the roles and tasks of the CHWs clearer to the staff and to the managers at the provincial health bureau.

The development of community participation is still weak in the PHC project as the project still does not meet certain needs of the people. Family planning is the prime example of such a need.

The question of salaries for the local health staff has to be discussed very thoroughly as this is a major concern for the CHWs.

There has been a major expansion in the coverage of the six national programmes, which is very encouraging. The impact should be studied as it could form the basis for future development of these programmes.

The provision of cement has presented a good opportunity for community participation. The experiences from this should be analysed and applied in other areas. **It is recommended that the cement component of the PHC projects should be increased.**

It is recommended that the extension of the PHC I project to Ha Tuyen and Vinh Phu provinces should be either expanded or phased out. The present form of implementation is based on the idea of replication of experience and is inappropriate.

It is recommended that certain components from the PHC projects should be merged and that proper training in these fields should be started in the two other provinces.

The PHC project has to be instrumental in the development of a more streamlined health care system and its experience should be analysed and presented to a larger forum.

In order to increase the impact of the PHC project it is recommended that the project initiate a workshop where different experience from the whole country is discussed. Invitations should be extended to all provinces who have demonstrated an interest in the development of comprehensive PHC programmes. Such a workshop could contribute to the diffusion of the concept and the ideas of PHC. The two hospitals, IPCH and UBGH, should participate in order to inform on the roles of hospitals in PHC. The workshop could lead to the start of operational research on Vietnamese PHC with the IPCH as a leading body.

Both UBGH and IPCH have established co-operation with the PHC programmes in several areas.

It is recommended that the co-operation between hospitals and PHC programmes be replicated all over the country, in as many areas as possible, especially where a medical teaching institute is located.

The IPCH has developed a paediatric nursing course. This could become very valuable, if specialised nurses are trained on a broad scale for the nursing care at paediatric hospitals.

It is recommended that the MOH takes speedy action to decide on approval of this training.

The UBGH has gained considerable experience in conducting Head Nurse courses.

It is recommended that the UBGH experience should be retained and used by making UBGH responsible for the running of Head Nurse courses for all the Northern provinces.

Both UBGH and IPCH have established a system for the training of newly recruited staff, on both hospital routines and treatment routines.

The Swedish nursing advisers have been instrumental in the establishment of the nursing departments of the two hospitals. The Vietnamese Head Nurses are now fully capable of performing their duties on their own.

It is recommended that the role of the nursing advisers should change from being hospital-based into more central functions.

It is recommended that the Swedish advisers should play an important role in the training of trainers for the Secondary Medical Schools and in the development of hygiene routines.

The two hospitals (IPCH and UBGH) have developed into leading medical centres in their respective fields. Efforts should be made to maintain the high standards achieved.

The long-term Medical Adviser to the IPCH left in 1990 at the end of the contract period. The IPCH has reached such a high level of competence that no long-term adviser is required. Instead, specialised short-term advisers may be needed for competence development.

It is recommended that the IPCH continue its activities without a long-term Medical Adviser, but that short-term advisers in specialised areas should be provided upon request from IPCH.

The equipment provided for the two hospitals has been in use for about twelve years. In spite of heavy use, most of the equipment is still in reasonable condition. There is, however, a need for an item by item inventory in order to determine which equipment should be replaced.

It is recommended that SIDA support the procurement of the equipment, which an equipment status inventory of the two hospitals suggests should be replaced. A condition for this support should be that a phase-out plan over the next five years for this type of support be established.

The boilers of the two hospitals are still in good working condition. The equipment supporting the boilers, however, has started to show signs of low fuel efficiency and general deterioration. There is a need to replace the boilers coal-loaders.

It is recommended that SIDA support the replacement of the coal-loaders for the boilers of the two hospitals.

The sewage treatment plant of IPCH has never functioned properly and should be closed down. Other methods to treat the sewage should be investigated. The alternatives should include the possibility of connecting the hospital to the city sewage system.

It is recommended that the IPCH sewage plant should closed down and that alternative treatment methods are identified by a comprehensive study.

The GTD departments of the two hospitals are able to perform all their normal duties on their own. Periodic visits by an experienced short-term adviser on specific topics should be considered.

The MTD at IPCH is of a very high standard. Its advice should be sought regarding the purchase of equipment. There is no need for an expatriate adviser in this area.

4.2 Provision of Drugs

The analysis of the POD project shows that most of the funds contributed to the project have resulted in financial support to the state budget or the MOH budget. The funds have been circulating in the Vietnamese system of production and distribution and in the process have served as a subsidy to the production units and sometimes to commercial units. The size of such subsidies has varied over the evaluation period and subsidies for the manufacturers have now been eliminated. However profits may still be generated in the distribution system from drugs supplied by the POD. These results are not in line with the objectives of Swedish support to Viet Nam or of the POD itself. Therefore, the procurement and the production part of the project is no longer relevant. On the other hand, the relevance of the regulatory control component of the project has increased due to the present drug market situation.

The objective of increased availability of pharmaceuticals at the PHC facilities has been met during the period being evaluated. However, it is the opinion of the Mission that this is not due to the Swedish support, but to the reforms creating a market economy where demand rather than the governmental production plan is guiding production . These changes started very early in the evaluation period and it is hence impossible to determine whether any positive effects were produced by the Project before the reforms. Consequently, the degree of achievement of objectives cannot be measured and we are not in a position to quantify the cost-effectiveness of the Project. However, the economic cost of drugs supplied to the PHC system would have been much lower, had it not included subsidies to the pharmaceutical industry or the consumers.

The POD project is not financially sustainable, mainly due to the changes of the system. However in terms of management, the degree of sustainability has increased during the period of evaluation.

The project has supported the implementation of the essential drugs concept and promoted the safe and rational use of drugs, particularly in the Quang Ninh province. However, the general situation in the country in respect of safe and rational use of pharmaceuticals, has deteriorated. This is because the role of the authority has not been changed to meet the requirements of the new legislation and free market situation.

The quality of drugs locally produced has improved and the SIDA support has been one important component in that process of improvement. However, without the change in economic policy, which created a competition environment, this improvement might not have occurred.

It is recommended that the support to the POD for procurement of raw materials is phased out. Swedish aid should support the reform process. Therefore, the imports of raw materials, drugs and equipment should be treated as financial support it should not be used in such a way that companies are subsidised in production or distribution.

It is further recommended that SIDA continue to support the MOH in the area of Drug Policy, Regulations and Enforcement, i.e. the Regulatory Control component of the present POD. This support should be strengthened.

Such support must take into account the different roles of the MOH and market forces in the pharmaceutical markets. At present, the Ministry of Health is not only a funding and regulatory authority for national hospitals, drug quality control laboratories,

medical and pharmacy faculties etc., but is also a commercial organisation in the pharmaceutical field. It is importing, manufacturing, distributing and selling pharmaceuticals. This creates a conflict. In a market economy the MOH should not simultaneously be both an authority and a pharmaceutical commercial unit as these two bodies have contradictory objectives and preferences. They also act on different mandates. The authority acts on behalf of the people and should ensure the safety of the consumer of pharmaceuticals. For that reason the authority issues laws and regulations and punishes those who do not follow these directives.

A major objective of a pharmaceutical business organisation (industry, importer, distributor etc.) is to create profits in order to ensure its own survival. Hence it does not favour regulations and prefers freedom, particularly regarding sales promotion and marketing.

SIDA should not support the MOH in its capacity as a business organisation, but only in its role as an authority. The support could be in the areas of regulatory control, inspections (of industries, wholesalers and pharmacies) and quality control. Even payment of the salary for staff members should be considered, given the urgency of the situation. However, the latter should only be on certain conditions, on a temporary basis and in areas where an expansion is deemed extremely necessary. A reduction of staff at the departments sponsored by SIDA, should always result in a corresponding reduction of the Swedish financial support.

A third recommendation concerns the wholesale distribution of pharmaceutical.

It is recommended that SIDA should act very cautiously in supporting the distribution (wholesale) of pharmaceuticals for the time being. The distribution system in Viet Nam is not rational. However market forces will probably soon rationalise the situation. There is a risk that any Swedish support in this area could disturb the natural development process. In the area of retailing (for example Revolving Drug Funds) more studies are required before support should be considered.

The fourth recommendation concerns a previously neglected area in the Programme:

It is recommended that SIDA should support the increased but controlled use of traditional medicine in the PHC system and participate in strengthening the legal framework in the area of traditional medicine in the country.

Traditional medicine is a subject that has not been addressed in this evaluation report as it has not been an area of Swedish concern. It is also well known that a lot a quack remedies exist. However, essential drugs, when used for the wrong indication, are much more expensive and dangerous than traditional medicine. For example, cough caused by a common cold is better treated with a herbal cough syrup than with an injection of streptomycin. Neither is a virus infection cured by a tetracycline capsule. Often knowledge about the disease is more helpful than a drug, but this fact is difficult to accept by many people even in industrialised countries. Therefore traditional medicine often has a valid role to play and its use should not be condemned but supported by SIDA. Experience from other developing countries, suggests that tough legislation is required in the area of traditional medicine to limit the activities of unscrupulous businessmen. Swedish support in this field could be most valuable since market forces are likely to play an ever increasing role.

The fifth recommendation regarding the POD Project concerns the pharmaceutical industry: **It is recommended that SIDA should not support the pharmaceutical industry, i.e. the production part of the present POD.**

Support for industrial development cannot properly be handled by health professionals, but should be handled by pharmaceutical industry specialists.

The new situation in Viet Nam should not prevent SIDA from supporting an independent pharmaceutical industry, but assistance should only be given under certain conditions:

- General training in management could be given free of charge under the condition that it is available to all industries, governmental, provincial and private.
- Consulting service of all categories, such as administrative systems, feasibility studies, factory design, market support etc. could be sold at subsidised fees to individual companies.
- Soft loans for investments should be considered by donors as a possible support component.

Finally, it is recommended that MOH and SIDA should commission a pharmaceutical sector study. A comprehensive sector study could be a very useful support component to the Vietnamese health authorities in their important and urgent future work in strengthening the legal framework of the pharmaceutical sector and in establishing the strategy for its development. Such a study should tackle all areas in the pharmaceutical field as laws and regulations, industry and trade, sales and distribution, research and development, education of pharmaceutical personnel etc. and thereby give the background information for proper regulatory control measures and development strategy formulation.

4.3 Central Fund

The Mission concludes that the CF is, on the one hand, carrying out functions of management and capacity building which are normal activities of the MOH, and on the other hand, distributing material support to institutions which are not purposely related to the other projects of the Programme. The latter activity utilises most of the funds. The management activities partially result from a design flaw in the Programme, i.e. its problems of verticality and lack of coordination due to the power vested with the Chief of Projects. The only activity that the Mission would single out for particular attention in the design of a future programme component is the Health Insurance Commission.

As regards the CF, the Mission recommends that the material support should be provided as financial support and that the management activities should be carried out by the MOH, but not through a specific project. Therefore, it is recommended that the Central Fund project should be phased out as a project. In this process, however, SIDA and MOH should give special attention to the Health Insurance Commission and the possibilities of supporting the development of workable health insurance systems. It is further recommended that some of the Programmes funds are placed at the disposal of the Management Group of the Programme. If SIDA and MOH agree to continue to finance rehabilitation of central institutions, it should be part of the financial support to the MOH.

4.4 Central Level Integration

The Mission concludes that the CLIP may originally have been a reasonable attempt to increase the acceptance of the concept of integration at the ministerial level. We also conclude that the achievements of the Project are few and only vaguely related to the integration efforts. The new organisation on the MOH side, with a Management Board for the Viet Nam-Sweden Programme will probably serve to gradually increase the acceptance of the integration concept at central level.

It is recommended that the CLIP be phase out as a project and that activities relevant for the development of the PHC management system be merged into the PHC projects.

4.5 TSSP

The TSSP has been fully functioning for just over a year, but seems to have had a promising start. The design of the project is more advanced than other parts of the programme and should be used as an example for future planning.

The main rationale behind the TSSP is competence development and the project will be able to play a more important role in an integrated and enlarged PHC programme. The training component of such a programme should be strengthened.

The explicit aim of the TSSP to strengthen the Training Department of the MOH to fulfil its duties more effectively, and the fact that the project operates from within the Training Department, is an example to be followed. The question of whether this process of integration can be continued, making TSSP even less of a project and more of a regular activity of a department of the MOH should be investigated further.

It is recommended that TSSP be given continued support. Increase of the support should be given only upon explicit request from the Head of Project.

4.6 Medical Equipment

It can be concluded that the ME Project may have contributed to the improvement of the availability of equipment in the health facilities in the beginning of the period of evaluation. However the economic reform process gradually, and to an increasing extent, rendered the Project concept inappropriate as it was designed for the old subsidy system. In 1991 the Project was no longer workable. In the meantime, the cost-effectiveness of the Project has been reduced by its provision of subsidies to production units. The beneficial impact of short-term advisers and training will be lost to the Health Programme unless the companies survive in a competitive environment and continue to serve the hospitals.

The Mission recommends that support for equipment and its maintenance in the Health Programme be given, if it is considered a priority, by financial support and short-term consultants to those projects within the Programme which need the equipment, but that the ME Project in its present form should be phased out.

4.7 Themes

In this sub-section conclusions and recommendations as regards the special themes of the evaluation study are presented.

Organisation and Management

The Mission has concluded that the present organisation and management of the Programme reflects progress in the co-operation. This is witnessed by the new MOH management of the Programme as well as the division of roles of the MOH, SIDA and InDevelop.

It is recommended that the present organisation of the Programme be further developed along the lines of the past two years.

The costs for managing and administering the Health Programme have been high in relation to the output, mainly adviser time and hardware. This is not to be blamed on any single of the involved actors, but is a shared responsibility of the MOH, SIDA and the Consultant. The reasons are to some extent historical, such as the camps which have now been taken out of the Programme.

It is recommended that ways are sought to reduce the administrative costs of the Programme.

Competence development

The term competence development needs to be defined in every project as it can mean different things at different levels. A clearer distinction should be made between competence development by training or retraining, and the development and support to an institution.

The need for advisers should be further analysed, taking into account the possibility of recruiting a Vietnamese expert , if resources are made available. Some of the present expatriate adviser posts may probably now be Vietnamised.

It is recommended that phase-out plans related to the objectives of competence development be established for the advisers in all job descriptions as well as indicators to measure progress (i.e. whether competence development has taken place) for each adviser.

The high turn-over of both long-term and short-term advisers should be reduced and the advisers should stay longer. In some cases long-term advisers should be replaced by short-term advisers and/or by co-operation between a Vietnamese and foreign institution.

The question of language should be analysed in each case and there should be a more flexible attitude as to whether foreigners should learn Vietnamese or Vietnamese should learn English. Knowledge of Vietnamese should be a key selection criterion for long term advisers. Reports by short-term advisers should be translated immediately into Vietnamese. The responsibility for the translation should be made clear in the advisers contract.

Gender

It is recommended that gender knowledge should be improved by organising gender training courses, mainly in Viet Nam. For selected key persons, training abroad could be considered.

It is further recommended that the Programme should identify: (i) gender interests and gender needs in health services; (ii) constraints and potentials of men and women, particularly poor men and women and women participating in programmes and projects

within the Vietnamese-Swedish co-operation. This will require a special study, using available material from Viet Nam.

It is recommended that women of fertile age should be selected as the first target group in the Co-operation Programme.

Finally it is recommended that the responsibility for gender aspects within the Programme should be moved from the Central Fund to the Management Group.

Financial management

The Mission concludes that the recently introduced system for the management of local cost is a step forward.

It is recommended that a plan be established for the further handing over of financial management and monitoring to the Ministry of Health.

Without being able to recommend a definite solution to the issue at this point of time, the Mission recommends that the Swedish fund should be channelled to one single entry point in the system. Ideally this should be the Ministry of Finance, but the on-going discussion in Viet Nam should settle the question before any action is taken in the Health Co-operation Programme. This is also related to the which solution will be applied on the national scale when it comes to the financial management within the health sector itself.

Due to the financial constraints of the health sector it is recommended that efforts be made within the Programme to identify alternative sources of finance, such as ways of mobilising local communities and a system of health insurance.

Replication of Experience

The Mission concludes that the Quang Ninh model may serve as one of several known models in Viet Nam. As recommended in relation to the PHC I, a national conference should be an interesting opportunity to compare experiences from those provinces that have tried an integrated approach to PHC.

Culture and Communication

The Mission has concluded that difficulties of communication among the concerned parties within the Programme still exist, but that they have been considerably reduced over the last years.

It is recommended that SIDA reconsiders its language policy for advisers to Viet Nam.

This recommendation has a strong relation to the effectiveness of competence development.

Procurement

It has been concluded that the long period of a permanent post as procurement adviser to the Programme has not produced the desired results yet, in that important function still are vested with the adviser and are not transferred to the Vietnamese authorities. There is no obvious explanation of this. It may be noted, however, that the Purchase Division of SIDA has not been consulted as to the recruitment or the job descriptions of the procurement advisers.

Efforts should be made to transfer the responsibility and the handling of purchasing to Vietnamese bodies. The competence of purchasing is at hand in the country and the monitoring system should be Vietnamese as well.

It is recommended that the post as Procurement Adviser be phased out of the Programme.

Cost-effectiveness

Due to the absence of quantitative output targets and of comparative output cost figures, it has not been possible to make proper cost-effectiveness analyses of the projects in the Programme. Some indications as to the relative costs of projects have been found and the consequences of those are presented in recommendations regarding the respective projects.

It is recommended that the next phase of the Programme should include a conscious effort to relate project objectives and output targets to cost monitoring and cost indicators in order to be able to identify ways of increasing the cost-effectiveness of activities.

4.3 The Programme

It has been concluded that the Health Co-operation Programme between Sweden and Viet Nam has developed historically on the basis of additional individual projects. Currently, the Programme consists of an administrative unity of individual Projects, that came to be for different reasons. Therefore, the evaluation criteria cannot be applied on the programme level. But the intentions of SIDA and MOH have not been to create a programme in the strict methodological sense. It is rather a sector support[76].

A programme without objectives does not have elaborated baseline data, indicators and monitoring possibilities. Co-ordination between projects is hard to achieve and thereby difficulties are at hand in terms of achieving larger benefits, than the sum of the individual project benefits.

It is therefore recommended that the future Programme be designed in a new way such that individual components support each other towards a common overall objective for the co-operation.

As this evaluation shows, the Programme is in a situation where change is necessary due to the changes in society. This report recommends (cf. above) that a some projects and project components be phased out at the end of the present agreement period and that some advisers be phased out as well. This given, even within the present budget limits, ample room for changes and new initiatives. It may be estimated that about 40% or around 20 MSEK are available for new forms of support, only by phasing out the raw materials procurement part of POD, the ME, CF and CLIP. Those parts of the latter projects who are judged to be necessary in the future could be supported in the form of financial support without any specific project label.

76. Cf. the conclusions in SIDA Evaluation Report Health Sector Zambia, 1989:3: The {programme} is an administrative concept, where different projects related to the health sector were given the same overall label and handled together in the agreements The outcome is said to be a greater flexibility in the use of resources and a smoother adaptation to unplanned changes in running projects. This can only be beneficial to both parties involved. p. 112

In the planning of the future Programme it is recommended to try to reduce the verticality of the Viet Nam-Sweden Programme operations and to simplify by reducing the number of projects through the elimination of projects not needed.

The Programme should be managed by the present Management Board system in order to avoid verticality problems by reducing the influence of the Heads of Projects. The Programme needs a strong leadership and it should be supported by financial resources, without therefore adding a separate project. The Management Board should be the responsible body for the achievement of the Programmes objectives. Thereby, the overall responsibility for the Programme is non-ambiguously vested with the Ministry of Health (rather than with individual Swedish projects.

Advisers to the MOH in different professional areas should not automatically lead to the creation of a project. Instead, the normal case ought to be that an adviser is attached to the relevant department of the Ministry. The adviser on regulatory control, for example, should be attached to the Department of Pharmacy of the Ministry, not to a project.

It is further recommended the new Programmes objective be carefully worked out and combined with a more narrow targeting, in regional and/or social terms.

This latter part of the above recommendation is justified by the expected increase of social differentiation in terms of access to health services.

Some previous activities and some financial support may be merged into a larger PHC project in the present provinces, but may be also by expansion of some items on the national level. The normal PHC programme of the MOH should then be the final recipient of the benefits from Swedish support to PHC.

The PHC project strategy should be based on an analysis of the causes and effects of the health situation in the country. One way of making use of the positive factors could be, for example, to put emphasis on health education (benefiting from the literacy rate). Two ways of trying to reduce the influence of negative factors could be, for example, to increase the water and sanitation inputs in the programme (reducing the effects of lack of such facilities) and to increase the support to family planning (reducing the effects of malnutrition and maternal health)

There is a huge need for family planning in Viet Nam. About 50% of all couples are not able to obtain any family planning devices. This hampers the decrease in population growth, which is a priority national target. The population growth rate is the single most important factor influencing the development of Viet Nam.

Therefore, it is recommended that SIDA increase its assistance to Viet Nam in this area, both bilaterally and multilaterally. The bilateral assistance could be in the form of training, IUDs and transfer of technology for production of family planning devices.

It is further recommended that the planning of the new Programme involves an explicit effort to include more of water and sanitation (including increase of the cement supply) as well as health education.

Finally, it is recommended that the studies proposed in this report are carried out as part of the planning process of the new programme, i.e. the study on gender implications on the health sector, the study of the pharmaceutical sector and the study of recent history of PHC in Viet Nam.

Annex 1:
Terms of Reference

Terms of reference for evaluation of the health sector cooperation with Vietnam

1. Background

Swedish health sector support to Vietnam started in the 1970s with the construction of two hospitals. It was broadened in 1984 to include support for Primary Health Care at provincial and lower levels as well as Provision of Drugs.

The health sector support to Vietnam was evaluated in 1985. The evaluation comprised Primary Health Care, the two hospitals and the Central Medical Technical Workshop. Three more projects were included in the support as from 1990, Central Level Integration, the Training Project and Central Fund. The provision of Drugs project was evaluated separately in 1988.

The total sum for Health Sector Support paid by SIDA since the start in 1972 amounts to SEK 701 million (including the fiscal year 1990/91). During the period to be evaluated (1986-1993) SIDA has paid out SEK 225 million (incl. f. y. 90/91). The present agreement, covering the period July 1990 - June 1993 consists of the following components.

- Primary Health Care in Quang Ninh
- Primary Health Care in Vinh Phu and Ha Tuyen
- Central Level Integration
- Training project
- Provision of Drugs
- The Institute for Protection of Childrens' Health
- Central Medical Technical Workshop and Medical Equipment
- Central Fund at the Ministry of Health

2. Reasons for evaluation

The evaluation is undertaken in the light of the ongoing economic reform in Vietnam.

The aim of the study is to evaluate the results of the cooperation during the latest two agreement periods, July 1990-June 1993, as a base for adapting a new agreement from July 1993, to the economic reform in Vietnam.

The forthcoming Population, Health and Nutrition Survey made by the World Bank shall be used as a background document for evaluation.

3. Scope and Focus of the Evaluation

Reference is given to the Specific Agreement on Support to the Health Sector in Vietnam (with annexes) for the periods of 1/7 -86 - 30/6 -89, 1/7 -89 - 30/6 -90 and 1/7 -0 - 30/6 -93.

The Primary Health Care (PHC) project in the province of Quang Ninh plays together with the Central Level Integration a central role in the Swedish Health Support to Vietnam. The evaluation team shall study the development of a comprehensive management system for the integrated delivery of Primary Health Care in the province. Special focus shall be given to how the experience from Quang Ninh has been applied in the province of Vinh Phu and Ha Tuyen. Furthermore, the relevance of the model and its economic consequences in the changed economic context need to be clarified.

Special focus shall also be given to the project concerning Provision and Utilization of Essential Drugs and its relations to over all health services in Vietnam and to other projects within the Swedish Health Sector Cooperation, specially the PHC programme in Quang Ninh. In addition a macro economic analysis of the drug sector shall be compiled in order to study drug regulatory control, drug production and drug procurement in the light of the economic reform in Vietnam.

For the Health Sector Support as a whole the evaluation shall comprise but not necessarily be limited to the following aspects:

- To what degree the objectives have been met in the Health Sector Support as a whole and within the separate projects.
- What relevance the separate projects have in relation to the present situation in the health sector in Vietnam.
- What the interrelationships are between the separate projects within the support as a whole when stated in the objectives.
- Cost effectiveness within the separate projects, including procurement.
- How the sustainability aspects have been considered, i. e. how has the Vietnamese capacity and responsibility (Vietnamization of the projects) been strengthened concerning both the development of competence and administration, procurement etc.
- The role of Ministry of Health and SIDA as well as the Consultant, InDevelop AB, in management, planning and administrative support to Ministry of Health and to the separate projects.
- To what extent the targets defined in job descriptions for the expatriate advisers have been achieved and particularly the transfer of knowledge and development of competence to the Vietnamese staff.
- To what extent the gender perspective has been applied in planning and executing of the different components of the Swedish Health Support.

- Recommendations for direction and objectives for continued Swedish Health Sector Cooperation with Vietnam.

4. Methodology

The evaluation shall be carried out by a team consisting of a team leader, an essential drugs specialist, a Public Health specialist, an evaluation analyst and a sociologist cum economist. The work will be followed by a reference group at SIDA.

The evaluation shall be carried out in three phases:

- review of existing documents and follow-up interviews in Sweden
- a visit to Vietnam for interviews with peoples concerned, expatriate advisers as well as Vietnamese, involved in the Swedish Health Support to Vietnam. If necessary, a target group study should be performed.
- report writing and following interviews

Before commencing the first phase, a plan of the study shall be presented to the reference group.

Documents relevant for the Swedish Health Support to Vietnam, such as project documents, reviews, evaluations, travel reports, agreed minutes from the separate projects, shall be studied and serve as a basis for the work.

The evaluation is estimated to employ 5 persons during six to eight weeks. The study should commence at the beginning of March 1992. A three to four week visit to Vietnam should be made in course of the study.

5. Reporting

Before leaving Vietnam the team should report on the immediate results of the evaluation to the SIDA DCO and to the Vietnamese authorities concerned.

A final draft report shall be submitted to SIDA not later than 1 July 1992. The draft will be commented on by concerned units in Vietnam and Sweden. After editing the report according to submitted comments and corrections the final report should be presented to SIDA not later than 1 September 1992.

A seminar on the results of the evaluation is tentatively planned to take place at SIDA in the autumn of 1992. The evaluation team is expected to participate in the seminar.

The final report shall follow the standard format as described in "Reports on SIDA Evaluation Studies – a Standardized Format".

The final report shall be typed on a IBM-compatible word processor in MS-WORD and be accompanied by a diskette to be used by SIDA. The report can be published without any further rewriting or editing.

Annex 2
Persons Met

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Prof. Nguyen Cong Khanh, Vice Director, Medical Director
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Mr. Vu Tuan Anh, Institute of Economics
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Uong Bi General Hospital
Central Fund, including units belonging to the Central Fund, i.e. Institute for the Protection of Mother and New-born, Emergency Care Bach Mai, the ENT institute, Viet Duc hospital, Institute of Medical Equipment, Health Insurance Commission, Technoimport Health Purchase Office, Biochemical Department Bach Mai, National Institute of Occupational Health

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Provision of Drugs
Uong Bi General Hospital
Medical Equipment
Central Fund

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IPCH
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Annex 4:
Recent Changes of Organisation and Finance

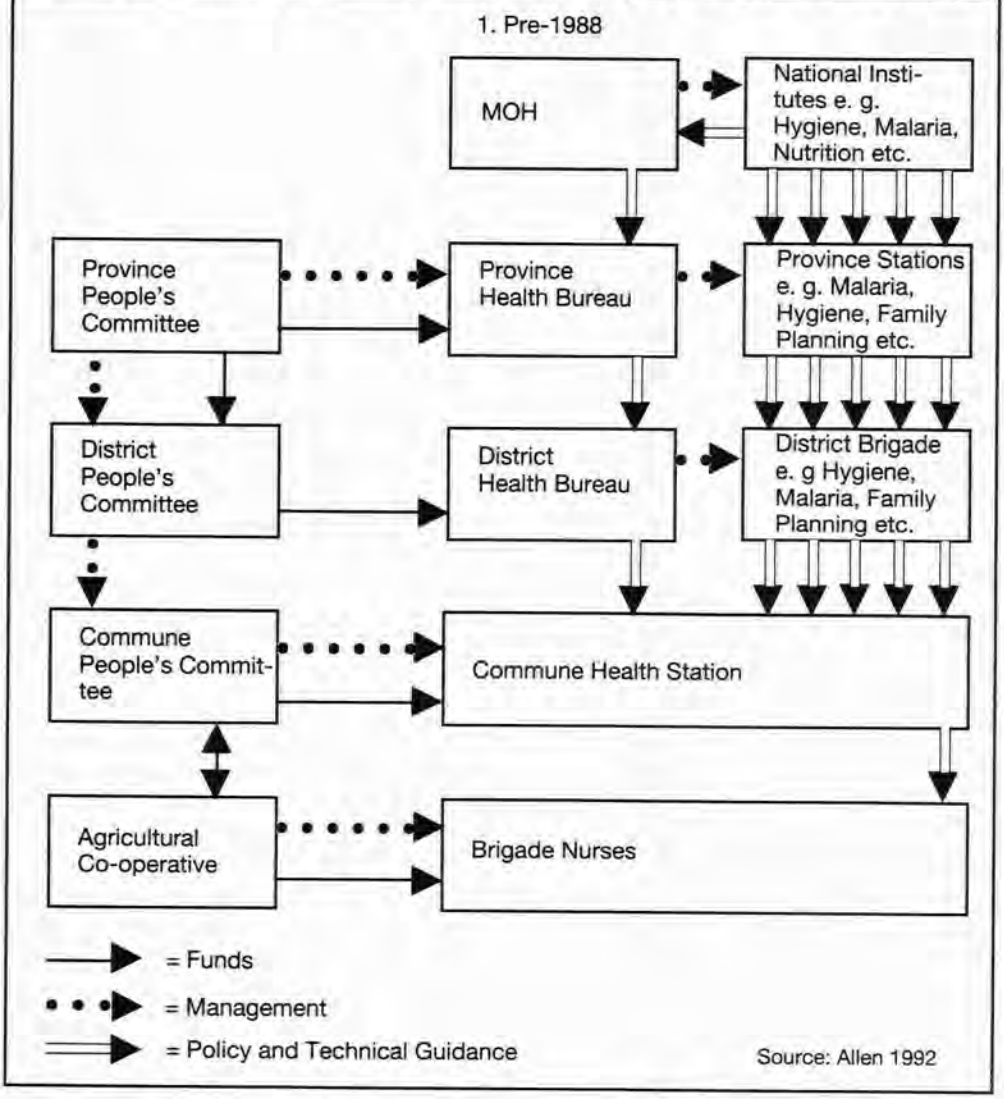
The domestic sources of funding are very limited and their mode of generation has been changing over recent years. According to Allen[77], three stages may be identified during the 1980s. In the process of change, the direction, the speed and the contents of the change, will vary from province to province, from district to district and from commune to commune. The following charts only illustrate a general tendency and some common characteristics of the process of change.

Before 1986, the PHC system was based on Commune Health Stations where services were free of charge. This was funded by the agricultural co-operatives, who paid the health workers. This system is illustrated in the chart 1:6, where the arrows illustrate funds, management and technical guidance, respectively. The pre-1988 system relied to a large extent on the agricultural co-operatives and brigade nurses, but funds also came from the levels of communes, districts and provinces.

It is interesting to note that the developments illustrated in the following charts, i.e. emanating from one author, correspond rather will to various existing finance models in the country according to other sources[78]. The on-going discussions within the health sector and within circles related to financial management are reflecting the changes taken place on the field as a consequence of the reform processes. It is therefore clear that it would be premature at this stage to indicate any final answer to the question of how to manage the financial system of the sector. The discussion in Viet Nam will probably continue until the reforms have been completed.

77. Allen 1992.
78. Cf. MOH, Conclusions 1992 and Trong 1992.

Chart 1:6 Recent changes in management and funding of primary health care services

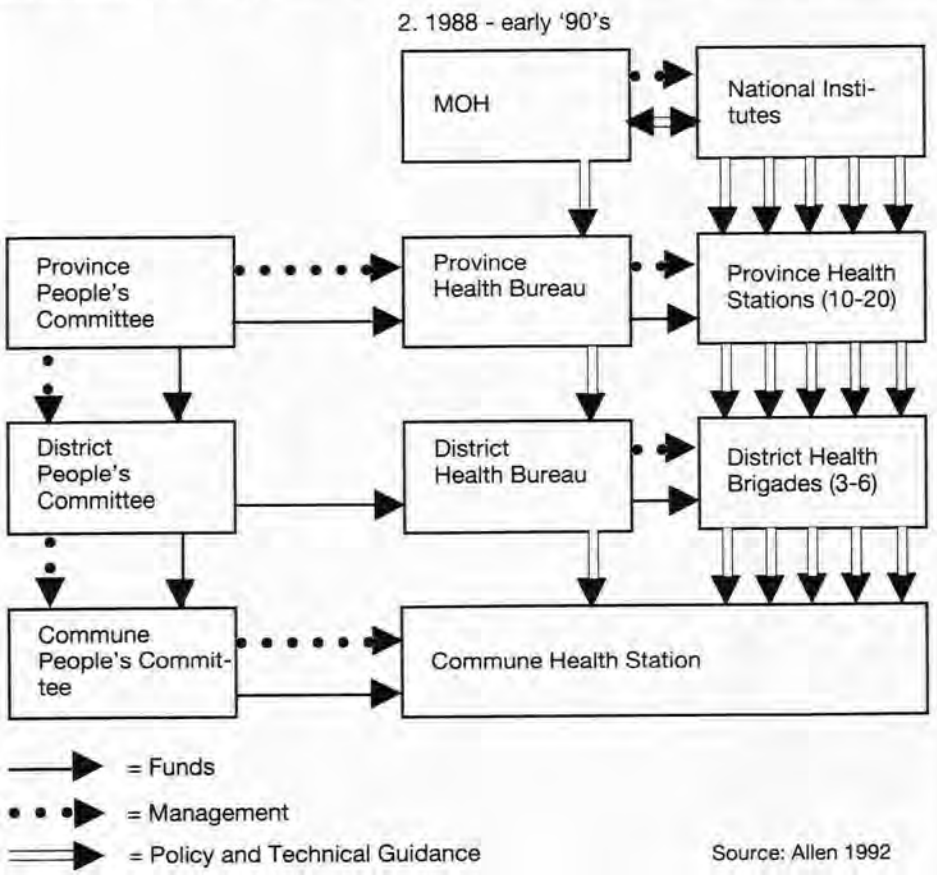


As can be seen from the chart illustrating the pre-88 period, funds are moving between levels under the control of the Peoples Committees and distributed to the health system at each level by them.

During the period 1986 to 1988, approximately, the communes began to manage and fund the commune health stations. This is the process, described above, following the changes of roles and the reduction of the number of agricultural co-operatives. The main thrust of this change was a consequence of the reforms in the basic ways of organising agricultural production, agricultural prices, and so on. It was an external influence on the

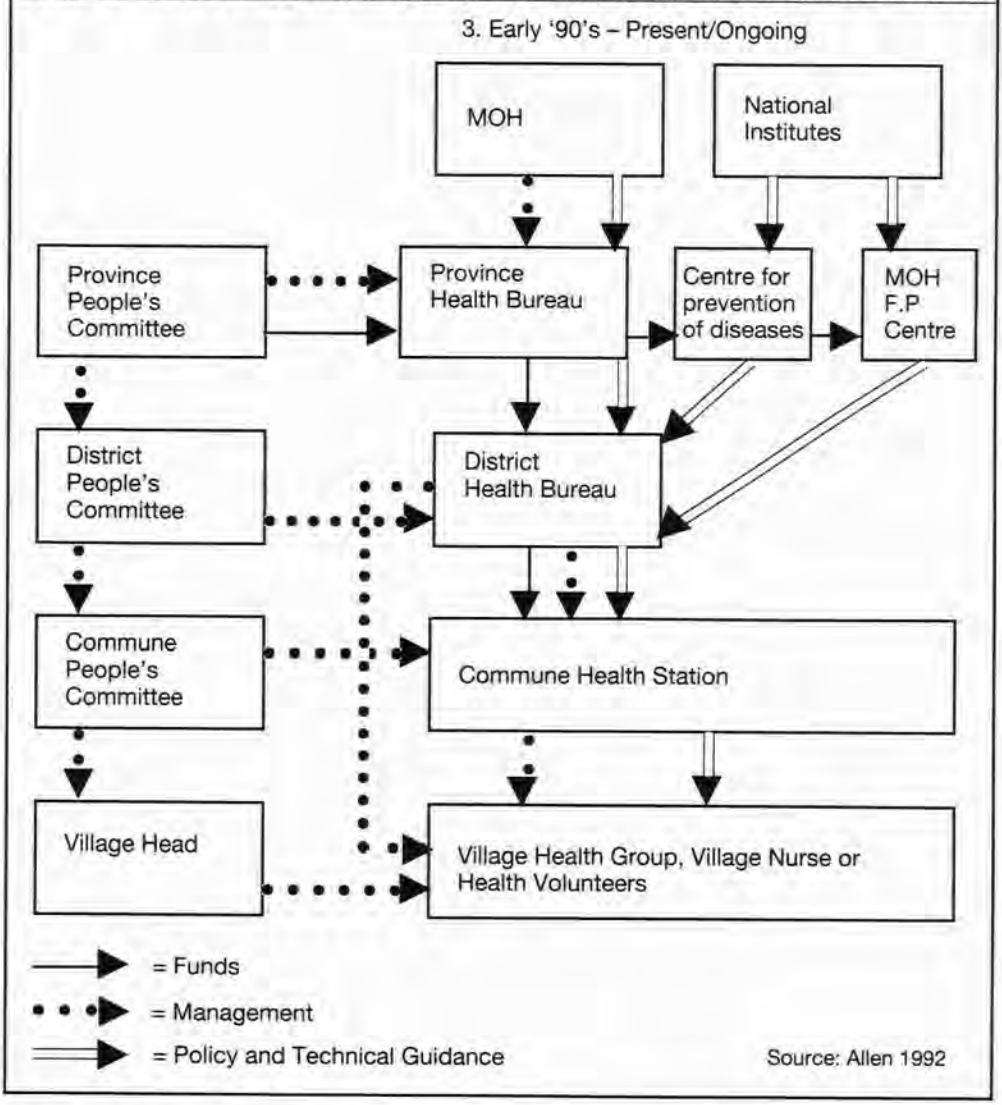
PHC system. The communes were completely financially responsible for maintenance and operations of the Communal Health Stations. The consequences for funding and management are illustrated in chart 1:7, covering 1988-early 1990s. The funds are still passing through the PCs and distributed by them at the respective level to the health system.

Chart 1:7 Recent changes in management and funding of primary health care services



The next phase involved steps taken by the state system, particularly to pay the salaries of three health workers at the Commune Health Stations, and in larger communes for a greater number of health workers, in proportion to the population of the commune. These funds were channelled from the province health services and down to the Commune Health Stations, i.e. no longer through the Peoples Committees. Other costs for operation and maintenance of the health stations remained the communes responsibility. These changes were made during the same period as user fees were introduced at hospitals and health stations in order to improve cost recovery rates.

Chart 1:8 Recent changes in management and funding of primary health care services



It is interesting to note that the analysis of currently existing financial systems[79] illustrates how the different developments in the different provinces have created different financial organisations which corresponds rather well to the organisational differences as described here. From the documents available it seems that the MOH at present prefers a final solution where funds are transferred from the Ministry of Finance to MOH. From MOH the funds are then distributed according to budget to province and

79. *Ibid.*

district levels, and the district distributes to the communes. In such a model the PCs at province and lower levels are not involved and the funds derive from a central source.

From the above presentation of the organisational changes of the health system it was seen that the initial changes were focused on the commune level, and emanating from the changes of the organisation of agricultural production. The current situation is marked by the reforms on the levels of province and district. The restructuring of departments at these levels implies a major reorganisation. Note, for example, the reduced number of arrows for Policy and Technical Guidance in chart 1:8, in line with the ideas of the PHC I project.

This development may be illustrated by the organisational change at the provincial level, where a tendency of reducing the problems of vertical programmes may be discerned. In order to present this tendency two charts are used to illustrate the pattern of change. Again it should be remembered that there are major variations between provinces. Chart 1:9 illustrates the old model for provincial organisation.

Chart 1:9 Province organization of health services (old model: discarded by most provinces now)

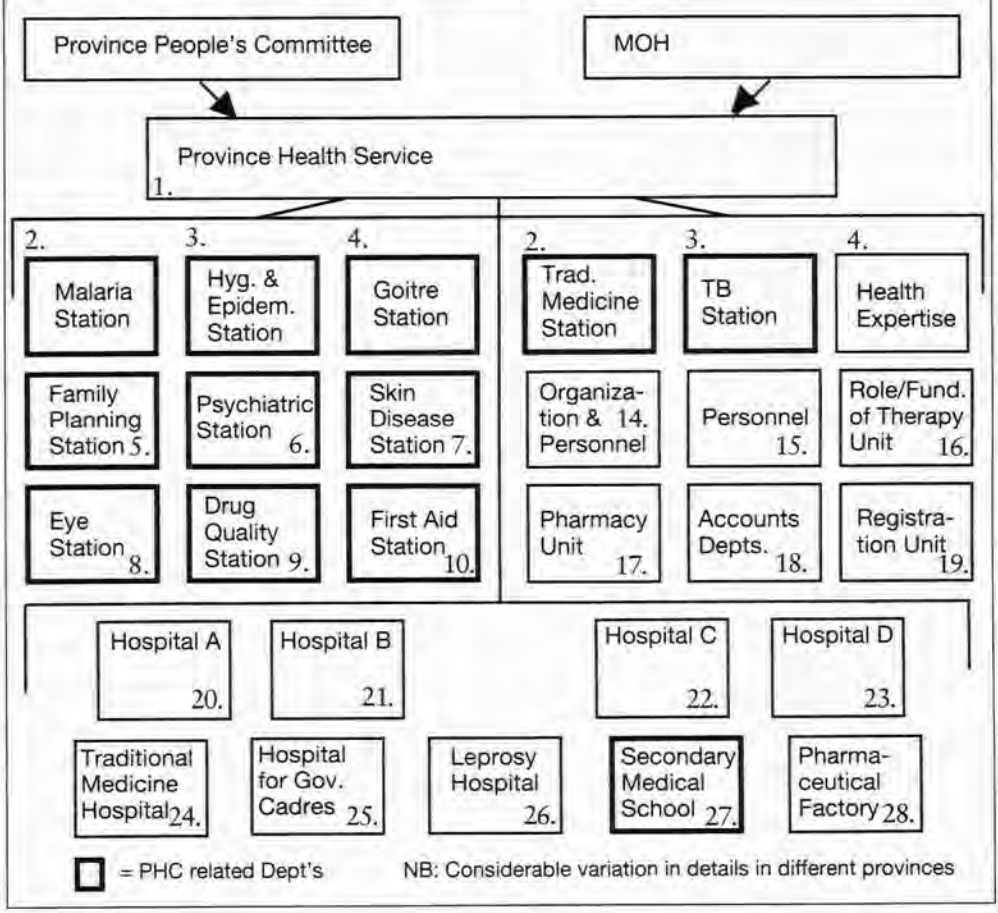
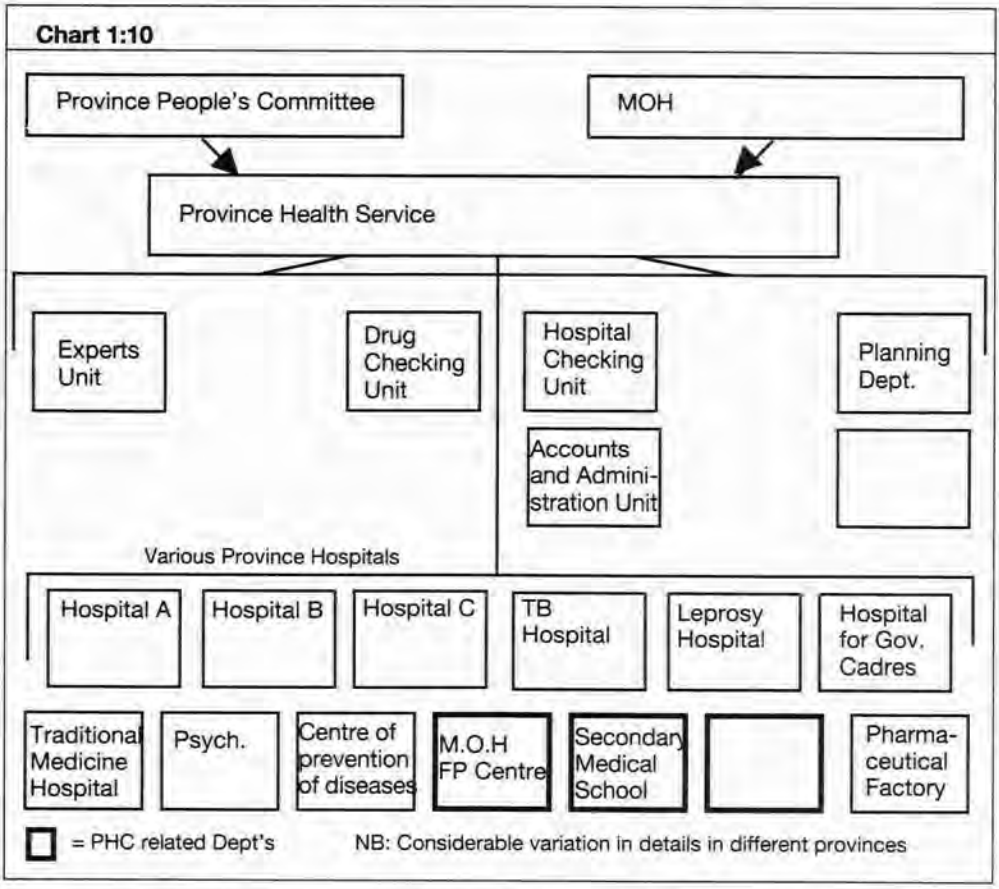


Chart 1:9 demonstrates the large number of specialised units corresponding to the vertical programmes. In various ways provinces have started to integrate the vertical programmes at provincial level by merging units into new broader centres. In order to give an idea of the various new models of provincial organisation, the chart 1:10 illustrates the changes.

Chart 1:10



From a financial point of view, which is the focus in this section, a major change has occurred in that funds now are increasingly being channelled from the provincial level down through the health system, i.e. not through the Peoples Committees. The Provincial Peoples Committee, on the other hand, assumes a very important role in this organisational set-up. Its funds are for the most part raised locally, while the contribution from the state budget will vary from province to province, depending among other things on the relative wealth of the respective provinces. The PPC will then allocate funds not only between sectors, but also within the sector, e.g. the crucial allocation between curative and preventive expenditures.

Annex 5

Evaluation Methodology and Criteria

Although the Team hopes to have brought out a few unexpected findings to the readers, the methods used in the study should be a surprise to nobody. The standard conditions imposed, necessarily implies standard methods in the implementation.

For data generation, the main source has been previous reports, documents, evaluations and studies, i.e. secondary sources. Some of the secondary sources are quite recent, e.g. the documents prepared for the evaluation study by different projects in the programme, as well as a few reports by expatriates. The only primary source of data are the observations made by the Team during visits to project sites, where interviews and discussions have been conducted. Interviews and discussions have been made as non-structured conversations, i.e. not following any questionnaires as used in surveys.

The Team has consciously tried to establish quantitative data series over time periods. Whenever reliable qualitative data series have come to our knowledge, we have quantified such observations.

Due to the barriers of communications in terms of language and culture, the Team has been very careful to double-check all data crucial to major findings or conclusions. Most of surprising or controversial observations have been tested against at least one different source and analytically discussed.

As a methodological convention for our work we make the distinction between monitoring and evaluation (cf. below). Monitoring can be a continuous activity, but is based on measurement of activities or outputs only. Evaluation is an activity that can be based on the measurements from monitoring, but where activities and outputs are not sufficient. Instead the evaluation requires the measurement of the impact (in terms of established objectives and target groups) of the activities and the output. This distinction is extremely important and useful in order to understand the nature of evaluation. Adherence to it in the process of project design will improve project implementation, monitoring and evaluation. Negligence of the distinction often leads to the lack of objectives or even lack of performance indicators in the project documents.

In such cases monitoring becomes meaningless and evaluation impossible. It is left to the discretion of each observer to judge whether the project is successful or not. Evaluators are often ready to accept this role, which means to accept being someone who puts forward views or opinions on the object of study. In this report we will try to demonstrate that evaluation can and must be made in a different way.

One short-coming of the evaluation methodology is inherent in the object of the study itself: the programme and some of its projects have neither had established objectives, nor

even established indicators of activities or outputs. From this follows that evaluation *per se* is impossible: in a situation of no objectives and no indicators, evaluation against objectives is by definition excluded[80]. The surprising part of this statement is in fact the empirical fact that a substantial part of the programme is without objectives and that no evaluation or review has made a case out of this long ago[81].

In order to compensate for the impossibility of measuring goal achievement, the Team has used the method of historical analysis in order to establish hypothetical relations of cause and effect as explanatory factors for the analysis of the programme. One such analysis is the historical process analysis of the origins and developments of the projects in the programme. The other one is the historical conceptual analysis of the project contents. This means that we have opted for the forth of the solutions possible, i.e. to give the evaluation an explorative and problem-oriented direction[82].

With no established criteria of evaluation, the observers values will of course play an important role. Currently, this factor is overlooked most of the time and in most of the cases. The Mission is conscious of being a carrier of implicit values as the individual Team members have different values who may play tricks on all of us in the analysis[83].

We would like to present one value that has influenced the Teams work and this report. In evaluating a programme whose origins in terms of project design are political[84] rather than technical, we believe that hard technical aspects should dominate over political ones in the evaluation work. We have been guided by this belief.

Performance Indicators

As mentioned above, the evaluation of the Programme should try to establish the impact in terms of its objectives. Unless there are established objectives, evaluation is not possible in those terms.

But impact measurement may be rather tricky even when there are established objectives. Most of the time, impact will only be measured indirectly by an indicator or a set of indicators. When such indicators have been established in advance, together with a set of rules for measurement and for the reading of impact, and are monitored during project implementation, evaluation can be made reliably during the whole process. In the short run, only short-term impact can be evaluated. Long term impact for the attainment

80. Lind 1979, proposes, following Weiss 1972, four methods of evaluation when objectives are absent or vague: 1) ask the responsible officers of the project to define objectives, 2) let the evaluators define objectives, 3) to let responsible officers and evaluators jointly define objectives for the evaluation or, finally, 4) to take note of the problem of lack of objectives and give the evaluation an open, explorative and problem-oriented nature (our translation).

81. Cf. below, where the absence of objectives is demonstrated. The evaluation from 1985 cannot be regarded as an evaluation proper, because there is no evaluation report from the study, only Malcolm Segalls operational report.

32. Weiss 1972, quoted in Lind 1979: Evaluations based on too-specific goals and indicators of success may be premature in a field where there is little agreement on what constitutes success {} In complex and uncharted areas, this may be a better strategy than formulating arbitrary and superficial goals.

83. We leave it to the reader to judge whether any serious damage has been made by the play of hidden criteria, but no one can accuse the study of being presented as if the Team believes in objective truth in the absence of even the simplest quantitative test opportunities.

84. Cf. Document I, in Fforde 1991, where the MOH view on the co-operation is spelled out by Mr. Loc.

of certain objectives may only be evaluated at the end of the period required for the activities to reach impact level.

In this evaluation we are faced with projects with no clear objectives and, almost all the period, with projects where no indicators have been designed or measured during the project period. On programme level, this becomes even more problematic. No indicators are readily available to measure even activities or outputs, not to mention impact.

Instead, the evaluation Team has tried to establish indicators during the evaluation. These indicators are identified with the purpose of measuring activities and output only. It must be noted, hence, that the indicators are not intended to produce results in terms of impact directly, in this case. The most important criteria in order to judge whether our indicators are workable, are reliability and validity. First, the indicators should be reliable in the sense that the data correctly shows the quantities or qualities looked for, e.g. over time or over objects of study. Second, they should be valid in the sense that they measure what we want them to measure.

Once indicators have been established and the necessary data have been generated, the data analysis should lead to an assessment of activities and outputs of the projects. Instead of impact measures we then use impact proxies[85]. From there, we continue to the phase of evaluation and towards criteria of evaluation.

Evaluation Criteria

Generally speaking, the Team has had the objective of using the four evaluation criteria currently used by SIDA[86]: achievement of objectives (on different levels), cost-effectiveness, relevance and sustainability. All these criteria should in SIDAs system be applied by a long-term view. To those criteria we have added Lessons Learned, often used by donor organisations, as another dimension of the evaluation. SIDAs criteria are so far, however, not sufficiently precise or defined[87] as to be able to serve directly for the evaluation of the health programme. Therefore, we need to define what is meant by each specific criterion in this particular study.

Achievement of Objectives

The criteria of goal attainment is being applied with the purpose of answering the question of whether a programme or project has fulfilled the objectives originally established for the activities. The criteria may be applied on different levels, i.e.

85. "A proxy measure is an outcome measure that is used as a stand-in for goal that is not measured directly", Rossi & Freeman 1989.

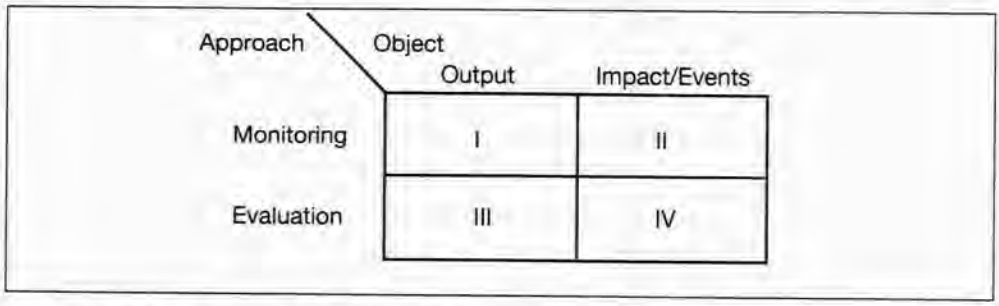
86. These criteria are a rather recent creation of SIDA. The first time a rigorous attempt was made to officially apply them, was in the FAF 92-95 (the long-term budget plan as presented to the government), i.e. during the fiscal year 1991/92.

87. I.e. in SIDAs official documents on methods and evaluation. Note for example the very common ways of simply calling the term cost-effectiveness something else, not to be repeated here. A further complication is the Swedish translation of the same term by kostnadseffektivitet, that could be taken to mean something else than cost-effectiveness. As a consequence, different senses of the term are in common usage. In Valdelin 1992, the Swedish term has been found to mean productivity. The differences in usage are not surprising, given the recent introduction of the concept as a criteria of evaluation. It is not intended as a point of criticism to bring this up in the report, but rather should the report be seen as an effort to contribute by proposing one way of using the criteria.

programme level, project level, activity level, etc., i.e. wherever objectives were set in order to manage the programme, project or activities. In the evaluation we are then focusing on the benefit side of the object of study.

The application of the objectives criteria is straight-forward once the objectives have been properly set and the way of measurement of the degree of fulfilment of the objectives has been agreed upon. In the ideal case the objectives are set at the start of the programme together with a set of precise measures. In most real cases, this is not done, i.e. either the objectives are vague or non-existent, or the ways of measuring their attainment are not defined or possible to define.

The second complication, that is more important and of greater theoretical interest, is the distinction between output and impact[88], which corresponds to the very distinction between the short term and the long term. These distinctions are best illustrated by the following chart[89].



The chart illustrates first of all the distinction between the two approaches of monitoring and evaluation and second the distinction between the study of outputs and the study of effects or impact. In the monitoring approach we are concentrating on the outputs of the activities in question, but may occasionally stumble upon impact or events of importance in the short run. The emphasis remains limited to the measurement and presentation of results. In the evaluation approach we are concentrating on the impact of the outputs from the activities, but may have to measure outputs as well in order to evaluate effects, while the emphasis is put on analysis and evaluation of results.

These distinctions are related to the distinction between time horizons for the study. In monitoring we may work with short-term outputs, while in evaluation we are interested in long-term impact of the activities and outputs of the programme or project. The focus may depend on the objectives of the programme. The time horizon of the evaluation should be governed by the set objectives, i.e. long-term objectives may only be evaluated over the long run, while short-term objectives should be evaluated in terms of the planned time horizon for the achievement of the objectives[90]. In the social sectors the programme objectives are often by necessity, i.e. by the time needed for social

88. A more elaborated version of this argument is available in Swedish in Valdelin 1992, to a large extent based on the works of RRV (The National Auditing Board) and Statskontoret.
89. RRVs guide-lines for the preparation of monitoring reports, RRV & SIPU 1990.
90. In many project design manuals of UN organisations, e.g. ILO, the distinction between development objectives and immediate objectives is used in order to clarify the priorities over time as well as the substantial relations between objectives of different levels or order.

processes, diffusion of knowledge, etc., of a very long-term character. What is meant by long-term and short-term, respectively, should always be defined in relation to the substantial contents of the object under analysis and, further, in terms of the time required in order to achieve certain targets or changes of conditions. The evaluation must then consider those definitions.

Cost-effectiveness

The criteria of cost-effectiveness, which is always comparative, is being applied with the purpose of comparing a project with others (or with itself over time) in order to find the most effective way of producing the targeted output. In the evaluation we are then focusing on the economic cost aspects of the object of study in relation to the set objectives (i.e. effectiveness and cost, which in turn means productivity).

The current use of the term cost-effectiveness varies between users. Most of the time it is used as a general way of expressing cost-consciousness. As mentioned above, SIDAs current use of the term as a criteria of evaluation, is not yet stabilised, but the criteria may mean different things in different contexts and interpretations. In this report the concept of cost-effectiveness is used in accordance with a strict and classic definition. In order to give the readers access to a straight-forward definition and an introduction to the underlying view-point, a technical **Annex 6**, *A Note on Cost-Effectiveness Analysis*, is enclosed[91].

Cost-effectiveness analysis is used to estimate the cost to produce a given amount of output over a time period. The method is used when the benefit side of an object of study is non-existent or impossible to measure accurately, which is often the case in the social sectors. In the dichotomy of financial versus economic analysis, the cost-effectiveness method is in the category of economic analysis, which means that it is based on opportunity cost. Unless this is the case, the analysis is restricted to financial cost analysis. In this evaluation, we try to use cost-effectiveness criteria as an economic criteria whenever applicable, given the constraints imposed by the availability of data.

Relevance

The SIDA criterion of relevance is related to the Swedish objectives of development co-operation and to the needs of the recipient country. This means that an evaluation of the Viet Nam-Sweden Health Co-operation should estimate the relevance of a programme or a project in relation to the Swedish objectives and the needs of Viet Nam. This criterion is, again, extremely difficult to use in a general sense, because the relevance of the activities should have been established at the initial stage of planning and in most cases they would remain relevant until the objectives have been reached or until the context of the activities has changed to the extent of rendering the activities irrelevant. In the strict sense of evaluation of past activities a project, therefore, becomes irrelevant when its objectives have been reached and it should then cease to be part of the co-operation. In this sense the irrelevance of a project may be a measure of successful performance.

In the current Vietnamese situation of social and economic transition, the other aspect

91. Annex 6 is taken from Valdelin & de Vylder, 1990.

mentioned above may be of great interest: the economic and social contexts of the Health Programme are rapidly changing, which may lead to such changes of the context of the activities that they become irrelevant for the needs of Viet Nam or the Swedish objectives. This if further commented upon in the following section.

In the application of the relevance criterion in this report the Mission has therefore added the dimension of the Vietnamese official objectives: in the current situation, the objectives of the economic reform process are of such importance that they have led to the inclusion of support to the on-going economic reform process as an overriding objective of the Swedish support to Viet Nam. The Team has assessed relevance of the Programme and its Projects in terms of relevance for the economic reform process, relevance for the Vietnamese objectives in the Health Sector as well as for Swedish development objectives. By applying the criteria over the past years, we are first of all interested in assessing whether the activities have been relevant in the past, but as a consequence this will be reflected in our recommendations as to future design of the co-operation.

Sustainability

The current craze of the term sustainability may have its correct justifications in terms of past experience of the (temporary) phase-out of the investment phase of international assistance, due to the repeated failures of recipient countries to manage the operations and maintenance of the investments. Like most fads the term sustainability invites abuse, but simultaneously may serve many good purposes in terms of emphasising many important aspects of international development co-operation. It underlines the importance of avoiding all sorts of dependence to be created by foreign assistance. On global level, as recently seen at the Rio Summit, it directs our attention to human dependence on the earth and thereby our need to rely on processes which are sustainable in terms of this planets ecological system.

As may be seen from these examples the term leaves us with a good number of choices as to what it should mean as a criterion of evaluation. With regard to health programmes two examples may be cited. A recent SIDA evaluation made an effort to define sustainability in relation to health services in Tanzania[92]. There, sustainability is defined as a combination of self-reliance and quality. Self-reliance is then assessed from the aspects of administration, finance and the health care provided. Another way of defining sustainability in health is proposed in an evaluation of health co-operation in Angola[93], where it is defined as survival, i.e. would a project survive or not without aid.

In this Evaluation we have restricted sustainability to mean only two dimensions of a project: financial sustainability and managerial sustainability. By financial sustainability of a project is meant a project where operations and maintenance can be handled by the national system without foreign support. By managerial sustainability of a project is meant a project where operations and maintenance can be handled by the national system without expatriate advisers. We are following the OECD/DAC definition of the term as quoted in a SIDA Evaluation Report[94]: A development programme is sustainable when

92. SIDA Evaluation Report 1991/3.
93. Andersson-Brolin, L. & Karlsson, A-K., 1992
94. 1991/3, op. cit. It would probably be a good idea for SIDA to consider adopting this definition for practical use in evaluations and to monitor how useful it is in practice.

it is able to deliver an appropriate level of benefits for an extended period of time after major financial, managerial and technical assistance from an external donor is terminated.

Again, the issue of sustainability merits a few words on the time perspective involved. In this evaluation we are concerned about the past performance of the programme. Much more so, than to assess the future prospects of a given project. What does it then mean to apply sustainability as a criterion of evaluation of past performance? It should imply that a project that was sustainable some time back should not have received any more assistance of financial or managerial kind after that point of its development. But should it not also imply that projects which have not become sustainable within expected time horizons should be scrutinised and probably re-designed?

The only way to reasonably apply the sustainability criterion seems to be as a means of assessing the future of a project: is the project designed in such a way that it will eventually become sustainable? A negative reply to that question should lead to a stop of the project, while a positive reply implies that the project should continue and eventually stand on its own feet. This means that the sustainability criterion will serve more as a criterion of appraisal, rather than a criterion of evaluation.

Lessons Learned

Over the years, a given co-operation programme will accumulate experience in terms of what has worked, what has not worked, and sometimes also why this has been so. Often such conclusions may be forgotten, because the system has a bad memory due to a number of factors. One way of avoiding memory failures and to improve the learning process of the system, is to spell out lessons learned by past experience. This is not a real evaluation criterion, but rather a way for the Mission to communicate the conclusions reached.

Annex 6:

A Note on Cost-Effectiveness Analysis

The purpose of this technical note is to achieve a common understanding between the Team and the readers as to the meaning of the concept of Cost-Effectiveness as applied in this Evaluation. The following text is a quotation from MANUAL Financial and Economic Analysis of Investments in Feasibility Studies, Valdelin, J & de Vylder, S., Interconsult 1990:

The role of economists in feasibility studies is to translate physical data into a common monetary yardstick. When this is done from the point of view of the investing company or project, the analysis is called financial analysis. Only costs and revenues accruing to the investing unit is taken into account.

In order to assess the profitability of a particular investment from the point of view of society as a whole, a number of adjustments have normally to be made. Private costs do not necessarily reflect social costs. When assessing social costs, the relevant concept is opportunity cost, which can be defined as the cost for society of using resources for a certain purpose, measured by the benefits or revenues given up by not using them in the best alternative use.

The financial analysis is the starting point for identifying social costs and benefits in the economic analysis. The basic technique in economic analysis is cost-benefit analysis, which consist of adding up all benefits and costs of a project to society. The technique used, and the adjustments of the financial analysis which normally have to be made, are discussed in Section 6 of this manual.

Sometimes it is difficult or impossible to calculate the benefits of a particular project in monetary terms. This is often the case in social sectors such as health and education. When benefits are difficult to measure, cost-effectiveness analysis can be used. This technique is used to calculate the lowest possible way of achieving a certain given objective to vaccinate 100,000 children, for example.

Figure 1 below illustrates the differences between financial analysis, cost-benefit analysis and cost-effectiveness analysis.

Figure 1.

From what point of view is the analysis made?	What is being analysed?	
	Benefits and costs	Costs only
Financial analysis	Financial investment analysis	Financial cost control
Economic analysis	Cost-benefit analysis (C/B analysis)	Cost-effectiveness analysis

Quite often, the techniques indicated in the different squares in the figure are confused with each other. It is not unusual, e.g. that analyses that are said to be economic analyses are nothing but financial analysis.

In cases where the benefit side of the project under consideration is difficult to measure, the rule of minimisation should be used, i.e. the alternative that gives the lowest cost for an agreed-upon output should be chosen (cost-effectiveness analysis).

When using cost-effectiveness analysis, the results will normally be presented in the form of cost per unit of output, e.g. cost per student in primary school per year. As opposed to the N(et) P(resent) V(alue) method, where the procedure is to translate all future costs and benefits to their present value at year 0, and then compare this sum with the original investment, the method used in cost-effectiveness analysis is often the annuity-method, i.e. to distribute the investment costs over the time horizon of the project in order to get an annuity of equal size each year. This annuity is then put in relation to the number of units, and the decision criterion is to minimise the costs, as measured in annuities, per unit of output. The method could be compared to the rules applying to annuity loans, for which the sum of interest and amortisation payments is the same each year.

B. Illustrative example of cost-effectiveness analysis in financial terms:

The construction of a school is expected to give the following costs

investment cost:
10.000 kwang in local currency, year 0
5.000 SEK, year 0

If the exchange rate is 1 USD = 6 kwang,
then the foreign component will be:
30.000 kwang, year 0

This puts the total investment cost at:
40.000 kwang, year 0

Recurrent costs	4.000 kwang/year, year 1 - 15
No of students/year	100, year 1 - 15

The annuity at a rate of discount of 8% and a time horizon of 15 years can thus be calculated:

Annuity = investment cost x the annuity factor + recurrent cost, i.e.:

8673 = 40 000 x 0.11683+4000

One measure of the cost-effectiveness is cost/student/year = 86,73 kwang. Other measures that could be used are cost/attending student and year, cost/graduating student etc. The choice of unit to be used as a comparison measure is crucial for the outcome.

The examples, given above, are of course simplified, but the mode of calculus is not changed as long as no further complications (e.g. changing recurrent costs over time) are added.

Annex 7:
Health Statistics

SOCIO-ECONOMIC AND HEALTH INDICATORS

	1989	2000 (Projections*)
Area (in 1000 sq. km.)	330,36	
Population	64411700	75683000
Annual growth rate (%)	2,29	1,26
Crude birth rate (per 1000 population)	31,3	29
Crude death rate (per 1000 population)	8,4	10,9
Infant mortality rate (per 1000 live birth)	34,3	
Low birth weight (%)	86	
Maternal mortality (per 100 000 live births)	12	
General fertility rate (per 1000 women 15-49 years)	126,7	
Total fertility (births per women during their childbearing years)	4,4	4,11
Number of surviving new-born	2017000	2195000
Population <15 years (%)	51,17	
Dependency ratio (%)	86,3	
Doubling time (years)	31	39
Life expectancy at birth (years)	66	57,5
Safe water, urban (%)	100	
rural (%)	66	
Adequate excreta disposal (%)	56	

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DOI MOI AND HEALTH

At present Vietnam is in a transitional stage between the earlier centralised plan economy and a decentralised market economy.

The pace of reform has been rapid during the last years. Realities of life change every day and development assistance must respond accordingly.

This evaluation of the Swedish support to the health sector in Vietnam demonstrates that most projects have been influenced by the reforms and that all project activities, taken together, have produced a considerable amount of training for the health sector.

The support to production of drugs and supply of materials for the drug industry are, however, not in line with the economic reform process and should be phased out.

The health sector in Vietnam remains an important sector for international aid and the evaluators suggest that Sweden should increase its assistance, or at least maintain it at the present level.

Sweden's bilateral co-operation, administered by SIDA, comprises 19 programme countries: Angola, Bangladesh, Botswana, Cape Verde, Ethiopia, Guinea-Bissau, India, Kenya, Laos, Lesotho, Mozambique, Namibia, Nicaragua, Sri Lanka, Tanzania, Uganda, Zambia, Zimbabwe and Vietnam.

Each year, around 30 of SIDA's over 300 projects are evaluated. A number of these evaluations are published in the SIDA Evaluation Report Series.

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