Sida Evaluation 01/03

Tackling Turmoil of Transition

An evaluation of lessons from the Vietnam-Sweden Health Cooperation 1994 to 2000

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Gunilla Krantz
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Authors: Alf Morten Jerve, Gunilla Krantz, Pham Bich San, Paul Spivey, Tran Tuan, Claes Örtendahl.

Sida Evaluation 01/03
Commissioned by Sida, Department for Democracy and Social Development

Registration No.: 1999-02749
Date of Final Report: February 2001
Printed in Stockholm, Sweden 2001
ISBN 91-586-8889-7
ISSN 1401–0402

SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
Address: S-105 25 Stockholm, Sweden. Office: Sveavägen 20, Stockholm
Telephone: +46 (0)8-698 50 00. Telefax: +46 (0)8-20 88 64
Telegram: sida stockholm. Postgiro: 1 56 34–9
E-mail: info@sida.se. Homepage: http://www.sida.se

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Preface

This evaluation has been commissioned by the Health Division of Sida's Department for Democracy and Social Development. It forms part of a planning process preparing for a possible continuation of the Vietnam-Sweden Health Cooperation (VSHC) beyond mid-2002, when the current agreement (signed in 1999) ends. It serves, as well, the purpose of providing an independent assessment of lessons and main achievements of the programme of activities covered by the 1994-1999 agreement.

Team members were selected by Sida and the Ministry of Health in consultation, with Mr. *Alf Morten Jerve* of the Chr. Michelsen Institute in Bergen, Norway appointed as team leader. Jerve is a social anthropologist specialising in poverty-related studies, rural development and aid issues. The other team members were Dr. *Gunilla Krantz*, medical doctor and public health specialist from Nordic School of Public Health in Gothenburg, Sweden; Dr. *Pham Bich San*, sociologist and primary health care specialist, currently special advisor to the Hanoi-based Market and Development Research Center, Mr. *Paul Spivey*, pharmacist and drug policy and control specialist, working as private consultant based in Scotland; Mr. *Tran Tuan*, health systems specialist, and currently the Executive Director of the Research and Training Centre for Community Development, Hanoi; and Mr. *Claes Örtendah*l, political scientist and former Director-General of the National Board of Health and Welfare, Sweden, now working as private consultant based in Stockholm.

This report is the collective effort of the whole team, where the outline, drafts of chapters and the main conclusions have been developed in a series of team meetings and peer reviews. Örtendahl is the main author of Chapter 3, while Chapter 4 is developed with inputs from Krantz, San and Jerve. Spivey drafted Chapter 5, Tuan Chapter 6, Jerve Chapter 7 and Krantz Chapter 8. The introductory (Chapter 1 and 2) and concluding (Chapter 9) chapters have been written by Jerve, with inputs from other team members.

The team wishes to acknowledge the support from the staff of the Programme Management Unit (PMU) of the Ministry Health in coordinating interviews and field visits. Special thanks go to the Head of PMU – Dr. Hoang Thi Hiep, who took time off her hectic schedule accompanying part of the team to Ha Giang and Tuyen Quang provinces. Similarly, the team benefited greatly from the support of the Swedish Embassy represented by Christina Larsson and Pham Nguyen Ha. Last, but not least, we thank the staff of the different Areas of the Cooperation, and the many other people, who shared important information and insights with the team. While we hope that their views are reflected in the way we formulate lessons of VSHC, some will no doubt take issue with some of the conclusions, for which the Team alone is responsible.

Alf Morten Jerve, Bergen, February 2001

Executive Summary

1. Sweden has provided assistance to the health sector of Vietnam for more than 30 years, with the first Sida project agreed in 1974 – the children's hospital in Hanoi. It took until 1999 before Sida phased out its support to the same hospital, which is an exceptionally long history for an aid project. Not surprisingly, many in the Ministry of Health today talk about Sweden and Sida as a *trusted partner*.

2. During this period the nature of the partnership saw *major changes* both in the relationship between the partners and the content of support. First of all, this reflected major changes in Vietnam, but also mirrored changes in Sweden's aid policies.

    - **1970s:** The decision to building two hospitals was essentially an act of political solidarity. Both parties greatly overestimated the capacity of the Vietnamese State as implementer, and the projects gradually took the form of Swedish *turnkey* operations.

    - **1980s:** Both parties now realised that Vietnam was not in the position to manage the two "Swedish-made" hospitals by the time the construction workers had done their job, and a major programme of *management support and training* emerged. Yet, the share of materials and equipment remained high. This is also the time when Sida turned the focus towards primary health care.

    - **Early 1990s:** The *doimoi* reforms of economic liberalisation took effect. The basic health system, based on communes and co-operatives, collapsed. State finances were extremely constrained, and with little priority given to health. A weakened Ministry of Health realised that the new Vietnam emerging required new approaches in health, and opened the door for Sida eager to help on broad based *institutional development,* and with the Programme agreement in 1994, also on *policy work*.

3. This study focuses on the period of the Vietnam-Sweden health cooperation from about 1994 until mid-2000, covering the period of the 1994–1999 agreement (hereafter referred to as VSHC-I) and the initial start of the 3-year follow-up agreement (1999–2001) – generally called VSHC-II. The 1994-agreement represented an ambitious scheme – backed by SEK 250 million – for sectoral reform including both the development of new policies to meet the challenges of *doimoi*, and increased capacity and efficiency of the Ministry of Health. There was a special objective to reduce inequity in health. The primary foci of the policy reform agenda were on health financing, primary health care and drugs, while capacity building were to take place on a broad scale, at the central Ministry and in the selected provinces (initially 5). The equity concern led to the setting aside of about one-third of the budget to the improvement of health service delivery in disadvantaged areas.

4. Final results came to deviate much from initial plans. Certain areas of support were dropped, because of lack of progress and a decision in Sida, halfway, to concentrate on fewer areas. Disbursement was slower than anticipated, not least because of the need to change approach in the Support to Disadvantaged Areas. This led to a reduction in "hardware" – construction, equipment and drugs, and a stronger emphasis on skills and organisation development. The same trend, to various extent, applies to the other areas of support, as well. The "software" approach met with a number of difficult constraints: lack of qualified staff to build the approach on, a poor incentive structure, frequent changes in management, inadequate delegation of authority and a weak organisational culture for learning and experimenting.

5. In spite of these constraints, the evaluation concludes that VSHC has made significant contributions in assisting Ministry of Health tackling the turmoil of transition. VSHC-I was a timely and relevant response to the emerging problems of the sector. The flexible planning mechanism adopted facilitated a learning process and adjustments along the way. There has been further building of trust, and the gradually improving effectiveness of international advisers is a testimony to this. The investments in individual competence development are starting bearing fruits, which has resulted in an increased capacity in policy development and planning in various sections of the Ministry of Health.

6. The following lessons can be made with reference to *weaknesses* in the cooperation. The large initial budget stimulated expenditure-driven planning rather than needs-based. There was little attention to capacity constraints. This has improved over time. VSHC lacked organisational strategies guiding the substantial investments in training made. Communication has remained a bottleneck throughout. This is an issue of language and the costs of translation, as well as the meeting of different institutional cultures. The responsibility to ease such problems remains primarily with the Vietnamese side, since foreigners come and go. VSHC has had a major contribution to the process of opening-up and internationalisation now evident in the sector. But institutional change takes time – and cannot be imposed from outside.

7. The main *achievement* of VSHC in the **Health Policy Area** is the build-up of a Health Policy Unit. It has demonstrated, the last couple of years, an impressive capacity for policy initiatives and commissioning of studies. Its important role in the development of national health strategies is acknowledged by the Ministry leadership, including important inputs to the current debate on health financing. The unit has become an integral part the Ministry's policy development structure. In number of staff it constitutes half the capacity of the Planning Department, of which it forms a part. The high degree of aid dependency, however, remains a concern. For this vital function of the Ministry, the share of government funding should be raised to a higher level. We recommend focusing more on governance issues in the analytical work of the Unit, not least to prepare more appropriate inputs to the process of implementing the new policies. Much work remains to be done here. We note that the Unit intends to make more use of independent consultants (i.e. staff not employed by MoH), and we recommend to reinforce this trend and assist building analytical capacity outside the Ministry's own set-up.

8. The **Support to Disadvantaged Areas** (SDA) seems to be struggling to find an appropriate strategy and institutional form, as far as we were able to observe. We fully concur with the overall objectives of this area, and strongly support arguments for continuing the efforts beyond 2001, building on the rich experience made over the last ten years. The main achievement of SDA is it work on building a new approach to training of Village Health Workers in remote rural areas, that is sensitive, not least, to the ethnic issue. The approach to integrated supervision of public health services at district and commune level has also been breaking new ground. Where we are putting a question-mark, is on the approach to local level planning and implementation by involving health sector staff in the extensive use of PRA-techniques. We also note that SDA still struggles with finding the right model for empowering local initiatives, in a system that still is very much centrally controlled. The role of the provinces in the SDA-model is a lingering issue. Finally, we see a need for more simplicity in the communication of what is the SDA-model.

9. A policy of open market economy has major implications for the pharmaceutical sector. The **Area for Drug Policy and Control** focussed, of necessity, on the development of policy and regulations that would strengthen the capacity of the Ministry of Health to monitor and control the availability, quality and use of drugs in Vietnam in both the private and public sectors. A lot

of the activities and outputs of ADPC provide the necessary basis for improving access to, and the safe, rational use of, quality drugs. There remains much to be done to implement the approved policies and regulations before their impact will be seen in the sector. A larger allocation of funds should be made to the promotion of rational drug use and improving professional competency. The pharmaceuticals component of the VSHC should continue to emphasise the two major objectives of the Vietnam National Drug Policy, namely the supply and quality of products, and their safe and rational use in health care.

10. The **Central Hospitals Area** aimed at preparing the two "Swedish" hospitals for the phasing-out of Swedish support. On the technical and infrastructure side, and in terms of medical and management skills, this objective can be considered achieved. There remains a major concern, however, with the financial viability of the hospitals, sharing the same problems as other public hospitals. This will of course affect the quality of treatment, but also reduce the ability of the two hospitals to continue their important role as training hospitals established during the period of Swedish support. With the current pace of economic growth and urbanisation the pressure on the "hospital sector" in Vietnam will further escalate, and Sida should consider reopening the sector for VSHC support.

11. With its support to **Aid Management and Coordination** VSHC was instrumental in setting the agenda for MoH. This resulted in the first donor coordination meeting, and more importantly to the forming of a special department to co-ordinate aid – the Project Coordination Department. The role and function of this department remain to be clarified, and the problems are not of a nature that money can cure. There appears to be substantial resistance from within the Ministry against too much coordination and what is perceived as centralisation of powers in dealing with donors. As has been the case with many of the issues brought up under VSHC, this also will need time to mature. Time and patience have proved to be an asset and quality of VSHC, and should be applied here as well.

12. Finally, we would like to summarise a few general recommendations from our short but intense exposure to the experiences of VSHC:

- *Sustain* the process and basic structure of VSHC – Sida has a role to play and is a wanted partner.
- Continue to invest in *capacity* for learning and organisational change.
- Keep the focus on horizontal polices – i.e. policies that give direction to the development of the *health system*.
- Improve the design and dissemination of *experiments*.
- Increase the focus on how to *implement* the new policies; and
- for VSHC this implies finding ways of working with the *provinces and districts.*

Abbreviations

AMG	Area Management Group
ADB	Asian Development Bank
AMC	Aid Management and Coordination
ADPC	Area for Drug Policy and Control
APO	Annual Plan of Operation
ARI	Acute Respiratory Infection
CHS	Commune Health Station
CHA	Central Hospitals Area
CMO	Cooperation Management Office
DAV	Drug Administration of Vietnam
DMG	District Management Group
DIC	Drug Information Centre
DST	Department of Science and Training
DQC/DQCI	Drug Quality Control/Drug Quality Control Institute
EU	European Union
HCMC	Ho Chi Minh City
HI	Health Insurance
HPA	Health Policy Area
HPU	Health Policy Unit
IMR	Infant Mortality Rate
IPCH	Institute for the Protection of Child Health (Children hospital in Hanoi)
IPO	InDevelop's Project office in Hanoi
LFA	Logical Framework Analysis
LTA	Long-term adviser
MoH	Ministry of Health
MCH/FP	Maternal and Child Health/Family Planning
MMR	Maternal Mortality Rate
MRDP	Mountain Rural Development Project (Sida-funded)
NIDQC	National Institute for Drug Quality Control
NEB	National Educational Board
NGO	Non-Governmental Organisation
ODA	Official development assistance
PCD	Project Coordination Department
PHB	Provincial Health Bureau
PHC	Primary Health Care/Support to PHC Unit
PMG	Province Management Group
PMU	Project Management Unit
PRA	Participatory Rural Appraisal

RDF	Revolving Drug Fund
SDA	Support to Disadvantaged Areas
SEK	Swedish currency
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STC	Short-term adviser
SDA	Support to Disadvantaged Areas
SWAP	Sector-wide approach
TB	Tuberculosis
TSSA	Training Systems Support Area
TSSP	Training Systems Support Project
UBGH	Uong Bi General Hospital
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
VHW	Village Health Worker
VNDP	Vietnam National Drug Policy
VSHC	Vietnam-Sweden Health Cooperation
VSHC-I	1994–1999 Agreement
VSHC-II	1999–2001 Agreement
WHO	World Health Organisation

1. Swedish aid to health system improvement in Vietnam – context and scope of evaluation

"An sach, uong sach, o sach – Clean eating, clean drinking, clean living"
"Phong benh hon chua benh – Prevention is better than cure"
(Slogans from Vietnam's health care policy in the 1960s)

1.1 A historical legacy that matters

It is a characteristic of most aid programmes that they appear as short-lived historical episodes. The Vietnam Sweden Health Cooperation (VSHC) is an exception. The relationship started forming already in the mid-1960s with medical supplies and equipment as part of the humanitarian aid managed by Swedish NGOs during the Vietnam/American War. The history of the relationship that unfolded over the next three and half decades sees some dramatic changes on both sides in the partnership.

Vietnam

Vietnam moved from a war economy with a high level of *political commitment and voluntarism* (lasting in many ways until the late 1970s), to a period of a progressively failing centrally planned economy and growing popular disillusionment, until government after the severe economic crisis in 1989 was forced to make a reality of the *doimoi* economic reforms approved by the Party Congress already in 1986. This started in 1990 the so-called transition period, which radically transformed economic life in Vietnam. The liberalisation of the market, removal of restrictions on foreign trade and abolition of agricultural co-operatives led to double-digit economic growth rates, and major improvements in living standards for the majority of the population.

The same reforms, however, played havoc with the fundamentals upon which Vietnam's health system had been developed. This was a system with an impressive track record in community based preventive health care, in reduced mortality rates, and in its equity profile. With the *collapse* of the cooperatives, the financial basis of the commune health system was suddenly removed. And with state finances in shambles by the end of the 1980s, there were no resources to keep to the promulgated political aim of free health services for all.

The combination of progressively deteriorating public services, improvement in personal incomes, and the growing availability of drugs in the market, led to a marked *shift in health seek behaviour* towards self-medication and the purchase of "private" medical treatment. The demand for the latter was mainly met by public practitioners taking additional payments from patients willing to pay for better service, and increasingly also starting more regular private practice. This informal financing system for health services spurred *inequity* in health, greatly favouring groups benefiting from the economic growth, leaving the marginal and poor further behind.

An uncontrolled establishment of private pharmacies took place at a point of time when trade with foreign producers of drugs was opened up. While positive consequences could be distinguished in the area of drug costs, very negative and potentially dangerous consequences followed by means of wild dispensing of active and dangerous substances and a rapid increase in *antibiotic resistant bacteria* due to uncontrolled use of prescription drugs.

Sweden

Sweden, in its role as a development cooperation partner, likewise has experienced some important changes. After the bombing of the Bach Mai hospital in Hanoi in 1972, which caused an unprecedented public protest in Sweden, there was massive political support for the idea of building hospitals. The war was causing great sufferings, North Vietnam desperately needed and wanted modern hospital facilities, and Sweden and Vietnam had just opened bilateral aid relations. A decision was made in 1974 to build a children's hospital in Hanoi (today the Institute for the Protection of Child Health – IPCH), and in 1975 a second hospital – the Uong Bi General Hospital in the Province of Quang Ninh north of Haiphong, was added.

The start of Sweden's involvement was first and foremost an act of *political solidarity* with the people of North Vietnam during the war, and not the outcome of a conventional development assistance approach at the time. There was little in the form of careful feasibility assessments. In fact, Sweden had very limited knowledge about how Vietnam functioned, and the Vietnamese regime did its best to keep it that way – confined by the logics of war secrecy and the threat of capitalist influence. This ignorance was paired with a remarkable *confidence* among Swedes in the capacity of Vietnam to manage its development. These Swedish sentiments were reinforced by an even stronger self-confidence on the Vietnamese side, stimulated by the victories of war.

The political "love affair" of the late 1960s and early 1970s, and the "marriage" of 1972, were soon to meet some difficult realities of being together in daily life. No one at the time believed that it should take until 1999 before Sida – at least for the time being – spent its last *krona* (SEK) in support of the two hospitals. What was envisaged initially as material and technical support to a Vietnamese hospital construction project took more and more the shape of a Swedish managed *turnkey operation.*

Sweden entered a process where it gradually expanded its management and control function, at the expense of Vietnamese partners (Ministry of Health and national suppliers and contractors) who reluctantly also came to accept weaknesses in their own system. When the construction workers finished (in 1982–83), however, Sida did not hand over a key and leave. Ministry of Health (MoH) had already by then submitted, and Sida had approved, a request to prolong the Swedish assistance beyond the construction phase, into full-scale support of hospital operation, including medical guidance, management, training at all levels, and medical and spare parts supplies.

By the early 1980s, the nature of the relationship had clearly changed. Sweden by now had become *a more interfering partner*. Using the power of the purse, supported by the international trend of aid conditionality, it started advocating the needs for change at various levels of the system. This was a time of changing international aid paradigms, both on development policies in general and health in particular (e.g. following the 1978 Alma Ata declaration on primary health care to people everywhere). The scope of the Swedish support to health increasingly included aspects of primary health care and drug supply. Sweden generally took a broader interest in *living conditions* and economic *reform*. Vietnam, in many respects, was now in a weaker position, and the pressure for reform had already started from below (in Vietnam referred to as fence breaking). In the health cooperation, this gradually led to a move away from supply of equipment to *transfer of knowledge* and *capacity development*.

While Vietnam continued keeping the aid in isolated project environments, the system gradually started opening up. All projects of the Cooperation – the two ongoing hospital projects, the rural health project in Quang Ninh (started in 1983 and reorganised in 1986), the provision of drugs projects (from 1983), and the medical equipment project (from 1986), progressively expanded their "software" components and slowly moved closer to the mainstream activities of the Ministry.

The programme agreement of 1990 marked a new shift. Now the development terminology had been further broadened to also include *'policy dialogue'*. Two new projects were created to support central functions of the Ministry (the Central Level Integration Project and the Training System Support Project), bringing the VSHC one step closer to the higher circles of decision-making. This trend was to be further reinforced with the agreement in 1994, which now took the next step conceptually and made *'policy development'* one of its cornerstones. The approach was broad based strengthening of the capacity of Ministry of Health, mainly at central level, involving most of its departments.

The period covered by the evaluation covers the Agreement, which we refer to as VSHC-I, which lasted from October 1994 to September 1999, including a 3-months extension, and about one year into VSHC-II (October 1999 – December 2001). Since VSHC-II, by and large, is a continuation and consolidation of VSHC-I activities as they matured towards the end of the 5-year period, we decided not draw the line by October 1999, for two main reasons. Firstly, the adjustments made in VSHC-II reflect important lessons drawn by the parties during the previous years, and the initial experiences with these adjustments, up until the time of our field work (October 2000), is of interest. And secondly, the key actors in the Cooperation, themselves, did not refer to October 1999 as a major turning point, presenting VSHC as a continuos and on-going learning process.

Hence, it is the experiences from the period since about mid-1994 of the Vietnam-Sweden Health Cooperation that is the focus of this study.

A relationship worth continuing?

Sweden and Vietnam agreed in 1994 on a 5 year and 250 million SEK programme, which turned into an ambitious strategy for institutional development, although this was not the perception, from the beginning, of all people involved from Ministry of Health. This strategy was prolonged in 1999 with a new agreement, amounting to 90 million SEK, which will last until mid-2002 (at the Annual Meeting in December 2000 the agreement period was extended by 6 month without additional funding). The expenditures during the first agreement averaged out at 51 million SEK per 12 months. This will drop to 34 million in the second period, which reflects that investments in equipment and materials have been scaled down even further.

Hence, the *main goal* underlying the support in the 1994–2000 period can be summed up as:

> *To improve the ability of Ministry of Health to formulate and implement new policies addressing the new realities of Vietnam – tackling turmoil of transition.*

In anticipation of the preparation of yet another extension, beyond 2001, of this long partnership, it is therefore timely to ask:

- Has Ministry of Health's ability improved?
- What are the results of the investments in production of new knowledge?
- Are the policies, regulations, models, experiments and ideas being produced relevant to the problems facing the health sector today and in the years ahead?
- What lessons can be drawn on the effectiveness of aid?

Before addressing these questions we have to remind the readers, and ourselves, not only of the history, but the volatile context within which VSHC operates, as well. The pace of change is rapid, as can been seen from the recent development trends presented below (chapter 1.2), and the future is full of uncertainty. Nevertheless, there are certain general trends in health system development internationally which Vietnam also will be affected by (chapter 1.3).

1.2 Vietnamese trends during the 1990's

The last decade was a period of dramatic improvements in the economic and social conditions for the majority of Vietnamese. There have been very striking reductions in the incidence of poverty over the last 5 years. The proportion of people with per capita expenditures under the official poverty line shrunk from 58 percent in 1993 to 37 percent in 1998, reflecting a near doubling of per capita incomes from 1988 to 1999.

Other indicators, such as human development, infrastructure access, and ownership of consumer durables also confirm the story of a rise in living standards between 1993 and 1998:[1]

- Primary school enrolment rates were already high for both girls and boys, but have improved further – they have increased from 87% to 91% for girls and from 86% to 92% for boys;
- Lower secondary enrolment rates have doubled for both girls and boys, and are now at 61% for girls and 62% for boys;
- Upper secondary enrolment rates have increased dramatically for both girls and boys – they have gone up from 6% to 27% for girls and from 8% to 30% for boys);
- Malnutrition amongst children below the age of 5 years remain high, but has declined from about half the population to a third;
- Infant mortality has declined to 37 per 1,000 live births, from around 50 per 1,000 live births in the 1980s.
- Access to infrastructure – such as roads, public health centres, clean water, and electricity – have all increased; and
- Ownership of consumer durables – such as radios, television, and bicycles – have also all gone up. In 1998, 47% of households own a radio, 58% own a television, and 76% own a bicycle.

These great achievements in poverty reduction, notwithstanding, Vietnam remains a poor country and the benefits of *doimoi* are unevenly spread:

- Vietnam still ranks only 108th of 174 countries in the world according to a composite index of human development reflecting life expectancy, education, and material well-being (UNDP's Human Development Index).
- Poverty and near-poverty remain widespread, especially in rural areas where 77% of the population live and where 45% of the people live below the poverty line.
- Urban poverty is likely to increase with the current rates of urbanisation, much of which escapes the official system of registering place of residency.
- Ethnic minorities, which constitute only 14% of the population, account for nearly 30% of the poor. Income gaps are slowly widening between urban and rural areas, and across the various regions. Incomes in urban areas are now (1999 figures) almost four times average rural per capita incomes.
- Inadequate calorie intake, especially during the months in between harvests, is a problem in isolated rural areas. The incidence of underweight and malnourished children under the age of 5 years is in the order of 39%, one of the highest such rates in the world.
- Landlessness is gradually increasing and contributing to pockets of persistent poverty in the face of slow growth in off-farm employment opportunities.

[1] World Bank, 2000. *Vietnam Development Report 2000: "Vietnam Attacking Poverty".* Joint report of the Government of Vietnam – Donor – NGO Poverty Working Group, Consultative Group Meeting for Vietnam, December 14–15, 1999.

- The abortion rate in Vietnam is one of the highest with one in three pregnancies still ending in abortion. This startling statistic reflects an extreme lack of choice facing many Vietnamese women, who feel they have little alternative but to endanger their health in order to avoid unplanned births.

Whereas *doimoi* caused radical shifts in economic policies, the Party and government has moved more slowly on reforms in other policy areas, with a tendency of being reactive rather than proactive. This accounts for reforms in the structures and functions of the State, in the policy environment for private sector development, to improve the quality of governance, and to increase the participation of the broader society in political processes. Nevertheless, there are significant movements of change in several important areas:

- The development of a system of rule of law, in particular a civil code.
- The reform of state-owned enterprises, makings workers and managers stakeholders in the system.
- The emergence of an information society.
- The deepening of international economic relation.
- The increased role of local independent organisations, particularly in the areas of research in science and technology (e.g. with the introduction of the Law on Science and Technology effective as of January 1, 2001[2]).
- The greater involvement of local independent organisations in community development programme.

All of these trends will in various ways influence the health system, health seek behaviour and health conditions of Vietnam. It follows that the Ministry of Health will need to greatly enhance its capacity for learning and organisational change to meet the challenges imposed by the trends above. VSHC has so far been an important source of funds, knowledge and inspiration, but the glass is still only half-full. It is premature to pass any final judgement on the effectiveness, relevance and sustainability of these investments. Only the future can tell.

1.3 International trends affecting health system development

There is a general agreement that health seek behaviour and health systems over the world are experiences major changes, which are related to new patterns of social, economic and cultural change, euphemistically referred to as *globalisation*. A common denominator among these many trends is that they are only partly controllable from a national standpoint – by the states and by ministries of health.

- Most states experience an increased **pressure on public finance**. The globalisation of economies tends to put pressure on taxation levels throughout the world. The possibilities of keeping them on levels considerably over that of the main economic partners have deteriorated. This tendency of "harmonisation" seems generally to have a downward character. Health financing in most countries is reacting by increasingly relying on financial sources outside the fiscal system – such as user fees, private insurance or other forms of pre-payment arrangements.

[2] Socialist Republic of Vietnam, 2000. *Law on Science and Technology*. Official Gazette, Number 28, July 31,2000, p 18–31.

A consequence of these new forms of multi-source financing is a lessening of direct political control of health care systems.

- **Population ageing** is now a phenomenon affecting both developing as well as developed economies – although stronger in the more advanced economies. Thus the introduction of a more costly morbidity situation in developing economies increases the pressure on public finance and accelerates developments in the direction of a multiple source financing structure for health. This leads to a situation of a rapid increase in the demand for health care for non-communicable diseases in countries that are still suffering from severe impact of communicable diseases (the so-called "double burden of disease"). Vietnam is a case in point.
- **Health technology advancements** take nations in a similar direction of cost increase, and with rapidly increasing literacy and access to media reporting on medical novelties, the popular demand is increasing. The introduction of wonders of technology seems to increase inequalities in health and raise difficulties for political control over the health system. There may also exist a trend of expensive health technology causing **poverty**, since people may decide to use economic assets (such as land or livestock) for health purposes rather than income generation.
- A changing morbidity pattern and increased reliance on complicated technologies also **changes the staff structure** of the health system. Increased training is needed. More staff with long education is needed also for remote places. In a situation of a troublesome public economy this opens the door to new arrangements where staff is financed increasingly by extra-budgetary means. **"Envelopes"** become increasingly popular in many countries. Publicly employed staff are in many places allowed time off from their positions and fewer working hours, to go into private practice as well
- A more critical view on quality of health care is also noticeable globally. The individual health professional is made increasingly more accountable and responsible to professional fora and to structures for medical surveillance. Simultaneously, there is an increasing need to create **legitimacy** for health care guidelines through transparency and strong involvement from professional organisations.
- The combination of a rapid increase in international travel, with growing therapy resistance for several "old" diseases and the emergence of new ones, creates situations where national health systems are left with much shorter response time to prevent epidemics.

Taken together, these global trends represent two important features of modern health systems:

- Medicine becomes increasingly **more expensive for the individual and inequality rises** correspondingly, unless economic development, renovated financial instruments and distribution policies are able to counteract this effectively.
- Direct **government control is weakened** and policy implementation thereby made more difficult – particularly calling for complicated consensus processes.

The above factors represent global processes that constrain the scope for nationally managed health systems, with adverse effects for citizens' health. However, globalisation is also bringing with it processes and initiatives that may increase the prospects and resources for improving people's health:

- There are several **global governance efforts** to control global health trends – e.g. tobacco control and vertical programmes on HIV-AIDS, malaria, polio and tuberculosis. There is also an emerging global accountability system with the reporting of WHO.
- We have seen the emergence of **new philanthropists** in health sometimes working outside government channels (such as through NGOs or directly to districts). The position of global NGOs has been strengthened.
- **Labour mobility** is increasing. It has become easier for health professionals to seek employment in other countries – a blessing for some, while a brain drain for others.
- Free trade agreements may reduce costs and increase availability. They facilitate the growth of a **global health industry**, with financial resources above that of a majority of nation states, which no doubt spurs technological development.

From the points of view of **national health policy** these trends demand a focus on a number of critical issues:

- New policies on *health finance* to counter the tendency of increasing inequities in health and to mobilise sufficient funding for the sector.
- New policies for *control* of the health provision structure to avoid market forces taking the lead and creating inefficient forms of health care.
- New policies on health staff to ensure their *participation* in the implementation of public health policies.
- New policies in working with *(re-)emerging diseases* to avoid them reaching a "critical mass".
- New policies to deal with the spread of *new technologies* in health care so as to avoid extreme costs, poor quality and ineffective priorities.

Sweden has undertaken to support health policy development in Vietnam and to be active in the selection process of projects. The health policy work of the Vietnam- Sweden Health Co-operation, therefore, needs to be analysed with these global trends in mind with a view to understand if selection processes and implementation processes can be improved to increase relevance of the policy development area.

1.4 Scope of the evaluation

The glass half-full or half-empty

Both Vietnam and Sweden should take credit for the fact the "love affair" still exists as a relationship thirty years later – a factor not least stressed by the Vietnamese side. It matters to the Vietnamese that the intervention in Cambodia, the inefficiency of the planned economy, the boat refugees and other matters did not lead to a "divorce". Time and accumulated trust have a value by itself. One can make the analogy with many old couples: as time pass they learn to live together and to live better.

Having said this, it must also be noted that a new generation is growing up with little affiliation to this history, but at the same time being far more open to outside influence. Vietnam is in a transition where a constant struggle between the old and the new takes place at different levels of society. The same is also true of the basic values of health policy, and the role the Ministry of Health. It is prudent to ask in this context whether VSHC is a case of a genuine development 'partnership' – as the development speak of today professes, enabling MoH to reform and find its proper and most

effective role, *or* merely a framework for accommodating the need of the various units of MoH and their staff to secure resources for their mere survival strategies.

We are not posing this rhetorical question believing that a definite answer can be given. It is meant to illustrate the point that VSHC operates in an institutional environment and in a society that undergoes rapid transformation, where several forces and counter-forces, open and hidden agendas are present at the same time.

What may appear at one point as a futile investment in training of individuals, catering more to people's personal ambitions than to building institutional capacity, may suddenly become a valued asset under different circumstances. What may appear as a carefully worked out policy on paper, may become toothless when meeting institutional realities at the level of implementation. As one Vietnamese observer put it: "All what VSHC is developing of ideas and polices rest on one fundamental assumption; that it is in the interest of the people in the system to follow them." Vietnam is not the only country phasing problems in linking the rationality influencing the planning process, to the often very different rationality of day-to-day life of public institutions.

We have to acknowledge that participating in reform processes and institution development, like VSHC does, is prone to be risky. No measure of logical planning can guarantee impact. With its ambitious objectives of change-making, VSHC is today a different ballgame altogether compared to when it started in hospital construction 25 years ago. While progress in construction is easy to verify, evaluation of progress and impact is inherently far more difficult with respect to VSHC today. There is generally a lack of good verifiable indicators. In the final analysis, much depends on whether one is inclined to look at the programme from the perspective of "the glass being half-full, or half-empty".

There is evidence to suggest that in Vietnam the glass is half-full, and the authors of this study acknowledge that the lessons summarised below reflect this spirit of optimism.

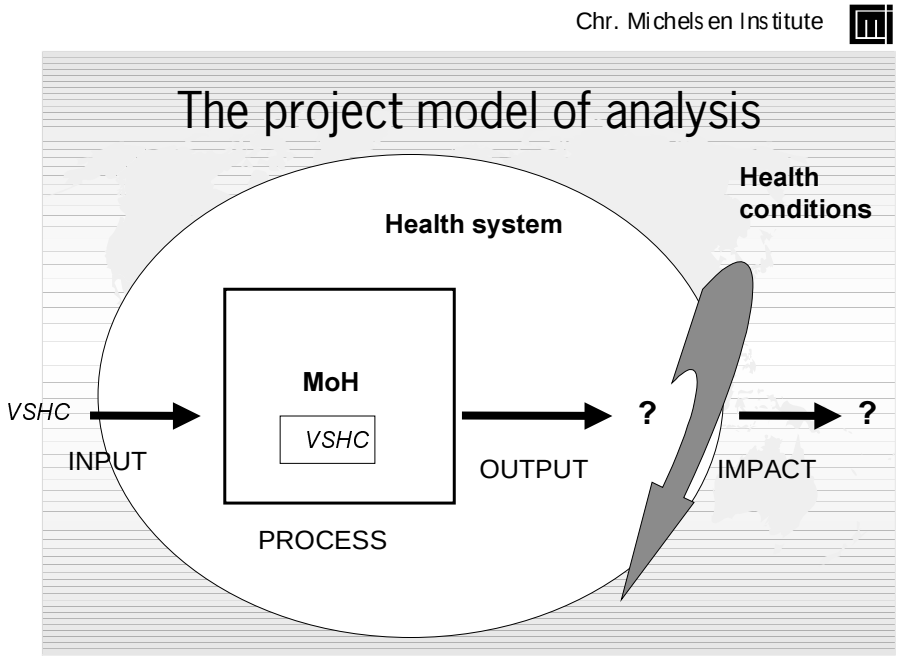
A formative evaluation

This study has been designed to be of use in forward planning of a possible extension of the Cooperation, beyond mid-2002. Thus, it makes the study a *formative* evaluation, as distinct from a summative evaluation. The latter means a type of evaluation using standard social science methods, and the collection of independent data, to analyse the extent to which a project met its objectives (effectiveness) within acceptable costs (efficiency). Summative evaluations are mostly done after completion of the project, to meet the requirements of the funding agency and its accountability vis-à-vis political decision-makers.

Our data are not independent – they derive from interviews mainly of people working with VSHC, and from reports produced by the programme. We have adopted a "lessons learned" approach, allowing the "voices" of the programme to influence our findings. They represent lessons that we have tried to systematise and generalise as inputs to discussions on future strategies and priorities for the Cooperation – hence, a formative evaluation.

Focus on process and outputs

We have adopted a few simple analytical frameworks to assist the way we have thought about VSHC as change-making process. It follows the scheme of a project model, as presented in the figure below.



VSHC as a programme of investments is characterised by:

- A number of *inputs* – financial resources, professional staff and their skills and ideas, equipment in kind, and administrative and management support.
- A certain *process* of implementation – involving plans, strategies, working procedures, and institutional arrangements.
- A set of planned, and subsequently achieved, *outputs*. These are results that can be directly attributed to the investment, such as physical infrastructure put in place, training accomplished, organisational structures established, and policies formulated.
- Various *impacts* – of a social, political, economic or attitudinal nature, that to a substantial degree have been influenced by the outputs of the investment. The term 'impact' presumes causality between outputs of an investment and patterns of *observable societal change*. This may relate to impacts on the health system, or by a longer chain of causality, peoples' health status.

The focus of this study is on process and output. It has not been possible within the time and resources available to make a reliable assessment of impacts.

Criteria of success

Ministry of Health is a complex public organisation serving many clients. Its overall mission is to ensure that *all* Vietnamese have access to affordable health care services relevant to their health problems. To accomplish this, it has so far mainly seen itself as a service provider, but increasingly its role as policy maker has been enhanced. As stated above, VSHC therefore gradually came to focus more and more on what is generally termed 'capacity building' in VSHC documents.

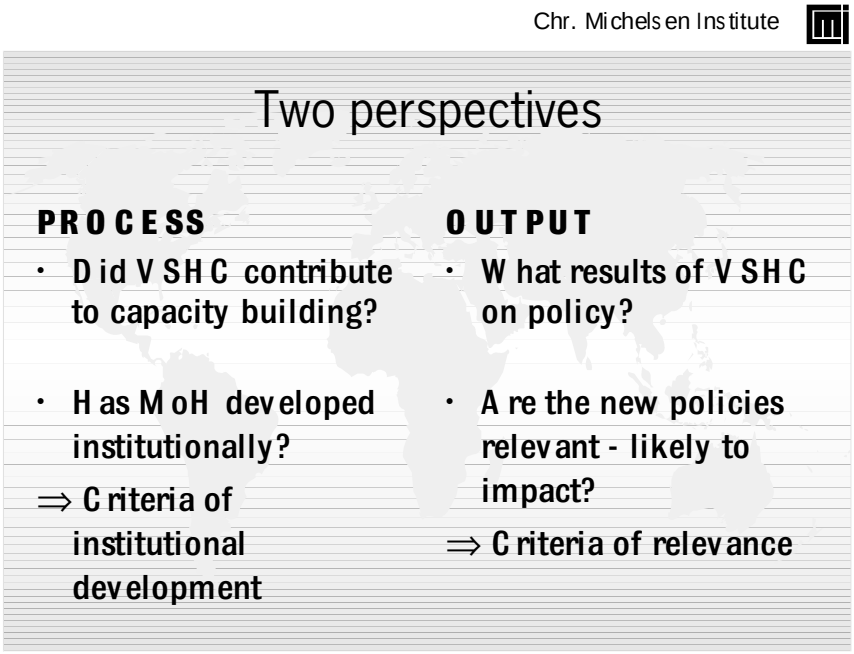
This refers to the *process* of VHSC (cf. the model above), and the *first* important criterion of success is the extent to which the inputs from VSHC have contributed to a process of institutional devel-

opment characterised by improvement in the *ability to change*, and the building of a culture of learning.

Has MoH improved its ability to change in response to clients needs and changes in its operating environment?

If we look at the *outputs* from Ministry of Health through VSHC, we see a an increasing focus on intellectual work, such as new knowledge, ideas, procedures and guidelines, and most importantly new policies for political consideration. The *second* important criterion of success is the *relevance* of this work. Are the kind of outputs produced by MoH through VSHC, considering quality and quantity**,** particularly relevant to the health situation of Vietnam?

This analytical scheme can be summarised as follows:



How to evaluate institutional development

It has not been possible in this study to make a comprehensive analysis of organisational change within Ministry of Health. Although institutional development and change was an official aim of the Cooperation since 1994, it was only gradually that MoH actively sought to improve its capacity for change, using VSHC. In parallel, Sida on its part has been struggling to find its appropriate role as a partner in this process, which had to be a role radically different from what had been the case in the previous 20 years. These processes are continuous, and it is premature to draw any final conclusions about the sustainable impact of VSHC, not lest because of the rapid process of transformation in Vietnam. Nevertheless, a number of interesting observations on institutional development are being made when we look at the different parts (i.e. Areas) of VSHC in more detail (Chapters 3 to 8).

Institutional development can be described as process whereby an organisation gradually improves both its ability to *deliver expected outputs*, and to *carry out changes* on its own making it more responsive

to its clients and to changes in its operating environment.[3] Development assistance, such as VSHC, essentially has two ways of supporting efforts in these directions, namely *money and ideas*. In the case of VSHC Sida provided both in various forms, and we shall look at the experiences with some of these forms.

Money has been provided for

- training of individuals: in-country and abroad;
- teaching materials and other publications;
- analytical work;
- recruitment of additional staff;
- recurrent expenditures: transport and travel, office equipment, and technical equipment; and
- changing the incentive structure.

Within the framework of VHSC Ministry of Health has been provided with new **ideas**:

- based on the technical/professional advise of individual consultants;
- from the managerial support provided by the consultant (InDevelop);
- deriving from requirements imposed by Sida; and
- in the form of models on alternative forms of organisation.

In the subsequent chapters we shall see a picture of great variation, both in terms of the stage at which various parts of MoH can be considered to be, and the impacts VSHC has had on the institutional development process.

How to evaluate relevance

The term 'relevance' is used to indicate the extent to which the investment complements, reinforces and is co-ordinated with other initiatives and investments driving at the same objectives. And moreover, that the thrust of activities reflects core political priorities, and at the same time our best knowledge about the most effective ways of addressing the priorities set by the programme.

Hence, the relevance of the policy work of VSHC can be assessed by comparing with:

- the problems and challenges identified in recent analyses of Vietnam's health sector and the health condition of the main targets groups of the Swedish support;
- international trends that might influence this situation;
- objectives and priorities Vietnam's health policy;
- Sida's guidelines on health sector support; and
- other donors' policies and programmes.

Outline of report

Chapter 2 gives a broad overview of the Cooperation and the main features of the 1994 to 2000 period.

Chapters 3 to 7 deal with the four ongoing and most important areas of the cooperation. Chapter 8 is a shorter presentation of three areas that were terminated in the course of the VSHC-I agree-

[3] Andersson, G. and P. Winai. *Diagnosis of Organisations in Development Cooperation*, report to Sida, Stockholm, 1997.

ment period. The presentation is organised along the two main dimensions identified above, namely lessons on institutional development and lessons on relevance.

Chapter 9 summarises some broad lessons on aid effectiveness.

2. VSHC 1994–2000 at a glance

"Preparing a plan usually involved people suggesting what they needed most. At the end, having pictured this on the white board with circles and arrows, we found that our priorities looked like a breadfruit." (In Vietnamese, by way of wordplay, a breadfruit is taken to mean something stupid.) (A joke told by an officer of Ministry of Planning and Investment)

2.1 A whole lot of new concepts

The run up to the 1994 agreement was a difficult period for both parties. At the higher level a consensus had emerged that Swedish support needed to include also health policy work and to reinforce the capacity building work already going on. But to get this somewhat abstract ambition translated into concrete and realistic plans turned out to be more difficult than anticipated. It was not made easier by a number of associated requirements put on the table by Sida.

Sida wanted to see a distinct move away from the project approach of the past to a more integrated programme, both in the way it would function as an integral part of the Ministry's regular work, and the way different components would reinforce and support each other. The concept of "*areas*" was introduced to facilitate this change.

There are different recollections as to the origin of this concept. Did the Vietnamese or the Swedish side suggest it? In any event, it functioned as a compromise between Sida's concern for better integration of the aid, and Vietnam's decision to continue separate management of aid. Hence, "areas" within VSHC are more than simply areas of investment within a broader range of activities of a department. An "area" is *de facto* a project organisation with its own temporary management set-up, including Head of Area and a team of implementers. The fact that areas are functionally linked to Departments within MoH, and the Head in most cases is also the head of the department, was an important step towards better integration of the Swedish aid to MoH.

Sida also wanted MoH to take a more direct responsibility for the planning process, and the first test on MoH's *ownership* was the drafting of the planning documents for the new areas. The aims were also to change the *role of consultants*, to become more advisory, as well as to reduce the overall level of technical assistance. In periods during the 1980s there had been more than 30 long-term consultants. Now Sida aimed for only one or two. It turned out that MoH was not capable of presenting plans of the standard wanted by Sida, and to prevent further delays consultants were brought in to assist the process. This resulted in a process where only a small number of MoH staff was involved in the drafting.

Finally, the planning coincided with the adoption by Sida of *logical framework analysis* (Result Oriented Project Planning) as a standard requirement, and Sida wanted the new VSHC planning document to reflect this format. Strangely, this requirement was introduced at the time when Sida already had announced the total amount it was prepared to spend – 250 million SEK. Not surprisingly, therefore, plans were crated in response to this level of spending, rather than realistic assessments of needs and capacity.

In retrospect, we see that the 1994 planning documents mainly served as a means to formally get the new phase started. They provided limited guidance on practical strategies for how to develop

the areas. On paper we see a complex and loosely defined programme for addressing a set of *very ambitious objectives:*

- Contributing to an *improvement in the health status* of the people of Vietnam, especially in disadvantaged areas.
- Increasing the *efficiency and effectiveness of the Ministry of Health* in providing health services.
- Contributing to a *reduction of inequity* with regard to gender, geographical location and ethnic origin in the provision of health care.
- Increasing the capacity of the Ministry of Health to address the issue of *financing health care* and to maintain the provision of services.

From day one of the 1994 agreement started a gradual process of finding and redefining approaches, and, probably the most difficult part for both MoH and Sida, developing a new system of aid management. The broad areas of support had been defined, but many things were to be changed in the process of slowly bringing VSHC "under the skin" of MoH. It is to the credit of Sida and Government of Vietnam that this process was greatly facilitated by a flexible planning procedure, based on annual reviews and plans of operation.

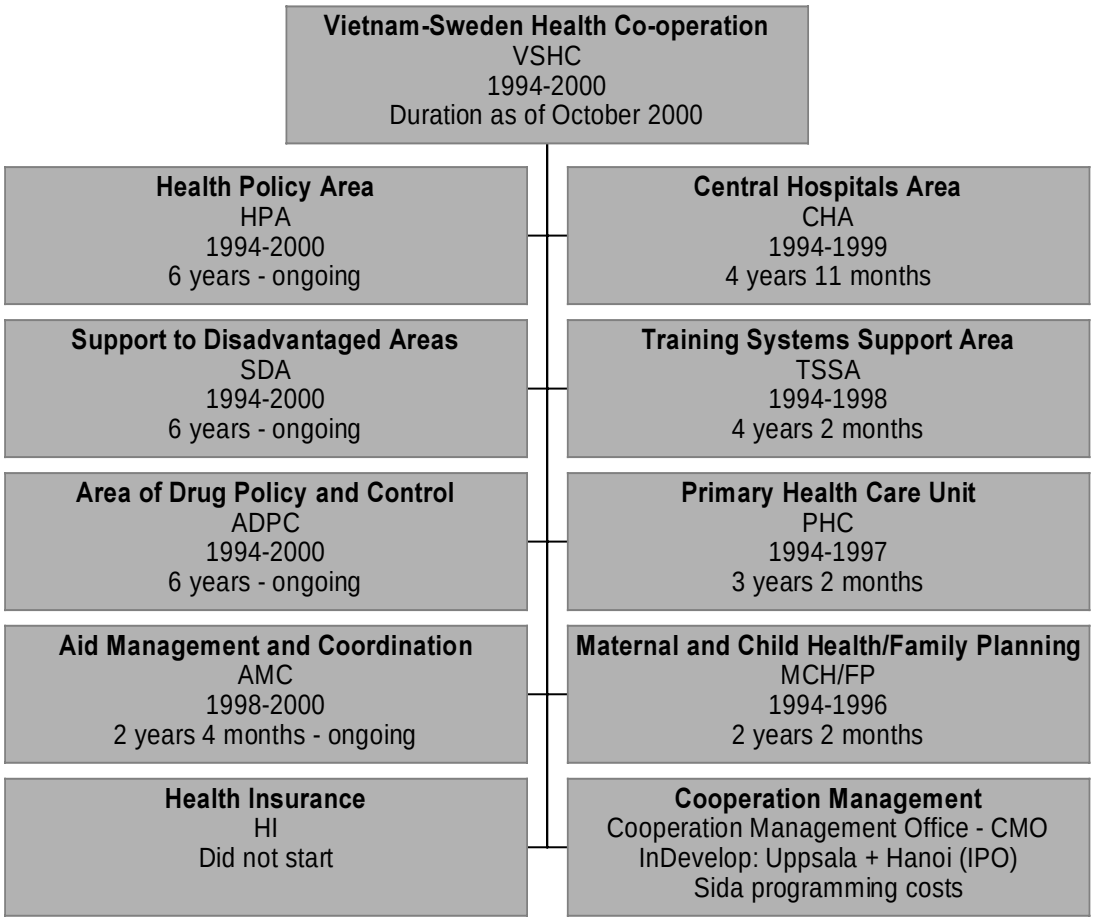
2.2 Little moves according to plans

The 1994 agreement contained support to eight different areas plus a substantial allocation for programme back-up services (a Cooperation Management Office within MoH, the work of the Swedish consultant – InDevelop – in Hanoi and Uppsala, and Sida follow-up). In addition, the parties agreed to add a new area during the agreement period, namely Aid Management and Coordination (cf. organisational chart next page for name and duration of the various areas).

If we look at the thrust of the activities in these areas from the perspective of the three broad purposes of the programme – improving service delivery, develop organisational capacity and production of new knowledge and policies, we can make the following groups looking at the thrust of the activities implemented (or intended). We see that the focus on capacity building and policy work is quite evident.

Improvement of service delivery	**Capacity building**	**Policy work**
SDA	HPA	HPA
CHA	SDA	ADPC
	ADPC	PHC
	TSSA	MCH/FP
	AMC	CHA
	CHA	HI
	PHC	AMC
	MCH/FP	

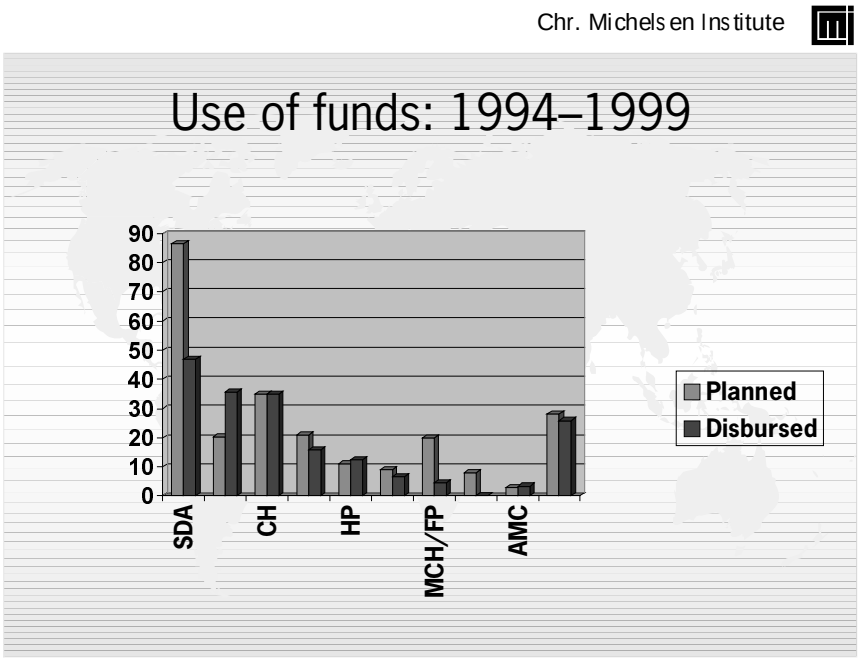
The structure and duration of VSHC areas from 1994 to 2000



During the subsequent five years a number of *significant changes* occurred:

- As many as four of the original areas were *terminated prematurely*, of which one (i.e. Health Insurance) never started. This was due to a combination of several factors, of different weight in the respective cases. Some ideas had primarily been pushed by Sida and lacked ownership in MoH, and even caused political opposition like in the case of Health Insurance. The reorganisation of Sida in 1995 led to a demand for a focus on fewer areas.[4] It was decided to sacrifice areas with slow progress (e.g. MCH/FP), areas where too many donors where crowding the field (e.g. PHC), and areas with major problems of management and cooperation (e.g. TSSA).

- Overall *disbursement was much slower than planned,* but with substantial variation among the areas. There were two remarkable deviations from the initial plans. ADPC took a much larger share than originally envisaged, while SDA alone represented the bulk of the shortfall in overall spending. These changes can bee seen in the graph below. The general delays in spending made it possible to extend VSHC-I by 3 months without additional funds.



- We see a shift from *less hardware to more software.* The second among the original objectives – capacity building – gradually became the one that influenced the planning process the most. It was seen as a precondition – a more immediate objective – for addressing the other objectives. The initial plans envisaged substantial costs associated with construction, equipment, materials (e.g. drugs) and logistics, which had to be scaled down due to implementation constraints. This was the case in particular with SDA, and explains much of the drop in spending in this area. CHA was an exception to the general trend, since the initial plans for re-equipping and refurbishing the two hospitals were by and large adhered to.

[4] With the reorganisation the official acronym changes from SIDA to Sida. For convenience we are using Sida throughout the report.

- There was gradually a more explicit articulation of VSHC as a model-making and idea-producing undertaking. The professional dialogue feeding into the annual planning process improved year by year, and key stakeholders in *the Ministry took ownership* in this aspect of the cooperation (especially with HPA and ADPC). Previously the planning was seen mainly as a way to allocate money in a manner that followed established regulations and the need to retain the internal balance of power.
- Very soon Sida started raising concern over *the uncoordinated planning and implementation of aid projects,* and offered to finance initiatives to address the problem. There was enough "savings" within VSHC to start a new area in 1998, labelled Aid Management and Coordination, with the main aim to develop the newly created Project Coordination Department.

These many changes reflect the duality of a programme like VSHC – the yin and yang, the Janus-faced. On the one hand, these changes came as a consequence of the many difficulties constraining public sector reform in Vietnam, and the serious problems that exist with the incentive structure needed to motivate staff. One may be inclined to conclude that VSHC will not be able to achieve its objectives. On the other hand, however, these changes are at the same a positive sign of learning by trial and error – which is a fundamental prerequisite for successful reform. In this perspective, one may conclude that VSHC is gradually becoming a better-designed instrument for the Ministry of Health to tackle the turmoil of transition. In the following chapters look at the main outputs in more detail.

VSHC proves the general lesson that successful public sector reforms – like that of Vietnam's health system – cannot be imposed, have to reflect local realities, and take time. The job has just begun!

3. Health Policy

3.1 Background and context

What makes health policy work effective – some basic concepts

While the history of VSHC first and foremost is a reflection of economic and political changes in Vietnam, at a more general level it is similar to many development scenarios in health co-operation. From a start in very concrete *physical investments*, mutual agreements have been reached over time to address successively more complicated and *system-oriented* issues. This chain of events, by itself, is a sign of considerable progress, which indicates that trust and confidence have deepened between the two parties concerned.

Understandably, mutual *trust* is a prerequisite, although not sufficient by itself, for effective co-operation in areas that are close to central political issues, as they relate to the basic value orientation of a health care policy. In addition, two other prerequisites are equally important – i.e. that the cooperation:

- supports the development of a sustainable *institutional capacity* for preparation and managing of analytical inputs to policy making; and that
- the policy work produces outputs that constitute *timely and relevant* responses to problems and changes in society.

In order to assess these two dimensions the concept of "health policy" warrants further explanation. It is useful to distinguish between two types of health policies:

- **Horizontal health policies**: these are legitimate political statements, which give clear direction to the development of a *health system*. This involves the question of setting borders for the system in relation to neighbouring systems (e.g. social welfare, education, private business etc.). It includes as well the means of raising economic resources for health (the use of taxes, health insurance, user fees etc.); systems of governance (policy decision-making, monitoring of policies, quality control and resource distribution within the system); the structure of the provision system (the roles of different health care providers, rules of communication and co-operation between the elements in the staff structure, etc.); and systems for setting priorities between needs.
- **Vertical health policies**: these are legitimate political and professional statements that co-ordinate and prioritise all actions within the health system in dealing with *specific groups of diseases or causes* of health-unhealth. A HIV/AIDS-policy thus is a typical vertical policy. Similarly an action plan to deal with traffic accidents is part of this segment of the health policy area.

Furthermore, horizontal and vertical health policies may be more or less *integrated*. This refers to whether all the elements of the policy fit together and whether policy instruments tend to support each other and pull/push the system in the same direction. Typically, integration is poor if the provision structure aims at caring for all basic health care needs at primary health care level, while economic incentives – laid down in user fees, costs of drugs etc., tend to push patients in the direction of specialised services. In addition, a health policy is considered *comprehensive* if it covers the whole policy area.

Criteria of success

Based on this conceptual framework an important criterion of success is whether the VSHC has brought about the existence of integrated and comprehensive horizontal health policies. Secondly, it is also deemed successful if it has managed to support vertical policy development in areas where such policies were missing or incomplete and if the areas covered are relevant from the point of view of their effect on the general health status of the population. Finally, the existence of an improved institutional capacity for policy work, is by itself an indicator of success.

Considering the relatively short time span it is still premature to evaluate the effect of all policy work supported by VSHC. Most of the VSHC-supported policy work has not yet reached the stage of full implementation.

3.2 Objectives and achievements

The central objective for co-operation in the health policy area is to:

Formulate effective and appropriate health policies in the context of a market economy.

In relation to this objective the following *indictors* have been drawn up:

- Health policies will exist which provide a clear framework for the provision and financing of health services in Vietnam and within which donor support can be accepted.
- There will be policy statements on methods of generating finance for health services.
- Similarly there will be policy statements on methods of allocating financial resources to health care.
- Policy statements will also exist on priorities for health care interventions.
- Policy statements on quality assurance will exist.
- The role of the private sector in health care will be defined.
- The numbers and the skill mix of health workers in Vietnam will similarly be defined in a policy statement.

As stated above, by the early 1990s, Vietnam had said farewell to the "subsidised" period, and the whole health system found itself in need of rapid and dramatic adjustment to work in an open market economy. The turn-around of the health system in this historic situation was, and still is, an immense undertaking.

When co-operation started in the Health Policy Area in 1994, policies that did exist sometimes must be considered remnants of the "subsidised period", or hastily created policies that had not been given a chance to find their place in a comprehensive and integrated system of policies. The baseline for our analysis of VSHC can be described as a Vietnamese health policy situation with the following characteristics:

- Many of the fundamental elements of an integrated and comprehensive horizontal health policy were lacking, and vertical polices were poorly integrated.
- Maintenance of buildings and equipment was deteriorating.
- The health system did not match the health seek behaviour of the population.
- Gradually the system was becoming considerably less equitable.

From this situation, we find that six years later *MoH has been able to lay the foundation for an integrated and comprehensive horizontal health policy.* This is evidenced in the following policy documents:

- *Strategic orientation for People's Health Care and Protection in the Period 1996–2000 and Vietnams National Health Policy*.
- *Strategic Orientation for People's Health Care and Protection to 2000 and 2020 – Government resolution no 37*
- *Strategy for People' Health Care During 2001–2010.*

In preparation for the Health Policy Area, MoH created in 1993 a Health Policy Unit. Initially placed under the Ministry of Health Cabinet, and in 1998 moved to the Department of Planning, it took time for the work of the Unit to gain momentum. Typically of aid sponsored institutional set-ups, it lacked a formal position in the system, and still does, but gradually the MoH leadership has taken a more active interest in the Unit's work. Of particular importance was the decision to recruit a Long Term Advisor – a proposal which initially was not supported by MoH, and the keen interest of the new Permanent Vice-Minister, Pham Manh Hung, in establishing a professional dialogue with the LTA and the Unit.

During the last three years the Unit and the HPA has been the main source, financially and intellectually, assisting the preparation of the strategy documents listed above. What can we learn from this process and its results to date?

3.3 Lessons on institutional development

VSHC has supported policy development through:

- The planning and monitoring system adopted
- The building of the Health Policy Unit through training and staff recruitment
- Policy studies
- International exposure
- International advisors

Planning and monitoring: LFA does not prevent omissions

Sida instructed MoH to adopt Logical Framework Analysis (LFA) for preparation of annual operational plans (APO) and the structure of these plans generally follow the LFA framework. Still, it appears to be difficult for MoH to retain a functional link between the formulation of objectives and the identification of activities. The objectives remain very broad and the situation analysis is often weak. We observe for instance, that there are omissions of a number of greatly important trends in Vietnamese society – such as urbanisation, modernisation of values, and new trends in health seek behaviour of the population. We also note that there is little continuity in the overall analysis from one plan to the other. For instance, few, or no, references are made to the original plan from 1994, in subsequent plans. And coming to 1998, the main objective is now formulated as:

> *"effective implementation of Government Resolution No. 37 on strategic orientation of peoples' s health care from now to the years 2000 and 2020…."*

The APOs tend to go rather directly to the point of formulating individual projects. It is rather difficult to find their relation to overall objectives. The possibilities of important areas being left outside the scope of work are normally not a matter of concern in the APOs. These critical remarks

should not obscure that the APOs normally give good and clear direction for work for the coming year.

An impressive number of progress reports have been produced, and in a major self-assessment from 1997 (the so-called *Result Analysis Report*) it is concluded that: "In the first half of the Cooperation cycle, the Health Policy Area has worked well and effectively by following closely the objectives stated in …the Planning document for Vietnam-Sweden Health Cooperation…". A number of difficulties and challenges are mentioned – such as lack of foreign language skills, and lack of capacity in the Ministry of Health for formulating effective and appropriate health policies. Furthermore, it is mentioned that society has changed rapidly and that health policy research and formulation to cope with the situation has become more and more complicated and delicate. Reform needs to come faster in view of changes in social-economic development (industrialisation and modernisation of the country). The result analysis also takes note of insufficient co-ordination between activities of VSHC and the co-operation in sciences and research between Sweden and Vietnam (through Sarec).

A later assessment[5] from 1999 finds that the studies performed on health policy "fit the objectives of the Health sector". The study also takes note of studies reflecting emerging health problems in Vietnam, thereby demonstrating sufficient flexibility in the selection of objectives for studies within HPA.

We concur with the findings of the two assessments mentioned which indicates that the relevance of the policy work of HPU has been strengthened over time, but with the additional remark, that the system developed for selecting studies still may lack a systematic approach to the needs in an comprehensive and integrated horizontal health policy.[6] As shall be further discussed below, there are two examples worth mentioning – that of few studies on *governance* problems that may handicap future implementation of the policies arrived at, and that of little attention to *the macro-economic dimensions* of health development.

Additionally, two areas of vertical policy stand out for relative little attention, namely *HIV/AIDS* and *mental health*. This may indicate that similar problems exist also in working with vertical health policies.

Finally a word of caution: health politics is different from technical planning. The instruments for technical planning – originally based on the needs in the building industry – are different from the needs in policy making. No political process can ever be fully designed by means of LFA. "Muddling through" is a much more relevant description of how it needs to work.

The Health Policy Unit: not yet a sustainable capacity

The Health Policy Unit in the Ministry of Health is a brainchild of VSHC. The unit "…is in charge of studying and synthesising policies on development of the public health system and constitutes a key body in studying and drafting the above-mentioned policies to be submitted to competent authorities for approval".[7]

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[5] Health Policy Area: Assessment of Cooperation between Vietnam and Sweden within the Health Policy Area 1994–1999, Hanoi, August 1999.

[6] See list of literature consulted (chapter 10) for a comprehensive list of assessments and evaluations of the Health Policy Area.

[7] Ministry of Health decision 1023/BYT-QD 22/12/1993.

Over the period HPU is frequently a matter of debates and concerns. The main issues around HPU seem to be insufficient manpower – particularly of senior officers – and its place in the organisation. It is frequently mentioned that HPU has had insufficient absorption capacity to deal with the policy studies administratively and in using their results.

To an extent we find this criticism unfair. The number of studies performed and the number of policy decisions taken on the initiative of HPU does not indicate strong limitations in its capacity to deal with matters administratively.

It needs also to be understood that the question of reformulating policy options from studies and bringing them to relevant political bodies for final comment is partly outside the mandate and competence of HPU.

HPU represents today a good base of knowledge and skills in health policy. Much valid training work has taken place to support capacity building inside HPU, but it should not remain for much longer an outfit primarily for making use of Sida funds. Today, practically all activities of HPU are Sida-funded. Sida is, however, not the only donor offering support to health policy work, but this seems not to have benefited HPU so far. In fact, in an EU-proposal currently being negotiated there is a provision for another "policy unit".

It will be a test on the sustainability of the HPU-investments, whether MoH gradually makes use of this capacity in all overall (i.e. horizontal) policy work, irrespective of source of funding. It is encouraging to note that HPU is playing a central role in the current dialogue with the World Bank. It remains to be seen, however, whether World Bank funded policy work will be managed by the "Swedish" HPU or some parallel outfit. It is our view that HPU needs to be further integrated in the ministry organisation, and increasingly become a matter of Vietnamese ownership. The strong involvement of the present Vice Minister has contributed to this and brought HPU closer to the leadership of MoH, but with another composition of ministerial leadership there is the risk that HPU may remain solely a manager of Swedish support.

Policy studies: the need to increase the degree of independence

There exists a need to draw a clearer line between HPU and the Ministry of Health on the one side, and the implementing organisations on the other. Studies will support efficient policy making better, if they reflect independent and professional opinions more clearly than now. In recent years more studies have been commissioned to structures outside the Ministry, which have contributed to a gradual build up of research competence also outside the political sphere. This already existing tendency of finding and supporting independent bodies, not involving important officers in the Ministry of Health, could help bringing about even better basic material for health policy development.

Having said this, we note with satisfaction that the methods used in the Ministry and by HPU to exert quality control over finalised studies is exemplary, and need to be documented for further use also in other contexts.

International exposure: access to the market place of ideas is important

When Vietnam opened up to the world outside the family of countries influenced by the former Soviet Union, few established networks were available. The relative generosity within VSHC to make available contacts with Japan, China, Thailand, Philippines, Malaysia etc. is a very positive contribution. The impressions from neighbouring countries will gradually influence Vietnamese policies in a direction that is well suited to its social and cultural background. And Vietnam will,

considering the progress in capacity building in health policy that has taken place, be an important source for development also in neighbouring countries.

Vietnam has a strong political tradition of independence in policy making, resisting what is perceived as impositions by outsiders. It is worth noting that Sida's flexibility in terms of international study tours has helped to bring about an understanding that Swedish support in policy matters has been non-aligned – not dominated by a wish to market a particular model. Interviews state clearly, that this strongly contributes to the credibility of information and advice given from Sweden.

International advisors: policy work requires particular skills

It took some time for VSHC to move its location into the Ministry of Health. It took some time also, to find and legitimise a long-term advisor for Health Policy working inside the Ministry of Health. All interviews that have touched on the subject seem to be in agreement with the value of this development.

A general comment heard was that earlier short-term advisors and long term advisors were competent and effective professionals, but that they often lacked the understanding of the political work in a ministry. The present long-term advisor has contributed with essential professional competence in this respect, and has played an important role in making HPU a respected advisor to the political leadership of MoH.

This general praise in interviews reflects the properties of this specific Long Term Advisor. But it may also reflect a weakness in the implementation of HPA so far. It is striking that so much is now attributed to the existence of one individual and not to the program as a whole.

3.4 Lessons on relevance

We find that Vietnam has made major progress in the health policy area in the period from 1994 to 2000.

A horizontal policy framework in place, but…

In the area of horizontal policies, it is characteristic that many of the "horizontal studies" came in late in the period of cooperation. Some important studies are still on-going, and a "Public Health Report" report for Vietnam is to be published in the near future, with strong support from VSHC. This work in progress, notwithstanding, it is still not possible to fully understand the *economic realism* behind the suggested policy framework. While mechanisms for resource mobilisation are being developed, the full impact of these mechanisms on the macroeconomic situation in Vietnam generally and in its provinces is uncertain. For some time yet, this will handicap the realisation of the policies that have been suggested.

Secondly, the *governance mechanisms* needed for the implementation of the policies suggested remain to be analysed and decided on. A general observation is that the policies have a slight tendency to see the health system of Vietnam predominantly as a government operation. While the understanding seems to be that the private sector will continue to play an important role, the needs of governance instruments – including the creation of a representation for private sector health care – is given little consideration.

The implementation of different forms of health insurance, for instance, will have a strong impact on the present structure of health governance. The position of central, provincial and communal health actors will be affected and their roles need to be expanded to deal with that. New relations

may need to be formed between central level bodies and provincial/district. Generally, the implementation of the suggested policies will need improved involvement of the civil society in Vietnam.

New important initiatives on vertical policies

In the area of vertical policies, an impressive number of statements are directly related to policy studies that have been undertaken within the framework of VSHC. Clear examples are the studies on accident and injury prevention, studies on perinatal mortality reduction in Vietnam, and studies on the national tobacco control policy.

However, also in the area of vertical health policies there are sectors given considerably less attention. Mental health is one of them. HIV/AIDS may also need a structured form of vertical policy analysis.

The two main policy documents (*Strategic Orientation for People's Health Care and Protection in the Period 1996–2000*, and *Strategy for People' Health Care During 2001–2010*) give almost no attention to *mental health.* The targets and indicators used include no objectives in the mental health field. The VHSC, on its part, has not funded any studies in this field.

There are at least a couple important reasons why the *HIV/AIDS* area warrants further analytical work to support policy development. Firstly, there have been some problems in getting information on the direction of the epidemic in Vietnam; and secondly, the spread of the disease from isolated groups of drug users to the more general population is linked to other sensitive policy issues, such as prostitution and drug use among adolescents.

3.5 Conclusions and recommendations

Some of the positive events in policy development would have taken place anyway. The VSHC is not the only source of inspiration for policy decisions in the health field. Vietnam has many resources outside the framework of VSHC that would have played a major role if VSHC had not been in place. It is noteworthy, however, that few studies outside the context of VSHC seem to have had a clear relation to the content of present strategies on health policy.

Interviews in Hanoi have made it clear, that the resources inside VSHC have been actively used to form the value base for the present health strategies. Special documents have been drawn up for use in the Central Committee of the Communist Party. Briefing papers have been produced for communications with the Deputy Prime Minister. VSHC representatives have been present and active on a top-level conference with the Prime Minister and 400 representatives from the Communist Party and other concerned Ministries with particular focus on improved health services for disadvantaged areas.

Independent observers among the family of interested parties in Vietnam's health development seem to be in full agreement on the strong influence from VSHC on the health policy.[8] One donor organisation indicated that their interest in working with health policy issues has gradually weakened, since it is clear that "the place has been taken". The fact that the preparation of the next World Bank loan to the health sector has lead to very slow progress in decisions on the format for co-operation is to an extent "blamed" on the fact that VSHC serves the government with much of

[8] No representative of the World Bank has given information in this context – a draw back from the point of view of World Bank's great importance in the area.

what is needed in the field of policy development. One may even speculate if World Bank advocacy for what is perceived by many in the MoH as a different policy direction has brought even more strength into the "alliance" for health policy development in VSHC.

The issue has been raised whether the investment of SEK 12.5 million in the Health Policy Area during VSHC-I can be justified, seen in relation to the outputs and their usefulness. It has not been possible for this evaluation to collect data that would enable us to adequately assess *cost-efficiency*. The progress reports produced by VSHC do not provide such information, and in any event it is very difficult to establish what is an acceptable level of costs for analytical work and skills development. While it is acknowledged that the quality and usefulness of various reports and training events vary considerably, which have to be expected, there is no evidence to suggest that the results of HPA could have been achieved on a significantly lower budget.

A concern with HPA/HPU for the time being has less to do with the issue of cost-efficiency, as the *capacity* to adequately follow-up the many outputs that currently are being produced. We find the volume of activity of HPU quite impressive for a set-up of this limited size. As noted above, there is also a good system of quality control on study reports. There is the danger, however, that HPU is stretching its initiatives too widely, and its own capacity to follow-up too thinly. This will reduce the potential impacts, and hence *cost-effectiveness*, of its work. This points at the need to combine the manpower resources of HPU with other resources of MoH to create a larger unit and an even stronger think-tank for policy work within the Ministry.

One final reflection on the importance of VSHC for the present direction of health policies in Vietnam: if this policy turns out to be well functioning for the people of Vietnam – the co-operative effort can take credit from this. If – on the other hand – it turns out to be less well functioning, the rather unique form of bilateral co-operation must share the blame for deficiencies in the policy. Only the future can tell.

Irrespective of whichever scenario unfolds there are several important lessons to be learned from the work of the Health Policy Area:

- It is possible to achieve health policy development support that is effective, but it takes a long time, it demands profound skills on both sides and it demands trust between the involved partners.
- The system of selecting policy areas shows some weaknesses that could be changed by means of a more systematic approach and by selecting a broader group of expertise from Sweden (or elsewhere).
- The relative flexibility in processes for planning of the Health Policy Area has contributed to a learning process that has gone on both in VSHC and in the Ministry of Health. Both seem to have "matured" in the process.
- The coordination between Swedish aid through Sida/VSHC and through Sarec has been rather low. There is a need to build stronger links between the policy work of MoH and independent research in the areas of health system development and health seek behaviour.

The relative success of the work in Health Policy Area takes us into a new set of challenges, namely to deal with the implementation of the policies that are soon to be decided on in relevant Vietnamese bodies. When *implementation of new policies* becomes the main concern of MoH the focus of HPA and VSHC may need to be changed. One outstanding issue where HPA could be in the position to contribute is the earlier mentioned problem of governance.

Institution building in provinces and local levels of the health system will be crucial to implementation. Increased civic involvement with health matters will also be important. Among the matters that may turn out to be of great importance is support to work with professional ethics and with bodies that represent these professions. For VSHC to become active in these areas may imply bringing in more competence in economy, political science and public administration, and bringing forward Swedish (and international) experiences on NGO development and regional health administration.

We are not advocating that Sweden should contribute directly in the operational aspects of implementation. That period is over.

4. Support to Disadvantaged Areas

4.1 Background and context

Looking back, the main character of Vietnam's health network was its high level of equity and orientation to the grassroots level. The approach rested on the mobilisation of different resources from agricultural co-operatives and the high voluntarism of Vietnamese during the revolution and the American war. Those difficult years also formed a way of thinking among Vietnamese valuing something by its hardware parts – the building, the medical equipment inside etc., while the software – the work regulations, the know-how etc., was of less interest.

With the economic reforms and the new market conditions, this health network was not sustainable. By the early 1990s, the commune health stations (CHS), which had been responsible for primary health care in rural areas, were in a desperate situation: health workers did not receive salaries regularly, and buildings were in a poor condition and lacked adequate facilities. In mountain and remote areas the situation was even worse due to the fact that people are poorer while prices for drugs and services are generally higher (due to transport costs). Also, many qualified health workers, working in these areas on government transfer, decided to leave for more prosperous places. It was almost impossible to ask newly graduated doctors to go to work in disadvantaged areas, now that government no longer took take care for their job. This was the general picture by the early 1990's. The Support to Disadvantaged Areas (SDA) came out of the general concern for weak and deteriorating primary health care services in some of Vietnam's poorest regions, and the home of several ethnic minorities.

People in remote areas, and ethnic minorities in particular, suffer from lower average life expectancy, higher rates of perinatal mortality, malnutrition among children under five, infant mortality, under five mortality, as well as maternal mortality, compared with the rest of the population. Although special attention has been given to the health care system in mountainous areas, it still suffers from insufficient manpower, equipment, drugs and buildings.

4.2 Objectives and achievements

Starting with a focus on delivery

The conceptualisation of SDA in terms of overall objectives has remained more or less unchanged in the first (1994–99) and second (1999–2001) phase, while at the level of strategy and activities there have been considerable adjustments over the years.

At the beginning SDA was set up with the following objectives:

- The inequalities in health services and in health status will be reduced by improving health services in selected disadvantaged areas.
- Health managers in disadvantaged areas will have increased competence with respect to capacity to generate and allocate financial resources, management methods, supply and rational use of drugs, and assessment of training needs for health workers.

The 1994 agreement makes SDA the largest of the support areas, outlining a strategy based primarily on upgrading infrastructure, working facilities and the availability of drugs. This was soon

found not to be effective, and the focus gradually turned towards management, technical support and capacity building. This shift implied reduced financial outlays, which led to an argument for expanding the outreach of the project. Originally 13 mountainous districts in the five provinces (Quang Ninh, Ha Giang, Lao Cai, Tuyen Quang, and Phu Tho) where Sida had been involved for some time, in health and forestry, were included. In 1998 another four districts were added. Within the 17 districts there are as many as 352 communes and 3694 villages to be served. Most of the 352 communes belong to the 1715 communes classified as being the poorest communes in the country. In each province one district was selected for pilot activities.

The budget frame for SDA was SEK 86.3 million, which was more than twice the amount allocated to any other Area of support, but actual expenditure during the agreement period 1994 to 1999 was not more than SEK 46.6 million.

6 problems and 6 components

The first annual plans (APOs) were developed on the basis of an analysis, which had identified six main problems, each of them leading to the identification of an integrated set of activities – called "components" (in the VSHC-II agreement it was decided to merge component 2 and 5 below). Unfortunately, these components tended to take the shape of sub-projects, which had not been the intention, making an integrated district-level approach more difficult. Nevertheless, SDA can document an impressive list of discrete activities in the 1994–99 period:

Component 1

Problem: Insufficient knowledge about the health needs of the communities, especially the ethnic minorities.

Approach: Mobilising the community and different sectors to specify needs, plan the intervention and carry out health activities to solve the health problems.

Main achievements: The first attempt to carry out a participatory survey of health conditions was made in 1995 by staff from Hanoi Medical School. With the assistance from Philippine experts on Participatory Rural Appraisal (PRA) SDA trained a core group of PRA-trainers (about 24 people). As of June 1999 1108 persons at commune level and 303 persons at district level had been trained in the PRA method – including needs assessment and planning. These were not only health staff but also cadres from the political authorities – Women's Unions, Farmers' Unions, Youth Unions and other mass organisations and sectors. In a few communes, People's Committees after the training declared the PRA approach to be in line with official policies and stated that it would be applied as a method in their future planning. The results of the first village intervention plans, however, seem not to have been properly monitored, and it is not known whether there has been longer-term impacts in terms of village level mobilisation.

Component 2

Problem: The management of health services at provincial, district and commune level is very week. It is especially true for financial management.

Approach: Improving management capacity in planning, financial and personnel management of health staff at province, district and commune level.

Main achievements: In each province 25 health managers (about 125 managers in total) and at district level 15 managers (about 300 in total) were regularly trained. Each province has a core group of 8 key trainers specialising in management and supervision training, and trained in teaching methods. Training material for planning, monitoring and evaluation were developed.

Component 3
Problem: There is a lack of basic equipment and drugs at district and commune levels. The health facilities are poor.

Approach: Upgrading buildings, providing medical and non-medical equipment and revolving drug funds (RDF) to ensure accessibility to essential drugs.

Main achievements: SDA provided medical equipment for operating theatres, delivery rooms and intensive care units in all 20 district hospital, as well as non-medical equipment (air conditioner, bed, motorcycle). 15 out of 20 operating theatres and emergency rooms have been upgraded. The number of operations across all district hospitals doubled during the period: from 907 in 1994 to 2071 in 1999.

At commune level, involving 343 communes, 22% of the CHSs have been upgraded, 41% received improved sanitary facilities and 38% got improved water supply. This represents close to 100% of the targets set for upgrading and supply of equipment (based on individual needs-assessment of the health unit). These output-related achievements notwithstanding, this component also clearly revealed weaknesses of the system, and demonstrated the importance of proper identification of needs, strict monitoring and coordination among donors to avoid duplications, inappropriate equipment, and misuse of funds. A special study conducted by Emilio Bagarella confirmed many of these problems.

Revolving drug funds (RDF) have been established in 184 communes, and it is reported that 95% of RDFs are maintaining or increasing their original value. A guideline on RDF management was issued. It remains a concern, however, to make poor people benefit from RDFs.

On average, during these five years, the number of patients doubled at the CHSs supported by SDA, and the number of deliveries at the CHSs increased by 24%. The picture, however, is very mixed, depending, not least, on the distance people have to travel, the attitudes of the doctors, and the degree of involvement of traditional midwives. In some districts the number of patients decreased (i.e. Bache, Hoanhbo and Binhlieu districts in Quang Ninh province).

Component 4
Problem: The number of health staff is insufficient at village and commune level and the health staff is often inadequately trained.

Approach: Training and building village health worker's (VHW) network, providing professional training to health staff at district and commune level.

Main achievements: All SDA supported districts have established district training groups, involving 176 persons in total, who have passed courses in teaching methods, VHW curriculum and VHW supervision. There are also trainers at the provincial level (74 in all), and surgical teams (from 20 district hospitals) have obtained refresher training and instructions on how to use upgraded theatres and equipment. During the period, some 3000 VHWs have been trained, of which about 500 followed the SDA-model.

The latter involves using a new curriculum that gives a better introduction to the health situation and the culture of mountainous communities. 40% of VHWs trained are women, and SDA has also developed methods and materials to train female, illiterate village health informers.

Component 5
Problem: The health network, especially supervision is very week and insufficient at all level.

Approach: Consolidating an integrated supervision system from district to commune and commune to village level.

Main achievements: District supervisory teams have been formed and trained in integrated supervisory skills. The application of these skills is at present more of a controlling nature while the aim is to change to a more supportive attitude, which is an ongoing process. SDA has also trained health staff at commune level, covering 54% of the communes in the target districts, in VHW-supervision and the formulation of supervision routines.

Component 6
Problem: The prevalence of malaria, ARI, infection, gynaecology and malnutrition were high.

Approach: Providing direct intervention in some prioritised areas such as ARI, parasites, malnutrition, gynaecological problems, tuberculosis, goitre, malaria, but also clean water and environmental hygiene.

Main achievements: SDA had provided 80.000 impregnated mosquito net in areas with malaria outbreaks, 50.000 doses of an anti-goitre drug as well supported for constructing 1000 latrines, financed improved water supply in selected districts, participated in the malnutrition program and involved in other health programs.

The making of SDA a model: a model for what?

One significant feature of the history of SDA is the gradual conceptualisation of SDA as a particular model. Both in the *Results Analysis Report* for 1994–1997 and in the 1998 *Review of SDA*, it is stated that the period 1996–1999 saw *"the birth of the SDA-model and the first development and testing of the model"*.

Turning SDA into a *model* for health planning came as a response to the problems of the districts at the time not being able to develop interventions for improved health services reaching the village level. Likewise, the provinces when taking over the initiative from the districts focused mainly on physical upgrading of health facilities. At this stage, ideas on how to reach the most poor and vulnerable people were formulated with the aim to find a model for needs-based health care in the most disadvantaged areas. In June 1998 MoH and Sida agreed that SDA should work to this effect.

The approach outlines three implementation phases. The first phase was to focus on *strengthening the health network* (component 1–5) and the second phase was to focus on *disease management and public health activities at district and village level* (component 6). The third phase, assumed to take place in a follow-up agreement, would *develop the model approach for improved health in a district* and ensure *continuation of the support to control priority health problems*. It is also being suggested to develop an *integrated approach* linking up with the Sida-funded Mountain Rural Development Programme (MRDP).

Although the idea of SDA as a model for health development at district level is repeatedly stated in project documents, we observe that there seems not to be a common understanding among implementers at different levels of what exactly defines the SDA-model, and what constitutes the process of model development.

It is not made quite clear whether SDA is:

- An *experimental project* aiming to try out new ideas in order to find a relevant model (or models) for health development in disadvantaged areas;
- Or a project for testing a model that has already been worked out – *a pilot project* of some sort;

- Or already a *project for implementing* a model that is tested, within the widest coverage possible, given the financial and manpower resources available.

While SDA was described by some implementers as an experimental project, at the same time this seems not to be reflected in the way APOs are developed. They describe activities and budgets in great detail, which seems not to leave much room for innovative processes. Furthermore, the Project Document for the current period has not formulated any objectives, and associated indicators, related to model development.

The intention in the experimental model formulated in 1998 was that the five components were to be viewed as an integrated programme and not as separate entities. However, the components were implemented at different points in time and the sequencing of components in practice seemed to deviate from the basic logic of the model. The direction of most of the components depend on the outcome of the needs identification component, but due to this being a very big and time consuming undertaking this component tends to be lagging behind.

This may not be a serious problem in reality, but does question the usefulness of conceptualising the SDA in its totality as an integrated model. Maybe a more useful approach, as suggested by some, is to consider SDA as a framework for several kinds of model development, model piloting, and even model replication and dissemination.

The idea is to make the districts responsible for the work, with the provinces and the AMG taking a co-ordinating, monitoring and supervisory role. In the VSHC-II agreement (1999–2001) activities have been reclassified into two, as opposed to five, components, and involve a planning and implementation process with the following main steps:

- Collect secondary data
- Select communes and villages based on the data
- Do participatory needs assessments and develop village/commune health plans
- Develop district health development plans (for use of SDA-funds)
- Train and prepare district health staff to implement the health development plan
- Implementation of plans at district, commune and village levels

It is, of course, too early to evaluate the progress of model development in the VSHC-II phase, but it is evident that the lack of a common understanding among key stakeholders about the nature of the SDA-model will hamper this dimension of the programme.

Project organisation: for experimentation or replication?

Although SDA is also referred to as an area in the VSHC-terminology, it is organised as a special project only loosely attached to the permanent MoH structure. Formally SDA was linked to the Department of Planning from 1994 to 1998, and thereafter to the Department of Organisation and Manpower, but implementation takes place within a tightly knit project organisation comprising three levels. Today, this involves at central level the Area Management Group (AMG) responsible for general management, including overall planning and monitoring, and to provide technical input for capacity building activities. At province level the Province Management Group (PMG) has mainly a supervisory role vis-à-vis the districts. The District Management Group (DMG) has the planning, coordinating and financial responsibility for local level activities.

A system for direct disbursement from central level (i.e. PMU) to DMG was introduced in 1999. The strong role of PMU and the partly bypassing of the PMG are features of SDA that raise questions. This is probably justified as a means to facilitate experiments in public sector reform at

the local level by empowering the districts, but it raises a question about the future role of the provinces in a model for needs-based health care, and is problematic if the set-up is a characteristic of SDA as a model. This form of organisation cannot be replicated in a large scale.

4.3 Lessons on institutional development

SDA is focused on strengthening the health network, in particular from the district level down to the cadre of village health workers. As noted above, while improvements in service delivery have been recorded, it is of course difficult to attribute effects of SDA to changes in people's health status. Of greater importance at this stage of the project, is to identify important lessons made with respect to improvements in the way of working of district and commune health staff. Does SDA represent a useful model for institutional development at this level? Will the model improve the ability to change, to better respond to the needs of society – of villagers and local health workers, and not the needs of those who are running the government apparatus?

Management: individual competence improved, but institutional capacity less evident

The building of management capacity is the second important aspect of SDA, next to needs based planning (see below). It is a common problem that Vietnamese health officers have little knowledge on management. In medical colleges management is not on the curriculum, and the training made available through other schools frequently does not fit with the market situation. By introducing modern management skill to provincial, district and commune health officers, SDA has definitely contributed to increasing the efficiency of the health network. But how much?

All local officers interviewed referred to the management training courses in positive terms. "Thanks to the training course of SDA, I have now prepared a work plan for our health workers, and at any time, 24 hours a day, there is somebody on duty at the Community Health Centre", the head of the CHS in Thuong lam (Nahang district in Tuyen quang province) explained. He had been in the service since the 1960s, and the new skills acquired had been a great inspiration for him.

At the individual level there are clearly positive impacts of the training, and fortunately the staff turnover is lower at the commune level. At the institutional level, however, the outcomes are less evident. Some observers argued that there is no significant difference in the way of managing services in the SDA provinces, districts and communes compared with others in the same condition but not belonging to the SDA areas. By visiting only a few areas, the evaluation team was not in the position to verify this. There is evidence, however, that the planning skills definitely have improved in the Health Centres of Vixuyen and Nahang districts visited.

The intention to develop improved systems of analysing health statistics from village to upper levels (i.e. based on Mapinfo and Medic software), may become relevant tools for improving quality control and planning in the health care network, but there is also the danger that it may become an end in itself and not a means to improve health services, as commented by one senior staff of VSHC. The tendency to use PRAs only as a data collection device (referred to as "incomplete PRAs" by SDA) is evidence of the same problem.

An *integrated supervisory system from district to commune and from commune to village level* is being tried out in all selected districts. The idea is that health workers shall give advice and handle health problems in an integrated manner, in the sense that the same health worker can supervise several vertical programmes, and be able to understand how various health prevention and promotion activities complement each other.

This is both a rational and highly justified initiative and has demonstrated its usefulness (e.g. in Quang ningh and Ha giang provinces), but implementation is difficult. First of all is the problem that different national and vertical health programmes have not adjusted their approach to facilitate cooperation in supervision. Secondly, the experience, hitherto, has confirmed several of the general problems of improving systems of supervision in today's Vietnam. There is a legacy of control-oriented supervision to overcome, and still few see supervision as a means to provide advice and assistance. Nevertheless, theoretical skills are not too difficult to disseminate. The problems are mostly in the day-to-day implementation. Except for very serious mistakes or misconduct, there are few incentives in the system to perform ordinary quality control. First of all, key health workers are so busy and supervision only means an added workload. Secondly, it is particularly difficult to do supervision in remote areas, because of communication problems and transport costs. And lastly, the recurrent budget for out-of-station work remains very limited, while actual costs are increasing. Understandably, SDA cannot do much to remove these constrains to effective supervision.

Investing in the Village Health Workers

Probably the best-known achievement of SDA is its approach to training of Village Health Worker working in remote areas. Training of village health workers is a prioritised area of intervention for Government as well as donor organisations. The SDA approach is built on existing models developed by MoH, modified to include more community level practice.

The SDA model is based on three 2-weeks-blocks with periods of practice at village level in between. The curriculum and training material for Block A (hygiene and sanitation) and B (MCH/FP) have been finalised, while Block C (most common diseases) is in the process of being completed. The same applies to a programme of refresher training (Block D). The curriculum is adjusted to the relatively low educational level, especially among female VHWs and minorities. It is encouraging that the SDA training curriculum has been used by other donor organisations as well, and has been accorded a semi-official status.

Trained VHWs are in place in about 70% of SDA supported districts. Similarly, training of commune and village health staff has now become a priority for many projects in Vietnam. The rationale is simple: by increasing the number and quality of health staff at grassroots levels access and quality of health care will automatically improve. Several provinces run their own programmes, and there are examples of provinces using their own resources, and skills and curriculum prepared by SDA. There is an important lesson to learn from this: *good ideas combined with simple and measurable targets and available software can motivate replication in Vietnam.*

The biggest question is why the network is under-utilised and whether better trained village health workers will overcome this problem. It is beyond the scope of this evaluation to analyse the relationship between quality of care and utilisation rates, but one interesting observation made indicates that there definitely can be a positive relation. In a remote area of the district of Vixuyen, the posting of a good obstetrics assistant doctor, made all the Dao people of surrounding villages come to her for birth delivery.

4.4 Lessons on relevance

Addressing inequality: by target area rather than target group

SDA has primarily a geographic focus, through the selecting of districts in mountainous and remote areas. In this way, SDA filled a lacuna in the health policy of Vietnam, in the early 1990s. Vietnam, at the time, did neither have the resources, nor any clear ideas on how to deal with the effects of the

market regulation on the health care of people in these poor and disadvantaged areas. With the VSHC, and SDA in particular, the assistance to remote areas gradually became one of the main tendencies of Vietnam's health policy.

It is also evident that there is considerable social differentiation within many of the SDA communes, despite their classification as poor, which raises the question whether there is an additional need for targeting the poorest as a particular group. Within the SDA components it is not clearly stated whether targeting of the *poorest as a group* is an objective in itself. This will require a somewhat different approach than selecting poor communes, depending on local circumstances. When assessing needs in the population there is a responsibility to ensure that the poorest people, women and children also are heard. It is not enough to include village leaders for PRAs, since their interest might differ substantially from those of the poor.

The motivation to seek health care seems to be limited among the poorest due to time and costs, given other pressing needs. Trained health care personnel are not always sensitive enough to meet the poorest people in a dialogue and this will also influence health-seeking behaviour. Even though mechanisms are put in place to secure free health consultations for the poorest, it does not always work. SDA intends to work on these issues during the VSHC-II period, and it is too early to judge how it will succeed.

The problem of incentives in the public sector may undermine the approach

The first five components of SDA address core problems for the health network at lower levels: district, commune and village. However, for the better running of the network, SDA needs one thing more: clear incentive systems for those people who are involve in the network.

After many years of working by voluntarism, now personal economic interest is one of the main factors that steers Vietnamese thinking. Supervision, which is very week now, cannot be strengthened unless the incentive system is improved, both economically and spiritually. There is a need to mitigate the tendency to split implementation into separately managed component, a style of working influenced by many years of central planning, when every unit tried to fulfil its own targets without regard to others. The district is the best level for promoting integrated planning and supervision, especially in remote and mountain areas, and SDA in the current phase rightfully has strengthened the district focus.

Needs-based planning: is PRA an appropriate method for a government line ministry?

The needs-based identification, planning and implementation approach using Participatory Rural Appraisal (PRA) techniques at village and district level is a relevant attempt at making the local health system network more *responsive*. To succeed means that also the needs of the poorest people and women are addressed, realising that women's needs probably are much different from those of men. Further, the techniques applied must be adjusted to local conditions, i.e. being easy to understand and apply. A precondition for success is that a felt ownership is in place so that the motivation is there to implement planned activities, even without subsequent support from SDA.

PRA, broadly speaking, may serve one or all of the following purposes:

- A tool for community diagnosis to identify health problems and needs in the population – i.e. as a participatory *research* method.
- A process for involving beneficiaries in planning of interventions – i.e. as a participatory *planning* method.

- An approach to stimulate emancipation among people lacking self-esteem, and a voice and influence in taking local initiatives – i.e. a method for *empowerment and community action*.

SDA already in 1994 adopted PRA as a tool to identify health needs in the population, but the full strength of the technique was not utilised at this early stage. The problem was that villagers identified their needs but authorities did the identification of solutions and the planning. Since then a second round of about 300 PRAs was performed in selected villages in the pilot districts aiming at including also planning and action. It is fair to say, that most of these exercises also stopped with the needs identification part. In the current agreement a new round of selective PRAs has just begun, trying to make use of the full potential of PRA.

Although PRA related methods have a proven record in many countries in community mobilisation, they represent no quick fix. Villagers take time in finding their own role in the process vis-à-vis the role of established authorities. It is virtually unavoidable that local power holders – Party and traditional leaders, dominate the process. Moreover, to manage PRAs requires intellectual skills that, in some remote villages, are hard to come by. To separate health needs from other needs is sometimes also viewed as confusing.

These problems notwithstanding, the PRAs definitely has the potential of improving the responsiveness of the health system. The biggest problem, and the one which makes us ask whether this is a relevant and appropriate tool for the Ministry of Health, relates to the absence of *an effective response mechanism*. It is not clearly identified in the SDA model how and where to find the resources once villagers have set their priorities, and what capacity this would require. There is a brief mentioning in SDA documents about the need for inter-sectoral collaboration at commune or district level between local authorities, non-governmental organisations, private providers and the community to assist in the implementation of activities, but no mechanism seems to be in place, or being developed, as yet.

As evident from SDA, to perform PRAs at village level under the management of MoH is time consuming, expensive and dependent on central support. In some places it took up to six days in the village just for the problem identification and needs assessment to be completed, without reaching to the planning of concrete actions (e.g. the PRA in Hoang suphi).

There is now valuable experience of how to apply this method within SDA, and how to give voice to the poorest and most vulnerable people. The way forward for SDA on the aspect of PRA is to carefully examine whether it is realistic for MoH to get involved in all three aspects of PRA, mentioned above. Concerning the third level – emancipation and community action, other actors ought to take the lead, and a role of SDA would be to provide opportunities for training in PRA for these actors. We are thinking of the mass organisations of the Party, but also non-governmental organisations (NGOs), which seems to be allowed to play a more active and independent role in community development.

Commune Health Stations: Rational use still a problem

There has been an *upgrading of facilities and equipment* at district hospitals and commune health centres since the mid-1990s. Operating theatres have been renovated and anaesthetic equipment provided to a number of district hospitals, opening up for increased and improved management of common diseases.

All commune health stations (CHS) were upgraded and equipped in a standardised way. However, some of the delivery rooms are not more in use today than before upgrading, due to the fact that among some ethnic minority groups women still prefer to deliver at home. At Trung thanh com-

mune (Vi xuyen district, Ha giang province) for example, only 39 of 86 registered cases of deliveries (January to October 2000) this year took place at the upgraded birth delivery room in the commune health station.

According to statistics available at district hospitals the number of operations performed have increased and referrals to higher levels of care are less than earlier. At the same time, it is observed that CHSs are highly under-utilised. On the average four to five patients are seen a day. The number of staff at the CHS seems appropriate – three or four professionals, but often only one person is available due to ongoing training activities and, perhaps more importantly, that staff take time off to earn complementary incomes since Government salary levels for health workers are extremely low.

In general, in mountain and remote areas the investment in CHSs may increase the attendance, but due to customary practices and lack of staff involvement this has not been the case in all places with upgraded infrastructure. In Bache, Hoanh bo and Binh lieu, the number of patients actually decreased. The cost-effectiveness of investments in facilities and equipment should therefore be carefully considered.

Gender concerns

In general, the evaluation team notes an awareness in VSHC planning documents and staff involved concerning *women's* health and needs of health care services. Women are in focus in MCH/FP services and a main target has been to reduce maternal mortality, maternal infections, iron deficiency during pregnancy and other strictly female conditions.

We note, however, that the *gender perspective* is less pronounced. For instance, we observe that there is a lack of sex-disaggregated data relating to prevalence of such conditions as child malnutrition rates, child perinatal mortality and under 5-mortality rates.

Concerning *men,* no specific men's health needs were presented in the 1994–99 planning documents. Men's life style behaviour differs from women's with respect to tobacco use, drug dependency, alcohol consumption and domestic violence. In VSHC-II, however, there has been a change especially at the policy level. A national health programme for tobacco control is being instituted during the period 1999–2001, and it is stated that special attention will be paid to preventing young people and women from starting to smoke. The rate of male smoking is among the highest in the world. Furthermore, violence and abuse issues, as well as issues related to tobacco, alcohol and drugs, are addressed in the first ever national policy on adolescent health being put forward in the present VSHC period. These public health initiatives constitute very positive developments.

Looking at SDA, one important concern has been to overcome the problem that many women, especially among the minorities, have a low educational background, which disqualify them for training opportunities. It is an achievement that 39% of the VHWs in SDA areas are women. However, we noted that still very few women were members of decision-making bodies such as People's Committees, and in the management oif commune, district and province health centres. There is reason to believe that not until women are present at all levels will there be a real integration of women's issues and needs in plans, budget allocations and health care services provision.

Young boys and girls form vulnerable groups in society. Today there are new threats to their health, such as HIV/AIDS. Also abortion rates are high and reproductive tract infections are present among adolescent girls. Since the MCH/FP Area was closed the responsibility for studies in this field, within VSHC, was taken over by the Health Policy Area. Two main surveys have been carried out, one focusing on sexual health (1996–97) and the other on tobacco use, alcohol con-

sumption patterns and also on violence and sexual behaviour changes (1998–99). As an outcome of these studies an impressive adolescent health policy has been put forward with the purpose to formulate an operational national strategy for adolescent health with particular focus on schools as an area for health promotion and health prevention.

In conclusion, our impression is that gender issues have been dealt with in SDA mainly by focusing on women and women's health and educational needs. SDA has been striving towards gender balance and women have been part of PRA activities and women's access to health care services has improved. Positive results have been achieved such as decreased abortion rates, increased use of contraceptives, increased number of female VHWs, and women have gained improved access to training activities at different levels. At the same time there have been difficulties in recruiting women, especially from the very poor households, as women often identify themselves as the primary caretakers of the household, and because of low educational attainment. We believe that SDA has an important role to fulfil also in the future in raising gender awareness among programme staff at all levels, including also men's issues. This will take a long time, as the step from gender theory to practice is a huge one – in any society.

4.5 Conclusions and recommendations: on SDA as a replicable model

Need to strengthen ownership

SDA from the very beginning was designed as a project more than an area of support. This was necessary given the ambition of developing new approaches to health care in remote areas. But six years later, it is a great concern that even people involved in SDA seems not to think that the SDA-model is something which can be *replicated* in the Vietnam health care network by itself. Answering the question of whether SDA can be continued without Swedish assistance, or whether it can be replicated in other areas without such assistance, the answers everywhere were definitely negative.

It is evident that SDA suffers from a lack of ownership within core institutions of MoH. Compared with the other areas it does not have a strong institutional "home". Considering its experimental character this is maybe unavoidable, and, in fact, becoming too integrated in the established bureaucratic structure will become a straightjacket stifling innovation and experimentation. But it is a well-known fact that public sector reform through experiments cannot succeed unless there is strong political backing from higher level. Unfortunately, SDA seems not to have the required backing.

Build strong local teams

SDA has suffered from high turnover of staff, both at management and operational level. At the central level, within AMG, there has been virtually complete change from the VSHC-I period. As a consequence, the long-term advisers have become stable element and wield too much of an executive influence within the AMG. There are valid reasons for this, but it represents a problem for building a sustainable and replicable organisational model.

Talking to officers at provincial and district level confirms the impression that the front-figures of SDA are the long-term advisers, and moreover that implementation of activities greatly depends on decisions and inputs from the central level. We know that this is perceived differently on the part of AMG, but nevertheless it is an indication that SDA may operate in a too *centralised* manner, which may even contradict its own objective of promoting bottom-up planning.

Improve the experiment

In retrospect it would have been better if the SDA model was developed carefully first, then piloted on places with different ethnic and geographical conditions for learning experiences and only after that expanded in the whole target area. We recognise that this option was not acceptable to MoH in 1994, and therefore not available. The transformation of SDA from a regular service delivery programme to a model development project has been gradual, and justified. It is of concern, however, that we were not able to find a general consensus of what the model is about.

In our opinion, SDA has two important challenges:

- Simplify the message by building on the areas of success, and formulate and disseminate several models of a practical "how-to-do" character.
- Improve the experimental design where experimentation still is warranted and politically supported.

To be able to learn from the experiments, it is necessary both to establish a baseline at the beginning of the experiment, as well as having a systematic and independent follow-up of changes and lessons learned. Maybe SDA has suffered from the fact that Vietnam is in shortage of good researchers in social sciences. International experts can provide useful concepts and ideas, but models of the kind of SDA cannot be successfully developed and tested without deep understanding of local culture and traditions.

Improve the salesmanship

As other observers have commented, SDA has been too "silent" about its approaches and achievements.[9] Although the evaluation team, together with many of the interviewees, has problems comprehending SDA as a model, it is acknowledged by all that SDA is particularly rich in operational experiences.

Today there are several large projects dealing with health care at grassroots level, for example with World Bank and ADB financing. The lessons of SDA, both successes and failures, would be very useful to these projects, and there are several instances of other donors and NGOs looking towards SDA for advise. By improving the dissemination of lessons and models SDA will play the role many expect of VSHC: to explore innovative ideas for new approaches in health care. A greater effort, therefore, needs to be taken by MoH to give the most promising of the SDA experiments an *official recognition*.

We recommend using a main part of the remaining of VSHC-II (until mid-2002) to formulate simpler and more replicable SDA models – in plural. Without an extra effort of salesmanship it will be difficult for people in disadvantages areas to understand what VSHC did for them.

Still a need for further scaling down – before scaling up is possible

We have noted that, during the VSHC-I period, there was a problem among implementers in understanding the SDA model, and that there was a lack of co-operation between the components. The attempt at redirecting SDA during this agreement period has slowed down implementation, and implementation at local level has remained dependent on heavy central level support.

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[9] Tamm, Gordon. Appraisal Report, April 1999.

While we support the adjustments made in the current phase, we are concerned about the capacity of SDA in relation to the scale of its operations. To have the time and manpower resources needed to finalise a model (or models) for health services development in disadvantaged areas, the volume of pilot activities might need to be further reduced. To reach objectives in all the 3 provinces, in the current phase, is probably too ambitious within the time frame given.

Furthermore, we note that the needs-assessment workshops are both time and people consuming, and the team observed a lack of ownership at district level. The PRA workshops depend still on considerable support from central level – AMG, and replicability is not yet secured. It is important to find a model for local level planning which is replicable and less dependent on outside support.

We believe it is necessary to reconsider the role of the line ministry in PRA-related activities. It seems not to be a viable approach to rely on District Health Centres as the primary PRA agents. SDA would probably benefit from scaling down this element to try out a way to stimulate PRA initiatives managed by community-based organisations and NGOs.

Lacking a response mechanism to popular statements of needs

It is not clear what resources that will be needed and what capacity the government system has to mobilise to respond to needs and priorities identified through PRA workshops.

There is a need to start work on mechanisms that facilitate inter-sectoral collaboration at commune or district level involving local authorities and various line departments. Moreover, there needs to exist financial intermediaries, like local development funds and banks, which can forge a functional link between the public sector and non-governmental organisations, private providers and the communities in local level projects.

The province needs to play a stronger role

There seems to be a lack of key staff at provincial level for training and supervisory activities and possibly also a lack of motivation. This could be due to the fact that the provincial level is being by-passed concerning financial management. Given the current trend of greater provincial self-governance, it is almost inevitable in the near future that the regular application of the SDA model (or models) will become a provincial responsibility, hopefully without jeopardising the innovations. Our impression is that the provinces still prefer to see SDA/VSHC as a potential resource for funding their regular programmes, rather than breaking new ground.

Let the experiment continue – if that is what it is

While many of the lessons identified above point at problems rather than achievements, we are not drawing a negative conclusion about the general thrust of SDA. It has been a bold attempt by both MoH and Sida to address some very difficult problems of inequity in health conditions and health care. The objectives of SDA are no less relevant today than in 1994. It is to the credit of MoH and Sida that they have realised the need to experiment to find new ways to meet these objectives. The fact that this experiment reveals problems is not negative, as long as the lessons form part of a learning process. *We would recommend* continuing pursuing the experiment and the learning process building on the strengths of the VSHC: patience, flexibility and trust.

5. Drug Policy and Control

5.1 Background and context

As a part of the Vietnam-Sweden Health Co-operation, Sida has provided support in the area of pharmaceuticals from 1983. In the agreements prior to 1994 support had been in the form of material support to encourage the development of drug management, the development of local pharmaceutical industry and direct support to supplement the procurement of drugs and raw material for government institutions and programmes.

The 1990–93 agreement introduced a partial change of emphasis towards support of the pharmaceutical sector, with more concern for quality control and the rational and safe use of drugs. In the 1994–99 agreement, the procurement of drugs element was omitted completely. The main focus was transferred to the development of policy and regulations that would strengthen the capacity of the Ministry of Health to monitor and control the availability, quality and use of drugs in Vietnam in both the private and public sectors. This change of emphasis was necessitated by the effect of the national policy change to a market economy. The introduction of a market economy resulted in the rapid development of a private pharmaceutical sector at a rate faster than the expansion of controlling capacity of the department of pharmacy in the Ministry of Health. Such a development had implications for the quality and safe and rational use of drugs by the general public, and there was an urgent need to develop and implement a legislative framework and systems to promote the safe manufacture, import, supply and use of good quality pharmaceuticals in Vietnam

5.2 Objectives and achievements

The timeframe for implementation of the ADPC component of the VSHC included the whole five-year period of the agreement from 1994 to 1999 with a subsequent extension of 2 years. The overall objective of the programme is stated as aiming for an "increased capacity" amongst the relevant institutions in the areas of drug control, rational drug use and health worker training. Although the objective was simply stated, the implications of the activities needed to achieve significant "increased capacity" required a long term perspective in view of the background situation. Some of the activities have not been completed, and some of the activities have not been started, nevertheless there has been obvious progress within the project timeframe.

Ambitious but realistic objectives

The original overall objective is contained in the Specific Agreement of October 1994 and is stated as follows;

> *"An increased capacity of the Department of Pharmacy and associated institutions to;*
>
> – Control the supply, quality and marketing of drugs;
> – Encourage rational prescription and use of drugs; and
> – Influence the training of pharmacists and other health workers including medical doctors."

This overall objective was further developed in the 1994 project document with the identification of indicators which pointed to activities in the following areas;

- A National Drug Policy and associated legislation will be agreed and approved.
- Mechanisms and bodies for enforcing the legislation will be defined, established and functioning.
- The National Institute for Drug Quality Control (NIDQC) and the sub- institute in HCMC will have upgraded equipment and better-trained staff.
- Pharmaceutical inspection systems will be strengthened.
- Methods for financing the purchase of drugs (e.g. RDF and HI) will be developed and more uniformly applied throughout Vietnam.
- Health workers at all levels will follow rational practices.
- Ministry of Health will have the competence and system to monitor the use of drugs.
- The public will have increased knowledge of both the beneficial and harmful effect of drugs. (Priority targets will be women and especially pregnant women.)

Whilst these objectives are appropriate and realistic it is regrettable that the whole area of *drug financing was omitted* from the original agenda. The system for drug financing is basic to the supply of drugs in the government sector therefore an important element of the programme was left aside. It should also be noted that improving the capacity and ability of the DQC Institutes does not of itself necessarily lead to improved product quality in the market, it can only provide information about the state of product in the market.

Substantial achievements, but biased

The project document stated that activities should be "co-ordinated by, but not take place within the department of pharmacy". In line with this the Head of ADPC has been the Director of the Drug Administration of Vietnam (DAV) but the ADPC has had a separate office staffed by a mixture of seconded Ministry of Health staff and directly contracted staff. Following the reorganisation of the DAV the ADPC was attached to one of the divisions whilst retaining its own structure. Many activities have taken place outside the DAV and this was necessary, there is however always a danger that the ADPC will focus more on the activities that are a priority for DAV.

Many of the activities listed in the project document have been initiated. Some of the activities stated in the original project document have not be carried through either because of the direction of government policy or because DAV and ADPC reordered the priorities.

Project Document Activities that were implemented either in full or in part.

- Form specialist groups to study the pharmaceutical sector in Vietnam and other countries, and define policies and propose legislation.
- Define and regularly update a revised list of essential drugs for each level of health facility. Develop guidelines for rational prescription at various levels.
- Improve facilities and procedures at NIDQC.
- Improve facilities, strengthen systems and increase skills of staff relating to monitoring of use of drugs and issues such as ADR and resistance.
- Establish inspection system to control import, distribution and sales.
- Initiate and co-ordinate programmes of information and education for the public on the appropriate use of drugs.

Many of these activities have resulted in outputs that are demonstrable. The only activity listed above that does not have a clear outcome is the establishment of an inspection system. It is included

in the above because there have been some moves which are precursors to the inspection system, and until the drug law is in force the legal basis for much of that work is absent.

Project Document Activities that do not appear to have been implemented.

- Evaluate methods of financing purchase of drugs currently used in Vietnam, develop and test improved methods and define national policies for drug financing.
- Advise hospitals and health bureaux on effective methods of procurement from state and private sectors.
- Co-ordinate with department of science and training to provide continuing education for current health workers at all levels and improve initial training for pharmacists relating to the guidelines.

It is significant that the above list of activities relate to drug availability, affordability and use, none of which are direct responsibilities of the DAV.

One evaluation statement that can be clearly made about the ADPC is that there have been a number of significant outputs during the period of the 1994–99 agreement and that these are being carried forward into the current two year extension.

The outputs are described in detail in the ADPC final report and may be summarised as follows under the heading of the five major areas of work.

Drug Management Authority at Central Level reorganised and control of the drug market improved

- Finalised in 1996 with an increase in staffing from 13 to over 50. The Department of Pharmacy became the Drug Administration of Vietnam (DAV). The central DAV is linked with provincial pharmaceutical management divisions.
- DAV has 6 divisions concerned with finance, practice, registration, quality control, information and advertising, and narcotic and psychotropic drug control.
- Training was provided in English, in computer skills and in specific technical areas.
- Supply of office equipment.
- ADPC is attached to the information and advertising division, with the head of the division as secretary of ADPC.

Vietnam National Drug Policy (VNDP) approved and associated drug law and regulations developed.

- VNDP was developed using a steering committee and several working groups.
- VNDP was officially approved in 1996 with a masterplan developed in 1997 and piloted in 7 districts thereafter.
- Pilot activities include improving competence in management skills, inter-sector co-ordination in control activities, training of pharmacy assistants, and increased involvement of the provincial People's Committee.

Develop, amend and update a drug law, a drug regulation system that is compatible with the challenges in the new drug market;

- A new drug law is being developed by a steering committee and working groups. It has reached the stage of a 10th draft based on wide national consultation. It is planned to be ready for submission for approval in 2001.

Capacity and ability of DQC institutes improved so that the quality of registered and marketed drugs increasingly meets set specifications.

- A total of 37 DQCI personnel received training including study abroad focusing on instrumental assay methods and methods for multi-component drug control.
- A large proportion of the budget was spent on analytical equipment for the national institute in Hanoi and the regional institute in Ho Chi Minh city

Rational and safe use of drugs improved

- Establishment of drug therapeutic councils in 70% of hospitals.
- Adverse drug reaction monitoring centre was established in Hanoi in1994 with associated training for health personnel in 27 provinces.
- A drug information centre established in the College of Pharmacy in Hanoi (1994) and the launch of a centre in HCMC in 1998. Hanoi DIC produces a clinical pharmacy bulletin with 10 issues per annum.
- Antibiotic sensitivity testing study (ASTS) established at Bac Mai Hospital with a network of laboratories collaborating to provide information, which is disseminated widely and frequently.
- Antibiotic Advisory Committee supported with the development of a policy, and treatment guidelines for common infectious diseases.
- Development of the Vietnam National Drug Formulary is underway with a few test copies of volume one recently produced for "test use".
- The national Essential Drug List was revised and reissued in July 1999.
- Public educational programmes on safe drug use, aimed at women and using some minority languages relevant to SDA provinces. Broadcasts on national and provincial radio and TV.

5.3 Lessons on institutional development

ADPC, with its large variety of activities, has contributed to the development of a number of health and educational institutions.

Successfully building the Drug Administration of Vietnam: but too much an isolated specialist

The major focus of the institutional development activities of the ADPC has been the DAV in the Ministry of Health. As indicated above, the VSHC has had a major influence on the DAV, being closely involved in the planning and the reorganisation of the DAV as one of the major objectives. The reorganisation was of major proportions in terms of function and number of employees.

Training in technical areas has included in-country workshops and educational visits to Sweden and regional countries. Work has begun on the registration of drug and cosmetic products, the control of advertising of pharmaceutical products, the licensing of manufacturers and wholesalers and the monitoring of drug quality. This is quite an impressive list of achievements in developing the role and skills of the DAV though the quality of output from the department is not measured.

Apart from the direct involvement in the DAV reorganisation there have been different levels of less formal capacity building through the management activities of ADPC under one division of the DAV. Involvement in annual planning, implementation and reporting requirements for VSHC, working alongside and interacting with long-term advisors, is a part of capacity building. Similarly the whole process and development of the National Drug Policy, the drug law, and the national formulary have involved wide consultative and collaborative activity planned and implemented by the DAV. The presence of only two international advisors (only one in post for some periods), along

with limited use of short-term consultants, implies that the national staff has performed the bulk of the work in collaboration with other stakeholders via the working groups. Normally a very effective way of developing capacity.

One potential negative aspect observed in terms of institutional development is the position of the DAV as being "independent" (a word used by the General Director DAV) but within the Ministry of Health. This probably results from the focus of the work of DAV being on pharmaceutical and cosmetic products, with no direct responsibility to be involved in patient care or the supply and use of drugs by individuals. Objective comments made by others during the course of the evaluation interviews suggested that the DAV was indeed an isolated specialist department rather than an integral part of the health ministry and health care. Drug therapy is one integral part of treatment available to the health care system and it would have been good to learn of closer collaboration with the department of therapy.

Drug quality control improved: but coverage still low

The Drug Quality Control Institutes have received direct development support as one of the main objectives on the ADPC programme. Although there has been a high ADPC expenditure in this area, on equipment, materials and human resource development, it is surprising to find that they are only able to analyse about 40% of imported drug products. The number of samples tested annually (1016 for Hanoi and HCMC combined) is relatively low but the number might be restricted by the level of funding for reagents. Whilst there has been institutional development in a technical sense, there is no clear evidence that there have been significant changes in the style of operation or the role and purpose of the DQCI in the revised drug control system. The role they fulfil appears to be much the same as before, yet the pharmaceutical environment in which they function is significantly different. There is a need to reconsider the role of the DQCI and integrate its operation with that of an inspectorate.

Supporting a wide network of institutions

Further evidence of institutional development is demonstrated in the development of the Drug and Therapy Council, Antibiotic Sensitivity Testing Scheme (ASTS), the Adverse Drug Reporting Centres and an increasing network of Drug Information Centres. All of these involve a co-ordinated activity at national level dependant on the response of institutions around the country. Each activity has required training activities in order to maintain the level and quality of the activity. The DTCs have improved the collaboration between health professional in the teamwork of hospital management and activity. For ASTS and ADR the quality of testing and reporting has to be constantly monitored resulting in a broad based development of skills with feedback which is intended to progressively improve the quality of work.

Implementation of the VNDP by the DAV has involved provincial training courses to introduce concepts and implications of the drug policy for drug management and control at provincial level, but in seven pilot provinces. (It does seem strange to announce a national drug policy but only "pilot" its implementation in about 10% of the country). There is no written evaluation of the success of DAV in transferring the skills and knowledge requirements to others, but in theory such cascade training should improve capacity at all levels. One vital area of development at provincial level has been the initiation of collaboration between the various sectors involved in drug control, and there is some reported success from campaigns in 42 provinces targeting the marketing of fake and substandard products.

Need to revise the institutional set-up for Rational Use of Drugs

The major disappointment of ADPC in terms of institutional development concerns the professional practice aspects of the programme related to rational drug use. The safe and rational use of drugs is closely linked to the training and daily practice of individual health workers in the provision of health care. There have been training courses on specific areas for pharmacy practitioners, but there has not been any attempt to influence the basic training of pharmacists or prescribers. The major focus for patient care within the Ministry of Health is in the Department of Therapy that carries responsibility for patient treatment, hospitals, guidance influencing drug supplies to public health facilities and treatment guideline development amongst others. Since the DAV does not have a "therapeutic" responsibility, some parts of the ADPC rational drug use programme probably could have been implemented more effectively by close collaboration with the Department of Therapy. In particular those aspects concerned with prescribing practice and the practice of hospital pharmacy. Closer collaboration between the two departments would have enhanced institutional development within the Ministry of Health.

5.4 Lessons on relevance

Relevance to government policy and national situation

The change from a centralised and monopoly pharmaceuticals situation to an open market economy demanded the establishment of a revised structure and established control mechanisms if the government was to meet its responsibility of ensuring the safe availability of quality medicines. Therefore the introduction of the VNDP, revised legislation, drug registration and improvement of quality control are all activities relevant to the situation of a market economy where lack of control has implications for the health of individuals and the community.

The development of the essential drugs list, Vietnam national drug formulary, adverse drug reporting centres and drug information provision are all steps which acknowledge the need to provide guidance for safe and rational use of drugs in a more open situation. They also address the need to begin to assess the potential dangers in the current developments and to try to minimise the negative consequences for the general public.

Therefore the support provided by Sida for the above activities is very relevant assuming that the developed policy and associated guidance principles are implemented.

Relevance to international trends

The activities implemented by ADPC are in line with current international preferred practices in response to trends of diminishing public resources, rapidly developing private practice and global market pressures. The WHO emphasises the need to ensure accessibility, product quality and the safe, rational use of essential drugs and tried methods to achieve progress are founded on national drug policies, drug selection, quality assurance in production and storage, and objective reliable information for prescribers and users.

Equity in terms of accessibility to drugs: no impact yet

The relevance of any programme on pharmaceuticals can be partially measured by assessing accessibility to drugs of acceptable quality. Accessibility is a comment on equity in that it includes both availability (geographical access) and affordability (financial access). The activities of ADPC have the potential to influence equity even though there is little in the programme which links

directly to drug supply in the public sector. A lot of the activities and outputs of ADPC provide the necessary basis for improving access to drugs.

One specific objective of the VNDP is to "ensure sufficient supply of good quality drugs at affordable prices and to promote equity in the supply of drugs to patients … ". The Policy later states that "Supportive measures should be taken to ensure a sufficient supply of essential drugs to all people including the poor and people of ethnic groups in remote and mountainous regions..".

Such statements are very relevant and promote equity. However such statements have to be translated into effective action. These policies need to be linked into and influence the drug supply systems in the public sector and in the private sector (which requires an efficient and effective inspection system as well as some mechanisms for price regulation – neither of which appear to exist). At present the VSHC does not impact on accessibility, it is *doimoi* that has improved accessibility and with many associated dangers for the health of individuals and the community.

It is not clear that the current public sector supply system does promote equity, and the very limited evidence gathered during the evaluation visits suggested that in its present form it works against equity by charging full cost for drugs at the first level of care. The systems of procurement and supply may not be efficient and appear to be tied into a monopoly state owned supplier. Such an arrangement does not favour lowest prices. ADPC have recognised this fact and attempted to try and minimise the negative effects of poorly operated revolving drug funds by collaborating with SDA to provide training in the management of the supply, care and handling of drugs. The achievements of this training cannot be evaluated yet.

What is very clear is that the private sector supply of pharmaceuticals in Vietnam takes place in an environment with limited or no control. There is very minimal control over the products traded, and there is no control or influence over the cost and quality of service provided. This has serious implications for those who are poor and are using pharmacies regularly as their "health care service". The exercise of control should influence both the cost and quality of service and therefore benefit all clients with proportionate benefits for the poor. Eighty per cent of expenditure on drugs is via the private sector.

It would be too much to expect that, within the time of the VSHC project, control over the pharmaceutical sector could have been fully implemented, but it does emphasise the lesson that the hardest and equally important aspect of introducing policy and control is the implementation of agreed policies.

Consistency of drug use: important groundwork done

Equity in terms of pharmaceuticals has to do not only with accessibility but also with consistency of drug use. There is much in the present system that appears to emphasise that the quality of treatment (in terms of drug therapy) depends heavily on the ability to pay (either of the individual or of the institution). It was frequently reported that limited funds result in only partial purchases of prescribed or self-medication treatment, also that a hospital in-patient will have to buy some of their prescribed treatments from the private sector and ability to pay may again influence the nature of the treatment.

Consistency is concerned with the rational and safe use of drugs in the care of communities and individuals in a way that provides equality of care without bias towards ability to pay. Thus it should ensure that treatment is always the best where "best" is defined as the most cost-effective care based on rational diagnosis and treatment. This consistency should ideally apply to treatment in any sector.

The principles of promoting and ensuring rational drug use are an attempt to produce equity in treatment, which would have financial and quality of care benefits for the clients. A lot of the activities and outputs carried out so far under ADPC are very relevant and provide the groundwork for rational drug use to take place especially in the government health facilities at all levels. As one official remarked "I am very happy to work towards the alleviation of the poverty of drug information in Vietnam".

It would good to see a larger proportion of funds allocated to rational drug use and improving professional competency in association with closer collaboration with the Department of Therapy in the Ministry of Health.

In the private sector there are reported inconsistencies in treatment recommendation and sale because there is currently no effective legal basis for the controlled supply of medicines and private pharmacy shops are not working to professional and ethical principles.

Gender issues reflected in drug information

Vietnam does not appear to be any exception to the common situation that the women in a household are the main decision-makers with regard to the need for and the nature and source of health care. It is therefore significant to provide unbiased and correct information to women so that health care decisions are the most favourable particularly for the poor whose proportionate expenditure on health at a maximum.

There have been parts of the ADPC that have given an emphasis to increase the knowledge of women, particularly in disadvantaged areas. The educational material developed for mass media use has had this focus and is to be commended for this reason. Such activities should be extended and emphasised.

Product quality in the market improved, but inspection still weak

It is good to read reports of a dramatic reduction in the presence of "fake and substandard" products in the market between 1994 and 1998. The improved capacity of the DQC institutes in analytical techniques will continue to be one relevant factor in the efforts to introduce increasing quality assurance in the pharmaceutical sector. In addition the reorganised DAV should also increasingly influence the quality of products licensed for manufacture in Vietnam, and products registered for import into Vietnam. Through these two areas of support ADPC has been relevant in beginning to the problem of quality.

Nevertheless there remains a lot to be done to develop a team of inspectors who can contribute significantly to an improvement in the quality of products in the market. Testing a limited range of products at the end point does not necessarily influence or improve product quality but rather informs of the current state of quality, and the validity of the conclusions that can be drawn is dependant on the quality of the sampling methods.

Objective drug information: a need to improve dissemination

Rational treatment choices can only be made if the information used to make choices is accurate. Information supplied by the manufacturing industry is rarely objective enough to be a basis for rational decision-making. Objective and evidence based information about drugs and their use is an important foundation and therefore easy access to good quality drug information is very relevant. The ADPC programmes associated with the development of hospital drug and therapy councils, adverse drug reaction reporting, assessment of antibiotic resistance patterns, drug information centres, and poisoning information are all extremely relevant to the promotion of rational drug use.

Objective information is needed for the development of drug lists and treatment guidelines on a non-urgent basis and on a more urgent basis for the determination of treatment for individual patients. Therefore ideally the information centres should be easily accessible to practitioners and is best provided in association with hospital pharmacy departments. It is questionable whether the drug information centre in the College of Pharmacy is in the most appropriate location. The number of enquiries received is few, and the range of books and journals available quite limited and therefore the benefit of the financial support may not be maximised. This consultant is not convinced that the regular publication of the "Clinical Pharmacy Bulletin", funded by ADPC, is relevant enough to justify the level of support. It would be helpful at this point for ADPC to reassess the contributions of various supported programmes in drug information and to ensure close collaboration between the elements to ensure efficiency and avoid duplication in gathering, storing and disseminating information.

5.5 Recommendations

The pharmaceuticals component of the VSHC should continue to emphasise the two major objectives of the Vietnam National Drug Policy, namely the supply and quality of products, and their safe and rational use in health care. In doing so the VSHC should;

- Enhance the capacity of the Drug Administration of Vietnam to implement already agreed policies, guidelines and legislation so as to have an impact on access to drugs and their quality and rational use.
- Maintain a concern for drug quality and support the Ministry of Health to develop a co-ordinated inspection and testing system to improve product quality (locally manufactured and imported) in the public and private sectors.
- Continue to support the collection, provision and dissemination of drug information in a co-ordinated manner and improve international access and collaboration.
- In collaboration with the Department of Therapy support the further development, co-ordination and contribution of Hospital Drug and Therapy Councils.
- Work with institutions and professional organisations to develop continuing professional development that will result in the improvement of the professional knowledge, skills and practice of pharmacists and prescribers already practising.
- Increase support to the basic and postgraduate training of medical doctors, pharmacists and other health workers in relation to rational drug use and best treatment.
- In collaboration with relevant stakeholders develop systems for the financing and cost-effective supply of drugs within the government health sector.

6. Central Hospitals

6.1 Background and context

Towards the end of the 1980's, Vietnam underlined its intention to move towards a public-private mix in the health care system by introducing private medical practices, private pharmaceutical sales, and introducing hospital fees. Reform-oriented policy makers advocated this direction to reduce the financial burden on the government, while ensuring an increased contribution from users in maintaining the upkeep of the health service system. The opening of private practices provided health staff with another avenue for income generation.

The hospital system was suffering from a serious crisis of funds. Government budgets for hospitals covered staff salaries and very basic recurrent expenditure. To continue operating, hospitals had to locate additional sources of income. Two main avenues related to support from overseas joint ventures or aid programs like VSHC.

During the early 1990's, the move towards a combined public and private hospital system in Vietnam was poorly conceived and devoid of any proper planning. An example of this was the introduction by many hospitals of separate wards, so-called needs-based service clinics, in addition to their usual service departments. The system was introduced to benefit three parties:

- Patients: to save them time and accord them better medical services, because they would consult higher quality staff and would be able to utilise better quality equipment.
- Hospitals: to increase their revenue through receipt of patients' fees, enabling them to respond to urgent needs in purchasing basic medical equipment, as well as supporting their staff through additional income.
- Government: to reduced the burden on Government healthcare expenditure for the hospital system.

Despite the lack of empirical data showing the impact of introducing private services into public hospitals, the creation of specialised private health care units in public hospitals certainly created enormous challenges. There was a lack of a proper legal framework and operational guidelines to run the public-private mix model. In addition, it created substantial inequality in access to health care, because the wealthy were able to receive both a good standard of care and access to the best medical equipment available. Yet, the vast majority of patients had to contend with long delays, inexperienced staff and poor equipment in the public system, as a direct result of the transfer of resources from the public to private departments.

In addition, hospitals in disadvantaged areas, where the majority of people were living under the national poverty line and almost all were without health insurance coverage, were at risk of not being able to run private wards, preventing improved financial contributions for their staff and the upgrading of hospital infrastructure. This combination of problems was primarily responsible for the degradation and sub-standard quality of the hospital system in the early 1990's, as well as for the increase in patient-visits leading to overcrowded central hospitals over the last five years. It was very unclear how the combined public and private healthcare system could become socially equitable.

6.2 Objectives and achievements

A strategy for phasing out of aid

As the result of the agreement in 1994, the two independent hospital projects, Uong Bi General Hospital (UBGH) and the Institute for Protection of Child Health (IPCH), amalgamated to form the Central Hospitals Area (CHA). The Department of Therapeutic Management (Therapy), which is responsible for the management and direction of curative services in Vietnam, was assigned to oversee the Area. This period represented the final phase in the provision of Swedish support for central hospitals.

The objectives of the CHA, according to the Planning Document, were as follows:

- More cost-effective utilisation of resources and reduced dependency on donor support, particularly at UBGH and IPCH.
- More effective methods of financial management.
- Improved competence and resources for cost effective and appropriate healthcare at a limited number of other central hospitals.

The overall strategy for the period, 1994–1999, was to ensure the ongoing operation and maintenance in standards of the hospitals, with no reduction in quality of service. A progressive reduction in funding was to be balanced in the longer term with increasing efficiency in operation and cost recovery.

On the basis of general objectives for the different stages according to the agreement, the Central Hospitals Area had defined specific objectives for their annual operation plan, as follows:

- To maintain and ensure the undertaking of regular operations and quality in medical care at central hospitals, especially the Institute of Paediatrics and Uong Bi General Hospital.
- To enhance the professional, technical and management competence of medical workers and hospital managers.
- To prepare policies and professional statutes concerning medical care services to enhance the role of the Ministry of Health (MoH) in management.

Filling gaps here and there

During the five years of activities from 1994–1999, the Central Hospitals Area made effective use of its full allocation of approximately SEK 35 million. While a major share went into rehabilitation (due to subsiding ground levels at IPCH, the land was levelled for safety reasons, and at UBGH a waste water treatment system was constructed) and replacement of old equipment at the two hospitals, there were also a large number of activities pertaining to human resource development, policy making, and purchasing of medical equipment for other hospitals. In fact, Sida was critical of the wide spread of activities, having expected that more resources would be concentrated at UBGH and IPCH to consolidate their development.

A total of 58 in-country training courses were organised for 2722 trainees. Eighteen groups comprising 68 persons in total, were sent abroad for studying. All training courses (at home and abroad) covered both speciality and management content. Training courses on hospital management were provided for the first time to all managers who lacked adequate knowledge in this area and who expressed a desire to be trained. Training courses relating to specialist areas provided in-depth training to update workers' knowledge in medical care. In addition, other training courses on

financial management, medical equipment management, maintenance of infrastructure, etc., were provided.

The policy documents established and promulgated in the curative system included:

- Hospital management (manual)
- Hospital technique procedures
- Procedural policy relating to the operation of the Drug Information Unit
- Development of hospital management software
- Policies and associated documents relating to co-operation between different units, both within and outside the health sector (e.g. forms for hospital statistics charts, standardised nation-wide case-report form, hospital statute, diversifying medical care categories...)

The purchase of medical equipment has been mainly for UBGH and IPCH, but other central hospitals have been partly equipped: Hospital E, Central Psychiatric Hospital, Bien Hoa Psychiatric Hospital, etc.

The centres of excellency at risk

IPCH and UBGH are two exceptional hospitals among 823 hospitals in Vietnam. The "whole package" support from Sida has enabled the hospitals to become two of the most modern curative health institutions in Vietnam. Although Sida had a policy of gradually reducing financial support to these hospitals, up until 1993, Sida still contributed approximately 50% towards the financing of the hospital budgets. However, these two hospitals also share a number of challenges in common with other hospitals in Vietnam, in terms of staff salary, hospital management, infrastructure upgrading and capacity building.

Following are some observations made of the two hospitals, illustrating the many problems still faced by these facilities in providing a high standard of health care.

> *"The two central hospitals financed by the Swedish Support, namely the Institute of Protection for Child Health (IPCH) and the Uong Bi General Hospital (UBGH), was remarkably degrading: Sinking buildings; cracking walls and leaking roofs, that cause poor sanitation conditions. The medical equipment at IPCH and UBGH had been operated over 15 years. Systems of boilers, electricity, oxygen supply, elevators, etc were out of date and not functional but there were hardly spare-parts for replacement.*
>
> *Hospital management competence was still low: the management of resources in the hospitals was not satisfactory, especially in terms of economic and financial management. Professional skills of the staff were not continuously improved. A nursing system was established but there was still a lack of skills and medical instruments for providing nursing care to patients.*
>
> *There was a lack of regulations on management, regulations on professional techniques and stipulations on important social policies for the patients, which would guide the people to work in accordance with the laws .."* [10]
>
> *"Hospital directors find themselves handicapped by too little responsibility to change the organisation, whether it concerns staffing or the structure of the hospital...*
>
> *Another problem is the low quality of the buildings and the technical equipment.. Naturally the big problem is the low salaries that makes it very difficult to engage the staff whole-*

[10] Tran Thu Thuy, 1997. VSHCP-CHA Result Analysis Report 1994–1997; page 1.

heartedly into their work. Very many of them have to earn money also outside their ordinary working time at the hospital.."[11]

".. the department was totally ignorant of common general rules for radiation protection at x-ray examinations. There were plenty of patients and parents in the rooms when exposures were made. The lead-rubber aprons were not used...

There is an extremely poor retrieval of previous exams of the patients...

Quality assurance: A simple way to start an interest for quality assurance is to count wasted film. In the department there is no such registration.."[12]

6.3 Lessons on institutional development

The continued operation of the two hospitals and the promulgation of policy documents in the curative system provide evidence of institutional development resulting from the CHA. The Area has focused on impacting management skills for management nation-wide. More than 500 managers (directors, vice-directors, chiefs and deputy chiefs of administrative boards at different hospitals, from central to local levels) have participated in training courses relating to hospital management, including economic and financial management.

The two hospitals, IPCH and UBGH, have focused on developing the medical skills of their workers through the provision of training. An evaluation of the effectiveness of these courses (undertaken in Vietnam and abroad) found that hospital services have been strengthened; compliance with MoH norms and regulations has improved; and, managerial effectiveness has been enhanced.[13] Given that the training related to hospital management at the Hanoi School of Public Health is not hospital-based, and the Hanoi Medical School does not provide these types of short training courses, then the training activities of the CHA have certainly improved the management and service capacity of people working in the central hospitals covered by the CHA.

The sustainability of such training courses depends on the capacity of each hospital in creating an appropriate learning environment, as well as on the capacity of MoH to integrate these types of training courses into the regular short training course programs operating at either IPCH, UBGH, or other medical training institutions. Currently, IPCH is one of the main university-based training institutions in paediatrics covering the Vietnamese health sector, while UBGH provides practical training for the nursing training program. In addition, UBGH is officially considered by MoH to be a model program in the provision of hospital management. However, it is of concern that despite the success of the hospital management training courses, the Department of Therapeutic Management has no plans in place to further develop these types of courses, which are so necessary in providing ongoing support and training to hospital management staff.

The Department is, however, pursuing other options than Sida for support to hospital management training. These include collaboration with the School of Public Health, the World Bank funded National Health Support Project and the Rural Health Project with ADB.

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[11] INDEVELOP, 1997. "Report by Dr. Mora Kallner on the consultant mission to CHA". Reference 89/97;

[12] Steffan Sandström, 1996. Consultant mission to IPCH 29/2-30/3/96; p.5.

[13] Evaluation Report of the Effectiveness of Training Courses in Hospital Management During the Agreement Period 1994–1999, and need Assessment of Continuous Training in Hospital Management, Hanoi Medical College- CHA, 1998.

6.4 Lessons on relevance

In reviewing the relevance of the CHA from 1994–1999, it is worthwhile remembering that at the time the healthcare system in Vietnam was heavily affected by the move towards a public and private mix system, as well as the emergence of the country, after approximately fifty years of war and conflict (1940–1989).

Responding to new needs: from a war-directed to a development-based society

As a result, the hospital system was in urgent need of upgrading and renovation. Reform-oriented policy makers, hospital managers and staff were all starting to learn how to run hospitals according to the context of a public-private mix. Meanwhile, policies and guidelines for hospital management were in a premature stage of development, and all modelled on what had previously happened in Vietnamese society. Given this context, the capacity building of MoH and central hospital management staff, through Sida supporting MoH in preparing policy documents for hospital management and providing training on hospital management (including financial management) was, and still is, most relevant to the development of Vietnam's health policy. In addition, the two hospitals, ICPH and UBGH, have taken a leading role by becoming institutions offering the highest quality of medical care in Vietnam. They are also the key training-based hospitals for both undergraduate and graduate health workers in Vietnam.

Phasing out of aid: a reasonable success

The Area focused on supporting the two hospitals in terms of purchasing spare parts and the necessary replacement of equipment for treatment and patient care. Additionally, the Area provided funds for the operation of the hospitals, with the aim of gradually increasing the level of government support, until the government could eventually take over running the hospitals. This support policy has demonstrated its relevance with evidence that contributions from the Area accounted for approximately 20% of total costs annually during the period 1994–1999, and were virtually phased out by the end of 1999.

With a strong political will in the area of health equity, and given the steady development of the country's economy, the hand over of the operation of the two hospitals to the Vietnamese government has been reasonably successful. This is evidenced by the fact that one year since the CHA has been phased out, the two hospitals have maintained quality operational standards, especially the UBGH. There is a need for an valuation of the two hospitals after 3 years of operation without Sida support in order to provide lessons regarding the future support of Sida in the hospital area, as well as to Vietnam in terms of how to receive financial aid assistance in a sustainable way for the curative system.

Another important indicator underlining the relevance of the CHA was that during the five-year period it was almost entirely implemented and managed by national staff, with the exception of one half-time Swedish advisor in 1996, and 19 weeks of short-term consultancy assistance.

Policy work: lacking in reality-check

However, the development of policy documents at MoH is one area relating to project design that is still lacking. CHA supported the Department of Therapeutic Management in developing a number of manuals and guidelines that were promulgated in the curative system. A lack of involvement by an independent organisation in monitoring and evaluating the implementation of those guidelines and policies, as well as evaluating the content of those documents has limited the effectiveness of these policies. The evaluation team, when reviewing documents related to areas

such as hospital technique procedures, recognised that a lot of input was still needed to bring these documents into a form suitable for practical application by the users. Such illustrations demonstrate the need for a clear classification of procedures towards level of service provided.

There is also a need to emphasise a systematic approach in producing policy documents and guidelines in the project. As CHA was almost entirely managed and operated by national staff, the weak points in policy documents and guidelines development were shown. Almost all of their activities were focused on developing policy documents and guidelines relating to the needs they themselves identified, and very little attention was paid to evaluating conditions for applying those policies and guidelines.

One way that Hospital Management Capacity can be evaluated is by assessing the operation of the hospital's information system, and the connection between information collected and decisions made in institutional functioning. The Department of Therapeutic Management developed a statistical network for hospital management information, with the purpose of developing forms for the collection of statistical information related to the health care activities of hospitals. However, it is not apparent what connection exists between this information collected and the policy documents developed, nor of any follow-up of implementing such policies in the curative system.

Can quality at IPCH and UBGH be sustained?

There is no doubt that the creation and operation of the Central Hospitals Area, for the period 1994–1999, was successful. The two hospitals, IPCH and UBGH, seem to be currently operating well in their first year without Sida support. But, how long they can continue to be successful is questioned by many people.

While for many years now a mixed public-private healthcare system has been operating in Vietnam, the public health system continues to play the leading role. A common phenomenon in the public curative system in general, but particularly at IPCH and UBGH during the last five years, is that the number of medical examinations at the central hospitals has increased each year. For example, at UBGH this figure increased from 46,993 in 1994, to 100,213 in 1998, reaching 101,088 in 1999, and at IPCH from 86,788 in 1994, to 144,525 in 1999.[14] At IPCH, there are currently, on average, about 800 patient visits per day, while in 1994 this figure was only 200. Such an increase in the number of patients presenting is definitely beyond the current capacity of IPCH and UBGH.

IPCH and UBGH hospital managers reported two main challenges for the future. The first relates to ageing equipment. Both hospitals have health equipment which is deteriorating, but do not have plans for their replacement. Secondly, financial management and future sustainability of the hospitals was a major concern. Both hospitals are currently running at a deficit. UBGH Director, Dr Nguyen Ngoc Ham, estimated that for the year 2000, the total expenditure of the hospital would be 20 billion VND, yet total revenue will only approximate 18 billion. Revenue sources include the government health budget (50%), hospital fees, and health insurance. While no data was available for IPCH, it is of grave concern that the hospital is running at a greater deficit than UBGH, as 80% of their patients are children, who are exempted from hospital fees.

[14] VSHCP–CHA (1999): Summing-up report of the 1994–1999 cooperation agreement of the central hospital area.

Hospital financing in jeopardy

Yet, it is unclear how hospital managers will respond to both these challenges. In relation to hospital equipment, management at both hospitals were simply searching for alternative donors. Concerning their future financial operations, in the short-term, both hospitals plan to seek additional funding from the government by proposing to increase their number of available beds. In responding to the increase in the number of patient visits, IPCH plans in the coming year to build a new clinic with the capacity for approximately 1000 patients. Whether or not they will receive the funding for this is uncertain.

As yet, hospital managers and policy makers from the Department of Therapeutic Management, have not fully explored avenues relating to research on health financing, nor have they developed plans to respond to the over-utilisation of Central hospitals. In essence, the team was greatly concerned about the uncertainty relating to financial management and sustainability of the two hospital systems, as well as the hospital managers' apparent lack of readiness for independence, despite the reducing grants from Sida.

- A possible explanation for the increasing numbers of patients attending central hospitals may relate to reasons concerning cost-efficiency (recognised by the users themselves) and the current health financing mechanism. There appears to be a perception that people's money is better spent accessing higher quality services and resources through the centralised, rather than localised, health systems. Addressing the gaps in quality of hospital services between district, provincial and central levels depends on many factors. Two important factors include the level of expenditure provided by government to the national health budget, as well as the reformation of health training institutions so that staff at district and provincial hospitals can upgrade their knowledge and professional skills.

Another equally important element in solving the increase of patients at central hospitals is related to health financing and poor salaries received by hospital staff. While the government budget generally covers approximately 60% of the central hospital budgets, and health insurance covers approximately 20% of the Vietnamese population, hospital fees therefore become a significant source of funds for the operation of the hospitals.

Significant proportions of user fees that contribute to hospital budgets are formally used by hospitals to contribute directly to staff income. As a result, patient visits are viewed by some hospital managers as a source of income for their own staff, but this often leads to disparity in incomes between the various hospitals, due to differences in the number of patients. Most disturbing, though, is that as a result of staff incomes being supplemented by user fees, there has been a tendency to pressure users to seek care in private wards in public hospitals. In turn, patients at the lower levels seem to be driven to seek care at the central level as a result of their own analysis of the cost-efficiency of different alternatives between private services at lower levels and the central level.

To resolve these issues, MoH has to implement a series of interventions for:

- Establishing standardised guidelines and policies relating to the quality of hospital care nationwide;
- Implementing a range of strategies to upgrade the quality of services for the most common health problems at district and provincial hospitals, in order to meet the newly established quality standards, starting from a reform of health education institutions; and,
- Restructuring the hospital fees system, based on a multi-disciplinary research approach, as well as independent research on the public-private hospital model. A master plan to respond to this

area is needed now. There seems to be nothing proposed in this area for the next five years, which is of major concern.

6.5 Recommendations

By way of summarising the analysis above, we offer the following recommendations for Sida and MoH, based on the view that the problems and challenges of the curative system ought to a component of a future Vietnam-Sweden Health Cooperation:

- There is a need for emphasising the importance of a systematic approach in policy development and promulgation in the curative system.
- The sustainability of the hospital systems is not secure, and there is an urgent need to improve financial planning and management. We suggest the immediate implementation of a short review program to assist in the planning and development of sound and creative strategies to address financial management and sustainability issues, to counter dependence on donor programs.
- It should be considered to make a study on factors contributing to increasing in-patient visits to the central hospitals, along with the development of a master plan to address the issue of increasing patient visits to central hospitals.
- It is also necessary to undertake an internal assessment and replacement strategy for ageing and deteriorating hospital equipment.
- There needs to be an evaluation of the operation of IPCH and UBGH after 3 years of operation without Sida support.

7. Aid Management and Coordination

7.1 Background and context

Vietnam entered the international aid arena relatively late. Until the mid-1980s foreign assistance had mostly been from the Soviet Union, Eastern Europe and China, with Sweden as a notable exception, being the first Western country to negotiate a bilateral aid agreement with then North Vietnam (Democratic Republic of Vietnam) in 1972, and the only Western country not to withdraw aid in the wake of Vietnam's intervention in Cambodia (1979). With the departure of Vietnamese troops from Cambodia in 1990, coupled with the economic reforms (*doimoi*) gradually taking effect at the beginning of the 1990s, Vietnam has rapidly become a focus of attention of the international development banks and most bilateral donors. The first Donor Conference for Vietnam was held in Paris in 1993, followed by several sectoral Aid Coordination Meetings in 1996 and 1997. The health sector was one of the latecomers when the first coordination meeting took place in March 1997.

Severely constrained in its domestic revenue the government of Vietnam welcomed and encouraged a rapid expansion of aid flows to the country, the health sector becoming one of the major beneficiaries.[15] There seems to be no fully reliable figures on aggregate disbursements of official development assistance (ODA) over the last decade, but it is estimated to have more than doubled between 1991 and 1998. The current ODA disbursement is in the order of USD 60–70million. Whether this constitutes increasing aid dependency within the health sector or not, is also difficult to ascertain. One source categorically states that the share of ODA in total public health spending declined between 1991 and 1998, due to an impressive 20 per cent annual growth in government health spending in the same period.[16] In another report it is concluded that ODA as a percentage of the government health budget has steadily increased up to 1997, and that the trend is likely to continue (from 12 per cent in 1995 to an estimated 22 per cent in 1998).[17] Whatever the trend may be in financial terms, aid has come to play an increasing role in the health sector, and with it a number of teething problems have emerged.

At the 1997 health sector coordination meeting, the government in its report to the meeting lists the following constraints:

- The management and operation of ODA are not closely linked with the health sector's planning.
- The combination of external assistance with domestic resources is far from satisfactory. There have been duplication and scattering.
- There are limitations in capacity for project formulation, review and evaluation.
- There are deficiencies with respect to organisation of project staff, and management mechanisms for external assistance.
- Management information is lacking.
- There is no uniform coordination of ODA sources.

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[15] A government decree of 1994 included the health sector among the 9 priority sectors for ODA loans and grants.

[16] Health Sector Review (draft), p.190

[17] Carlsson, B.T., *Final Report on Aid Coordination in the Ministry of Health Vietnam*, SIPU International, May 1998

In his address to the meeting, the Minister of Planning and Investment, Tran Xuan Gia, added the problems of:

- Lack of familiarisation with donors' procedures and regulations.
- The time required for establishing a legal framework for good management.

Already in 1994 Sida had discussed with the World Bank, now seeking a role as a major investor in the health sector, the possibility of Sweden taking the lead among donors to the health sector in preparing a comprehensive policy oriented donor conference, backed by a series of policy studies, for which the Bank was also seeking sponsors (e.g. Sida). Although Sida recognised its unique position as a donor, in terms of the long history of its presence in the health sector and the policy development focus of the VSHC, Sida at the time also questioned whether the ambitions of the World Bank tallied with the wishes of Vietnam. Is a donors' coordination meeting the forum for policy discussion Vietnam wants, or do they want to restrict the purpose of such a meeting to sharing information with and between donors, the then Chief Adviser to Sida, Göran Dahlgren, asks in an internal Sida memo.[18]

The developments on aid coordination that unfolded in the years to come, proved that Sida's uneasiness reflected some real constraints. Sida took upon itself to support the financing of the March 1997 meeting and soon thereafter, in 1998, agreed to use excess funds under VSHC to support the establishment of a focal point within MoH for aid coordination – the Project Coordination Department (PCD).

7.2 Objectives and achievements

The first agreement period from 1 November 1998 to 30 September 1999 (11 months) was defined by a number of concrete objectives, reflecting great uncertainty with respect to the commitment of MoH to establish an effective aid coordination mechanism. The objectives were:

- Develop a management system for aid programmes and projects
- Make an inventory of on-going and committed aid projects
- Establish a financial management and control system for aid projects
- Support the organisational development of PCD (staff training and working routines)

The final report of the first phase is rather discouraging:

> *"While the commitment to reforming the aid management system in the Ministry still seems to remain intact, the process of reform seems to have been halted. Changing the attitude of many senior officials from one of receiving foreign aid as gifts towards one of active development cooperation has emerged as a critical factor of success of the project."*[19]

Despite a rugged start, some important groundwork was done to assist the reform process. The Area made further studies on the problems of defining the role of PCD, and conducted various capacity building activities (training/workshops/study tours). The most tangible output was the *inventory of donor projects* (now called a "Compendium") completed as of end 1998. This documented

[18] Dated 18 December 1994.

[19] SIPU International AB, 1999. *Consulting Services for the Project Co-ordination Department in the Ministry of Health. Final Report for the period 1 November 1998 through 30 September 1999.*

for the first time the complexity of the aid scene, even without including NGO-funded projects. The inventory gave the following picture.

- 252 projects in total
- 27 different donors
- A total budgetary commitment of USD 937 million of which only 30% had been disbursed.
- The 6 largest donors in terms of disbursement where: World Bank, Japan, Netherlands, UNFPA, Germany and Sweden, in this order.

The justification for continuing the process had clearly been established, and was supported at the highest level in the Ministry, despite resistance further below. It is probably not of great significance, but in view of the uncertainty of the process, it is somewhat surprising that the Project Proposal for 1999–2001 go as far outlining a 10-years strategy. The overall objectives were to:

- Increase the effectiveness of grants and loans
- Attracting more external resources

Progress has remained slow, and has also been hampered by delays in filling the position of a long-term adviser. Still, VSHC can take credit for some important achievements concerning aid coordination. It played a role in getting donor coordination meetings established, currently facilitated by the International Support Group reporting to PCD, and was instrumental in getting PCD established.

Of potentially great importance, is the establishment of five working groups within the Ministry with the mandate to come up with proposals on:

- An organisational model for an aid management system
- A project management system
- A programme for human resources development
- A financial management system
- An aid amendment information system

The groups have not yet submitted their reports.

7.3 Lessons on institutional development and relevance

Highly relevant, but for whom and for what?

There is no doubt that rapid growth of donor funding has created major problems, with respect to overlapping and competing activities, inefficiency and misuse of funds, and inconsistency in strategies and policies. But it is necessary to ask whose interests improved coordination of aid is supposed to serve. Broadly speaking, there are four different agendas related to coordination of aid:

- Coordination of *overall policies* and strategies. The question is in what way this would involve the main donors. The concept of a Sector-Wide Approach (SWAP), as promoted by some key donors, is based on the assumption that it is possible and desirable to aim at a process of consensus building between the Government of Vietnam and all major donor to the sector. The Government appears reluctant to take on-board this concept as a matter of sovereignty in policy making. We note that a recent study on the feasibility of SWAP reported:

"It was made abundantly clear that all policies and plans are the responsibility of the Vietnamese government, not the donors."[20]

- Coordination at the level of project *planning*, including the monitoring of *financial flows*. This necessitates an effective information system, including record keeping on plans, budgets and expenditures. In order to ensure coordination, not merely data collection, some unit in the system needs to be empowered to intervene, if necessary, in fairly detailed processes of activity planning and disbursement of funds. There is reluctance towards centralising such powers.
- Coordination of *lessons* and model-development coming out of the many donor projects. This implies that MoH establishes capacity to assemble, compare, analyse and disseminate lessons from the "living laboratory" of donor projects.
- Coordination of *procedures* for managing externally supported activities. It is on this agenda that the prospects of achieving short-term results within AMC seem the greatest.

What role for PCD?

Progress of AMC depends entirely on the sustainability of the idea of having a PCD, which again depends on which of the four coordination tasks above should make up its mandate. There are obvious conflicts of interest between PCD and existing departments within MoH, and many are afraid of the consequences of creating some sort of super-department responsible for managing the total aid portfolio of MoH.

- Should PCD have a role in the negotiations with donors, which currently is the responsibility of the International Relations Department?
- Should PCD be involved in management of financial flows after signing of project agreements with donors, which currently is a main responsibility of the Finance Department?
- Should PCD have a responsibility for result-based monitoring, which currently is done by various implementing g departments and agencies?

It makes it even more complicated that MoH prefers to keep the support from individual donors separate, and have it managed through so-called Project Management Units (PMU). There is one for Sida (VSHC), one for World Bank, and so on. Formally, these units have been integrated in the PCD, but without any change in management procedures so far. It is a major worry, expressed also by staff of PCD, that the imposition of more cumbersome bureaucratic procedures might seriously delay planning and implementation.

Skills development

There is clearly an important role for PCD to play in enhancing the general knowledge within MoH on how to work with donors. Likewise, donor representatives and international consultants need to be offered training on how MoH prefers cooperation to be. Language skills are also a major factor constraining effective cooperation.

PCD could take the responsibility for developing a training course for programme officers working with donor projects.

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[20] Community Health Training and Consulting Network, 2000. *A sector-wide approach to health care support in Vietnam?* Report submitted to the embassies of the Netherlands and Sweden, p.12.

8. Support to other policy areas

As many as four out of the eight areas identified in 1994 were terminated during the agreement period. This indicates that the ownership within MoH for some of the original ideas and plans had not really been secured, that the much-heralded partnership did not develop in all areas, and that the flexible planning system in fact allowed for adjustment to changing circumstances both within MoH and Sida.

Three areas of support were terminated during the agreement period and one area of support never took off. At the end of 1996 the MCH/FP area was terminated and a year later, in December 1997, the PHC area was finalised and so was the TSSA at the end of 1998. The Health Insurance Area did not start at all.

8.1 Maternal and Child Health/Family Planning

This programme was considered to be one of the most important in the planning document leading to the 1994 agreement. By that time Sexual and Reproductive Health and Rights (SRH) was considered a highly prioritised area for Sida. This area was negotiated into the VSHC and accepted with some reluctance by the MoH. The MCH/FP Area was integrated into the Department of MCH/FP at MoH and the director of the department was appointed Head of Area.

Due to some initial hesitation at the department and difficulties in making the first annual plan of operation (APO) a senior adviser was appointed. An APO was hereafter approved of and the area was able to start its activities in April 1995. The capacity and capability of the staff at the MCH/FP department was at the time not sufficient to carry out such a programme and there was a lack of commitment from Head of Area for this undertaking.

The *objectives* of the MCH/FP was to improve the capacity of the Department of MCH/FP to develop policies and guidelines, including adolescent health and HIV/AIDS. Also to reduce risk of disability and mortality of women during pregnancy and childbirth; and of young children and as well to reduce disability and death among adolescents and young adults resulting from sexually transmitted diseases and abortion.

The *activities* performed were study tours and four working groups were established to develop policies and guidelines within the area. Two books were published, a Manual in MCH/FP and one on Adolescent and Reproductive Health.

Two pilot districts were selected to provide a model for maternal health issues and adolescent health. Working routines were developed but never implemented. District Peoples Committee supported the undertaking and a clear division of responsibilities was put in place. Some good results were reported but no LTA was ever appointed.

After a slow start the Area took off, but then suddenly Sida decided to withdraw its support to this Area of support. The reason given was that Sida needed to concentrate its activities and also that many other donors were active in this particular field. Sida decided to terminate the MCH/FP area at the end of 1996, after only 20 months of operation. The decision to terminate the MCH/FP programme came as a surprise to most of the people engaged. It created a great confusion among staff in the two pilot districts. The director of CMO and the senior adviser, we have been told, were both strongly against the decision.

The policy part of the programme was to be taken over by the Health Policy Area including the adolescent health policy and strategy.

A very promising initiative is the first policy paper ever on adolescent health, which is being put forward for the agreement period 1999–2001. The aim is to formulate an operational national strategy for adolescent health with particular focus on using schools as an arena for health promotion and disease prevention.

Today many international as well as national NGOs are active within the field of sexual and reproductive health (SRH). There are also many government actors in the field of HIV/AIDS and SRH. There is at present a need to co-ordinate all these efforts and to create a link to the MoH for making best use of available resources and to get a comprehensive picture of whom is doing what within this important field.

8.2 The Primary Health Care Area

Primary Health Care units have been part of the health care system in northern parts of Vietnam since the 1960s but covering the whole country since 1975. In the 1980s a number of national vertical programmes with specific objectives developed and initially they had a good impact on the health of the population. However, during the late 1980s and 1990s more and more such programmes were introduced at grass-root level. There was no unified monitoring, common direction or integration of these programmes but rather an overlapping that sometimes gave the grass-root level an unnecessary work burden. As a result the PHC Unit was established at the MoH in 1993 to advice on matters within primary health care.

Sida decided to support the work of the PHC Unit as part of VSHC, but the support lasted only until December 1997.

The *objective* of the Area was to improve the capacity of MoH to collect and analyse information about primary health care, commission research and studies in PHC; formulate and propose PHC policies and legislation. Further to develop and test PHC procedures and guidelines, develop and evaluate methods of local financing for PHC and co-ordinate donor support for PHC and generally to promote PHC.

The *activities* carried out were diverse. A number of studies were performed and a Sentinel Surveillance System was set up for continuous data collection in the population. The rapid economic and social change going on in the country had an impact on the health situation of the people, and this was to be followed up continuously.

A PHC library was established and a journal and a newsletter were produced and disseminated to all CHSs. Numerous guidelines, handbooks and journals were produced and disseminated.

Donor co-ordination was not a very successful activity due to the lack of authority of the PHC Unit to shoulder such an activity. A national policy for PHC was drafted but it resulted only in a circular that later was to be implemented in 61 provinces. The results of this never became available as the Area was terminated. It was suggested that the Health Policy Area should take over this responsibility from 1998 and onwards.

Many of the activities of the PHC Unit had limited impact as they were not effectively introduced and used by other PHC programmes.

During its last year, 1997, the PHC Unit tried to finalise as many of the ongoing activities as possible. The Area of support was terminated in December 1997. From the Sida office in Stockholm it was said that a concentration of activities was necessary and that many other donor organisations were active in this field. This seems not to have been a too controversial decision. The policy part of the programme was transferred to the Health Policy Area.

In the project document for the Health Policy Area 1999–2001 it is stated that major emphasis will be put on formulating a long-term vision for the health care sector. A main aim is to reduce social and gender specific inequities as regards access to and utilisation of preventive and curative health services particularly at commune level. Of high priority is to provide all communes with qualified midwives and 40% of the communes with physicians. Particular attention will also be given to developing a subsidised health insurance system, especially for the 1715 poor communities included in the Government's overall Poverty Alleviation Strategy. Most of these poor communes are located within the SDA catchment area. National public health policies and strategies are also being formulated with regard to injury prevention/safe communities, tobacco control, adolescent health and for reducing perinatal mortality.

8.3 Training Systems Support Area

With the transition from a central planning economy to a market economy, there was no clear mechanism how to guide changes in the training system. Managers were in need of retraining to adjust to the new realities and be able to adopt new approaches to management. Funds provided by the Government were totally inadequate. The Training System Support Area (TSSA) sought to fill a part of these gaps.

TSSA, one of the eight areas of the agreement in 1994, was a continuation of the Training System Support Project which started in 1990. TSSA aimed at more ambitious changes in the MoH's training system than the former TSSP, by integrating its activities into the mainstream training responsibilities of the Department of Science and Training (DST).

The *objective* of TSSA was to achieve an improved capacity of the DST to plan the health work force, to finance training and retraining from its own sources, and to manage the training system. The training system of the MoH includes a network of university and technical training schools, about 80 institutions in the country, for which the DST has a technical responsibility.

The *activities* were many: defining a national policy for health worker training, definition of key management procedures, secondary medical school management was strengthened, a number of curricula, textbooks and examination papers concerned with nursing and medical care were published. Further, terms of reference for a National Educational Board (NEB) was prepared and submitted, study tours to neighbouring countries were performed, teachers training units were established, a health manpower plan was drafted.

From the start in October 1994, a total of three APOs were prepared. The number of objectives to be reached was scaled down over the years in an attempt to concentrate the activities. The results achieved are well documented in the External Evaluation of the Area by Claudio Shuftan and colleagues. The evaluation report gives a rather positive view of the achievements of the DST during the implementation of TSSA although there were some real difficulties related to management of the Area during the whole period. Some of the main achievements related to:

– The development of a retraining system – a new area in Vietnam
– Planning, financing and management of health staff training
– The upgrading of training curriculum to regional and international standards
– Introduction of new training methods

The management problems were related to lack of co-operation within TSSA and the lack of integration of LTAs. It has been reported that AMG meetings became irregular and at times transferred to DST meetings in which the LTA did not participate. TSSA meetings were not used for strategic discussions and APOs were poorly used for monitoring purposes. The two LTAs contracted for the area both experienced difficulties in collaborating within the management of the Area, and they felt they were kept outside decision-making processes and in this way highly under-utilised. They felt they had insufficient access to financial information, that there was a lack of co-operation between CMO and DST, and that staff within DST suffered from poor skills and leadership competence. Further, there was a perception within Department of Science and Training that the LTAs "were not culturally sensitive to factors in government administration".

The interest among staff to study English was initially strong, but faded over the operating period. There was an incomplete follow up on recommendations from short-term advisers (STA) even though they were considered of good quality and accepted by the leadership of DST. There were few women appointed in the DST and there was a lack of gender awareness in policies and activities.

In general, Sida felt there was a lack of recognition in MoH of the management deficiencies within TSSA. Sida did not approve the 1998 APO, and agreement on a revised APO was never reached in subsequent negotiations. This resulted in a decision to phase out the Area and the LTA at the time tendered her resignation four months prior to end of contract. As this was close to the termination of the agreement period it was decided not to close the Area in advance.

Most of the TSSA activities have not been continued after the Sida support was withdrawn. The evaluation team outlined a number of recommendations to DST and to VSHC in their evaluation report. It is not mentioned in the Final Report of the Cooperation, MoH March 2000, if any of these were followed up upon.

There was also a suggestion to institutionalise a School of Public Health for post-graduate training in Vietnam. A suggestion was outlined in a report by a Vietnamese-expatriate team (Public Health Training in Vietnam: A report to the MoH and Sida, January 1996). Discussions between MoH and Sida concerning budget allocation and affiliation of the School of Public Health were not brought to a satisfactory conclusion and the idea was not pursued.

9. General lessons on aid effectiveness

There have been several attempts over the years to answer the big question: "Does aid work?" and if so under which circumstances is aid most effective. The report "Assessing Aid", published by the World Bank in 1998, has generally been accepted to reflect current wisdom, summed up in the following bullet points:

The "Assessing Aid" study concluded:

- Money works – once countries reform
- Ideas work better than money in
    - generating reform
    - improving public service
- The value of development projects is to strengthen institutions and policies
- An active civil society improves public services

It is interesting in the context of VSHC that the World Bank report presents Vietnam as a country where aid has been particularly effective. Sweden and UNDP, together with the World Bank, it says, played a key role in providing ideas, helping Vietnam to learn from the policy experiences of its neighbouring countries. The VSHC represents a form of aid that falls in line with the conclusions on aid effectiveness above.

Changing the scope of the Cooperation in 1994 to prioritise institutional development and policy work, was obviously an appropriate and necessary move. The new visions and concepts underpinning the 1994 Agreement, however, were not widely shared in the Ministry of Health. Both the capacity and the incentives of the designated departments and agencies within the Ministry to actively take part in an institutional development process varied and generally were overestimated by the architects of VSHC-I. The Ministry at the time had a very weak organisational culture for learning and experimenting.

As we have seen, in some instances the VSHC-initiatives did not work, while in others there have been encouraging results. What can we learn from this? Let us look at negative lessons first.

9.1 Problems – negative lessons

- VSHC has had *too much money*. It was a mistake to announce a large budget before the planning process had really started. Three problems developed from this. Firstly, a planning process developed that was driven too much by a pressure for spending beyond what realistically could be achieved. Secondly, the large budget sent mixed signals into the system, since high spending was only possible through financing of regular service delivery operations. SDA, in particular, suffered from this mixed message, trying to develop a new model in parallel with furnishing "the old model" with materials and equipment. Gradually, however, the demand for new ideas increased. "Ideas work better than money in generating reform". Thirdly, we see a tendency that the soft budget constraints led to a lack of cost-consciousness in the selection and design of activities, and a growing problem of cost-control. On several occasions Sida raised concerns over potential misuse of funds, and in a few cases requested an inquiry. The cost-control rou-

tines have improved steadily over the years. It is also commented by some, that none of the key stakeholders in the Cooperation had any incentives to develop more modest plans and budgets, and this included the long-term advisers as well.

- Related to the above, the programme has had a problem with respect to *quality and result-based monitoring*, and MoH in its own assessment concluded: "Throughout the Cooperation, the focus of achievement has been on quantity (e.g. expressed in the number of activities, budget and expenditures). There is a need to shift the focus to quality".[21]

- There are concrete attempts to improve monitoring in VSHC-II, but it is premature to evaluate these efforts. A word of caution is warranted, however. It is always difficult, and at times impossible, to find relevant and monitorable indicators of qualitative changes in policy development and institutional change. The most important is to keep the focus on the direction of reform and invest in continuous *learning and dialogue* rather than putting too much emphasis on "logical frameworks".

- There have been major achievements in *competence development* at an individual level, across the areas, but this has not benefited the institutions in a systematic manner. While in some cases there has been a gradual build-up of competence and experience in the organisation, there has been a general problem of high turnover of staff. In addition, it is reported that the selection of staff for training has not always been the most relevant. For instance, MoH has been criticised in some instances for selecting candidates for study-trips abroad based more on seniority than function.

- *Language* skills are still a major impediment to development cooperation in Vietnam, although it has improved dramatically since the early days of hospital construction. VSHC has invested generously in English language training, but the effectiveness of much of the advisory support from especially short-term advisers can be questioned. Very many of their reports exist only in English, and there is considerable scope for improving the dissemination of findings and recommendations.

- The *quality of training* depends on good interpersonal communication. Most observers argue that on-the-job training has by far been the most effective. Furthermore, that the system benefits more from long-term advisers, compared with short-term advisers, provided "the personal chemistry is right". This places special demands on the recruitment process. Sida, through VSHC, has supported a process of allowing MoH to play a more active and decisive role in the recruitment of advisers. This facilitates important capacity building, as well as providing the best starting point for the one to take up the assignment. The second most effective form of competence building is well-prepared courses in Vietnam using high calibre international lecturers.

- The *costs of advisory support* constitute a major share of VSHC. PMU reports that the total expenditure for LTAs and STAs is 40% of the budget, and if local consultants and advisers are included, the figure raises to 60%. In an institutional and policy development programme this is not a staggering figure, but it calls the attention to the importance of focusing on the efficiency of the Technical Assistance component of VSHC.

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[21] MoH. 2000. *Final Report of the Cooperation*, p. 48

- The *culture of learning* within MoH needs to be further strengthened, and there is a particular problem, and a challenge, with respect to designing of projects as experiments. There is a tendency that pilot projects are created as a means to distribute funds to the operational level, as widely as possible, rather than with a clear experimental design in mind. We have argued that SDA suffers from a poorly developed experimental design, despite its clearly stated objectives in terms of model development.

- A major constraint on achieving the objectives of VSHC is the *incentive structure* within the public sector. There has been frequent changes of management of the Areas, and it has proved difficult to attract and retain the best qualified staff. This leads to the classic dilemma common to most aid-dependant countries: a pressure to use donor funds to give special incentives to workers in donor projects, over and above the general standard of the public sector. We would argue, however, that the primary focus has to be on performance and quality of outputs rather than equity in benefits. MoH did approve certain facilities for VSHC to be able to attract quality staff, and we would encourage PMU and Sida to keep up the pressure this issue.

- The downside of allowing for a flexible planning system, to a donor, is the sense of loosing financial control. The response of Sida was to impose very elaborate *planning and reporting requirements*. It was realised, however, that much of this did not serve the purpose – that too much time was allocated to the preparation of documents that only marginally improved quality of work. It is a lesson for the future to establish a less labour demanding and costly planning and reporting system.

9.2 Achievements – positive lessons

It is an important observation that problems, such as those listed above, can represent both lack of success and progress at the same time. This is typical of an institutional reform process. Indicators of progress are related as much to the process (the way the institution improves its way of working) as to the outputs themselves. A major test of progress is whether there is an ability to learn from problems and progressively do something with them.

There are indications that VSHC, compared with the situation in 1994, has become an important element of several learning and reform processes of the Ministry of Health – which indeed was a major objective. We shall refrain from speculating on the outcome of these processes, but do find much within VSHC that gives room for optimism with respect to the continuation – i.e. that these are reasons for seeing the glass as half-full:

- The *ownership* by MoH of the institutional development processes and policy-making process has steadily increased over time.
- There has been a continued building of *trust,* and transparency with respect to internal operations is improving.
- The *quality of the policy-making* processes is improving, for instance with respect to consultation with other stakeholders and the quality of the research inputs. It is recognised that policy-making is "muddling through" rather than a "logical" exercise, and that it takes time.
- The management of the aid is becoming *more integrated* into MoH, greatly facilitated by the decision to merge the consultant's office (IPO) with the MoH office for VSHC (CMO), now called the Programme Management Unit.
- There has been an improvement in the *professional dialogue* and the use of international advisers. The "advice-receiving" capacity of MoH has significantly improved.

- The *flexibility* in planning has allowed for a fruitful trial and error approach.
- The management of the aid has gradually improved. VSHC represents today, according to MoH, the *best managed* aid programme in the Ministry. The procedures established ought to be standardised and used in other donor projects. Only then can the major overhead costs involved really be justified.

9.3 General conclusions

We started out by identifying two perspectives for an evaluation of lessons learned within VSHC, namely:

- Has the investment in capacity building resulted in institutional development within MoH – i.e. in terms of the ability to deliver expected outputs and carry out changes?
- Has the investment in policy development resulted in more relevant policies?

There is a mixed picture being painted above, for the different areas, but we give an affirmative answer to both questions above. Many positive developments have been reported. While it is not possible to draw any conclusions with respect to impacts of VSHC in terms of the health status in the population, it is possible to infer that the programme has assisted MoH responding to changes in peoples' living conditions and health seek behavior brought about by the economic growth in recent years.

Investing in reform is a high-risk form of aid. Achievements are neither predictable nor easily measurable. General lessons on aid and reform have told us the limitations of donor-driven approaches. Policy-based conditionality has not been effective, at least not in the long run. Investing in reform means operating in an institutional and political environment where other forces than the aid relationship dictate progress. On the part of the donor, it requires ability to adjust to new opportunities being created and sensitivity to domestic political matters. On the part of the recipient, it requires a felt need for change and willingness to engage in partnerships for mutual learning. To both parties, time is a crucial factor, and the ability to communicate is critical. We find that individuals matter a lot – as builders of trust and carriers of insight and empathy about the other party. On both sides there needs to be a meeting of minds and a sense among key players that they are able to forge a strategic alliance. Neither donors, like Sida, nor recipients, like MoH, represent monolithic agencies. Taking the risks of investing in reform – and to succeed, require brokers and entrepreneurs on both sides of the partnership.

We find that VSHC has parts of all these elements in place:

- A flexible planning process
- A long history of cooperation with building of trust
- A sense of shared values in terms of health politics
- Individuals with a long-standing commitment to the cooperation
- An increasing number of people with relevant skills

All of this will not by itself create a successful reform, but it increases the probability that investment in capacity building leads to institutional development, and that investment in policy formulation leads to effective implementation of relevant policies. In this respect, the job of MoH is far from completed! The glass is only half-full.

- While there has been significant improvements in individual competence, through VSHC, there is still a lot to do to improve institutional efficiency. We have not attempted to assess the cost-efficiency of the VSHC investments, but there is obviously a need to continue the work towards reducing the overhead costs of the progamme, much of which is related to the lack of trust on the part of Sida in MoH's own monitoring and financial control procedures.
    - MoH has a job to do to improve the level of confidence on the part of Sida, to pave the way for more partnership and less control.

- While VSHC has contributed to an impressive number of policy-relevant studies, and the enactment of concrete policies, there is still a long way before this policy work has made a real impact in the field.
    - There is a need to shift the work towards operationalisation of policies. How to implement the new policies?

- While we conclude that there are many reasons justifying a continuation of the cooperation, based on the established framework of cooperation, we see the need to continue modifying and adapting the content of the programme.

    - Much of the future work of VSHC will have to deal with *provinces and districts.* Supporting the implementation of new health polices will require new institutional frameworks for cooperation at those levels.

    - Sida should not get involved in implementation in the sense of carrying regular operational costs, but should continue assisting the process of *disseminating* new ideas and models. There is now a great need to focus on how to replicate at lower levels what is being produced at the policy drawing table in the centre.

    - There is also a need to take a fresh look at the configuration and conceptualisation of areas within VSHC. It has not been the purpose of this evaluation to look into the future scope for VSHC, but we note that there is a need to reintroduce, in one way or another, the *hospital sector* to the Vietnam-Sweden Health Cooperation. It is not for sentimental reasons, being where it all started in 1974, but in recognition of where the brunt of popular pressure on health services is going to come.

10. Literature consulted

10.1 Some general literature on health development in Vietnam

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Tripping, G., Truong, V.D., Nguyen, T.T., and Segall, M.M., 1994. "Quality of public health services and household health care decisions in rural communes of Vietnam", *IDS Research Report*, No 27, Brighton:IDS.

World Bank, 1999. *Vietnam: Consultations with the Poor*, a synthesis of participatory poverty assessments from four sites in Vietnam, Hanoi: World Bank.

10.2 Vietnamese health policy documents

"Strategic Orientation for People's Health Care and Protection in the Period of 1996–2000 and Vietnam's National Drug Policy". Socialist Republic of Vietnam, Ministry of Health, Hanoi, 1996

"Strategy for Peoples Health Care During 2001–2010", Socialist Republic of Vietnam, Ministry of Health, Hanoi, 2000

"Strategic orientation on health care and protection for people in mountainous and remote areas, period 2001–2010". Socialist Republic of Vietnam, Ministry of Health

10.3 Project documents (chronological list)

Programme overall

1992	*Doi Moi and Health: Evaluation of the Health Sector Co-operation Programme between Viet Nam and Sweden*, Sida Evaluation Report 1992/3, Jan Valdelin et al
1993, June 24	Promemoria. Förlengning av stöd till hälsosektoren i Vietnam 1993/94
1994, April 20	MoU on the development cooperation. July 1, 1994 to December 31, 1997
1994, September	Planning Document for VSHC 1994-1999
1994, Sept. 21	Insatspromemoria
1994, November	Specific Agreement; October 1, 1994 – December 31, 1999
1995, April	Agreed minutes Semi-annual Review
1995, November	Inception Report, InDevelop
1995, December	Agreed minutes Annual Review
1995, December	Annual Review Meeting: Agenda/Documents
1996, June	Agreed minutes Semi-annual Review
1996, June	Guidelines for Planning, Reporting, Documentation etc in Vietnam-Sweden Health Cooperation according to revised minutes of the semi-annual review, Hanoi June 1996 + list of reporting requirements
1996, December	Instruktion. Instructions to Sida delegation at annual review
1996, December	Agreed minutes Annual Review
1996, December	Annual Review Meeting: Agenda/Documents
1997, February	APR 1996 (Annual Progress Report)
1997, April	"Health Cooperation between Vietnam and Sweden", General presentation, Anders Wikman
1997, April	Gender issues, Wikman/InDevelop
1997, May 29	Riktlinjer för halvårsgenomgång
1997, June	Instruktion. Instructions to Sida delegation at semi-annual review
1997, June	Agreed minutes Semi-annual Review
1997, June	Semi-annual Review Meeting: Agenda/Documents
1997, June	Collaboration between MoH staff and advisers. Discussion Note, A Wikman
1997, September	Audit for the year ending 31st December 1996, Price Waterhouse
1997, September	Result Analysis Report + Annexes
1997, December	Instruktion. Instructions to Sida delegation at annual review
1997, December	Agreed minutes Annual Review
1997, December	Annual Review Meeting: Agenda/Documents
1997, December	Agreed Minutes: Annual Review
1998	Aggregated Annual Report 94-97, InDevelop
1998, February	APR 1997
1998, May	Program Status Report
1998, May 25	Promemoria. Inledande beredning. C. Larsson
1998, June	Instruktion. Instructions to Sida delegation at semi-annual review
1998, June	Agreed minutes Semi-annual Review
1999	Project Document July 1999- December 2001

1999	Evaluation of competence development within VSHC
1999	Assessment on the implementation of training abroad activities 1994-1999
1999, January	Audit Report for the year ended 31st December 1997, Price Waterhouse Coopers
1999, May	Sida comments on the Project documents presented in April 1999
1999, May	Instruktion. Instructions to Sida delegation at semi-annual review
1999, May	Agreed minutes Semi-annual Review
1999, May 24	G. Edgren, "Building Partnership in the Vietnamese Health Sector", Memo
1999, June	Final Report of the Consultant, InDevelop
1999, June	Assessment on the implementation of gender issues
1999, June 21	G. Edgren, "More effective use of ODA Money through stronger partnerships"
1999, September	Inception Report, InDevelop
1999, October	Memorandum on Examination for the year ended 31st December 1998, Price Waterhouse Coopers
1999, December	Agreed minutes Annual Review
2000, March	Final Financial Report for VSHC 1994-1999
2000, March	Final Report of the Cooperation, Ministry of Health + Annex
2000, April	Memorandum on Examination for the 21-month period ended 30th September 1999, Price Waterhouse Coopers
2000 April	Annual Report on Consultancy Services 1999.07.01 – 2000.03.31
2000, May	Vietnam-Sweden Health Co-operation 2 (VSHC-2), Monitoring report, Permanent Advisory Group, Staffan Engblom et al.

Health Policy

1994, October	Plan of operations 01/10/1994 – 31/12/1995
1995	Revised Budget, Plan of operations 01/10/1994-31/12/1995 – as of 31 March 1995
1995, April	Consultancy Report, Bo Stenson
1996	APO 1996
1997, April	APO 1997
1997, September	Result Analysis Report on Cooperation (from 10/1994 TO 6/1997), Nguyen Quang Cu, Hanoi
1997, October	Consultancy Visit to Vietnam, Report by Bo Stenson, Senior Advisor to Area of Health Policy, Indevelop, Uppsala
1997, November	APO 1998
1998, May	Addendum to APO 1998 for Jan-Jun 1999
1999, May	Consultancy visit to Vietnam, Area of Health Policy, Internal Assessment of the 1994-1999 projects supported by Sida, Agne Andersson, Indevelop
1999, July	Planning Document for 1999 – 2001
1999, August	Assessment of the Health Policy Area 1994-1999
n.d.	Minutes of the Evaluation Meeting Appraising Policy-Related Scientific Studies carried out within the Health Policy Area
2000	*Various working papers from HPU:*

	HPA – A self-assessment as regards competence development, equity focus, relevance and aid management (focus on 1998 – 2000) Studies and Reports from the Health Policy Area, Ministry of Health 1994-1999. HPA List of Implementing Institutions/Departments Health Policy Area – List of Duties/responsibilities as related to the implementation of the plan of operation for 1999-2001

Support to Disadvantaged Areas

1997, December	APO 1998
1997, December	APO 1997
1998	SDA Review, Support for Disadvantaged Areas: past present and future (Bagerella)
1998, January	Annex to APO: Planning Schedule January 1998 to June 1999
1998, January	Annex to APO: Activities/outputs January 1998 to June 1999
1999	Final Report 1994-1999
1999, April	Appraisal Report. Gordon Tamm
1999, July	Project Document. July 1999 to December 2001
2000, September	SDA Presentation Folder (draft)

Drug Policy and Control

1996	Paul Lalvani et.al. "Report of a Ministry of Health/WHO/SIDA Joint Mission for Development of a Masterplan for the National Drug Policy of Vietnam". WHO/Indevelop. Uppsala
1996, December	APO 1997
1997, August	Project Document: July 1999 – December 2001
1997, October	APO 1998
1999, May	Appraisal Report. Dukes and Everard
1999, July	Project Document for the period 01/07/99-31/12/01
1999, October	Final Report 1994-1999

Aid Management and Coordination

1998, May	Final Report on Aid Coordination, SIPU, Björn Tore Karlsson
1998, November	Decision on Aid Coordination Project + Plan of Operation
1999 January	Inception Report, SIPU
1999, May	Project Proposal: Building capacity for aid management and coordination in the health sector
2000, February	List of document for the appraisal of the AMC
2000, May	"Aid Management and Coordination in Health Sector", Appraisal report (draft). Community Health Training and Consulting Network
2000, July	"A sector-wide approach to health care support in Vietnam". Exploratory report (draft). Community Health Training and Consulting Network

Training Systems Support

1996, October	APO 1997
1996, December	Consultancy Report, Fred Abbatt; Monitoring of the TSS
1997, November	APO 1998
1999, March	External Evaluation (Shuftan et al.)

Central Hospital

1996, March	Consultancy report; Rolf Nilsson
1996, May	Consultancy report; Staffan Sandstrom
1996, December	APO 1997
1997, February	End of Contract Report; Mora Kallner
1997, October	APO 1998
1997, October	Consultancy report; Mora Kallner
1998, July	Addendum to APO 1998 for Jan-Jun 1999
1999	Assessment of the performance of the plan of action of the Central Hospital Area 1994-1999

Cooperation Management

1995, September	Consultancy Report; Agne Andersson
1996, April	Consultancy Report; Agne Andersson
1996, December	APO 1997
1997, October	End of Contract Report; Anders Wikman
1997, November	APO 1998
1998, January	Plan for strengthening interaction between CMO and IPO, and for better utilisation of long term advisers
1998, March	Aggregated Annual Reports 1994 –1997 InDevelop
1998, June	Addendum to APO 1998: Jan-June 1999
1998, September	End of Contract Report; Olle Henriksson, Financial Adviser
1999	CMO Final Report 1994-1999
1999, March	Annual Report 1998 InDevelop
1999, March	End of Contract Report; Melinda Öjermark, Chief Adviser

Primary Health Care and MCH/FP

1995, August	Consultancy report; Jayprakash; sentinel surveillance
1996, December	APO 1997
1997, January	Consultancy report; Bengt Höjer

11. People interviewed

Ministry of Health (general)	
Prof. Pham Manh Hung	Vice Minister
Ass. Prof. Le Van Truyen	Vice-Minister
Dr. Hong Ngu	MCH/FP Department, Project Officer
Dr. Nguyen Kim Phong	Former Head of VSHC/CMO
Sida	
Per Lundell	Councillor Development Cooperation, Embassy of Sweden, Hanoi
Anders Nordström	Head, Health Division
Susanne Lokrantz	Programme Officer, Health Division
Christina Larsson	First Secretary, Embassy of Sweden
Pham Nguyen Ha	National Programme Officer, Embassy of Sweden
Programme Management Unit (PMU)	
Dr. Hoang Thi Hiep	Head of PMU
Nguyen Nam Phuong	Interpreter
Tran Lan Phuong	Project officer
Nguyen Dinh Cuong	Program Officer
Nguyen Thu Cuong	Accountant
Nguyen Hoang Nga	Secretary
Nguyen Van Nguyen	Accountant
Max Blumenberg	Financial/Management Advisor
Project Coordination Department (PCD)	
Dr. Hoang Thi Hiep	Vice Director of PCD
Phung Lan Huong	Project Officer
Ha Van Thuy	Project Officer
Duong Quang Tao	Project Officer

Department of Planning and Health Policy Area	
Dr. Duong Huy Lieu	Director, Dept. of Planning
Ass. Prof. Truong Viet Dung	Vice-Director
Tran Van Hien	Deputy Director
Luu Hoai Chuan	Vice Head, Health Policy Unit
Dr. Göran Dahlgren	Long-term advisor
Dr. Nguyen Hoang Long	HPU officer

Vu Van Chinh	HPU officer
Hoang Thi Giang	HPU officer
Ngo Tien Loi	HPU project officer
Dr. Nguyen Quang Cu	HPU senior officer
Area of Drug Policy and Control (ADPC)	
Dr. Nguyen Vi Ninh	General Director, Drug Administration of Vietnam; Head of ADPC
Tran Duc Chinh	Secretary, ADPC
Prof. Nguyen Thanh Do	Head of Vietnamese National Drug Formulary (VNDF),Editing Board
Nguyen Xuan Hung	Programme Officer, ADPC
Vu Thuy Phuong	Programme Officer, ADPC
Dr. Sam Törnquist	Rational Drug Use Advisor, ADPC
Prof. Hoang Tich Huyen	Head Advertise Drug Research Centre (ADR)
Dr. Tran Thi Nhung	Programme Officer, ADR
Vu Thi Ngoc Thanh	Dept. of Pharmacology, Hanoi Medical School; ADR part-time member.
Prof. Trinh Van Quy	Director National Institute of Drug Quality Control (NIDQC), Hanoi
Nguyen Trong Lun	Head, Planning Dept. NIDQC
Tran Duc Chinh	Secretary ADPC; Head Drug Information & Advertising Control, Drug Administration of Vietnam
Einar Magnusson	Pharmaceutical Advisor, ADPC
Nguyen Xuan Hung	Programme Officer, ADPC
Prof. Tu Minh Koong	Dean, College of Pharmacy, Hanoi School of Pharmacy
Nguyen Manh Pha	Drug Information Centre
Prof. Nguyen Thi Du	Director, Poison Control Centre, Bach Mai Hospital.
Prof. Le Dang Ha	Director, National Institute for Clinical Research in Tropical Medicine; Chairman, NPSAR
National Institute of Paediatrics, Hanoi	
Prof. Nguyen Cong Khanh	Director
Dr. Loc	Medical Director
Uong Bi General Hospital (UBGH)	
Dr. Nguyen Ngoc Ham	Director
Dr. Nguyen NgocTan	Vice Director
Dr. Le Van Thiem	Vice Director
Dr. Vu Van Tam	Head of Department of Planning

Institute of Health Strategies and Policies (IHSP), Ministry of Health	
Prof. Pham Huy Dung	Deputy Director
Nguyen Khanh Phuong	Researcher
Reproductive and Family Health Center (RaPH)	
Nguyen Thi Hoai Duc	Director, RaPH centre
Department of Therapy	
Dr. Tran Thu Thuy	Director
Nguyen Thi Phuong Cham	Pharmacist
Hanoi School of Public Health (HSPH)	
Le Vu Anh	Dean
Ministry of Planning and Investment	
Do Xuan Thong	Senior Officer, Department of International Relations
Bach Mai Hospital	
Ass. Prof. Nguyen Thi Du	Director, Poison Control Centre, Bach Mai Hospital; Deputy Head of Emergence & Intensive Care Medicine Department, Hanoi Medical School
Thi Hong Chau	Head of Pharmacy Department, Bach Mai Hospital

Institute of Clinical Science of Tropical Diseases	
Prof. Le Dang Ha	Director, and Head of Antibiotic Resistance Surveillance Program (ASTS)
Pham Van Ca	Secretary, ASTS
Quang Ninh Province (general)	
Dr Nguyen Thi Thep	Director, Provincial Health Bureau (PHB)
Dr. Hien	Head, Dept. of Planning, PHB
Dr. Hoa	Training department, PHB
Dr. Minh	Director, District health centre, Binh Lieu
Dr. Minh	Director, District health centre ,Hoanh Bo
Dr. Trang	Director, District health centre, Bache
Dr. Hoa	Dean, Secondary Medical School, Hong Gai
Dr. Phuong	Director, Provincial Hospital Hong Gai
Dr. Thao	Dept. of Infectious Diseases, Provincial Hospital Hong Gai
Binh	Provincial Quality Control Laboratory, Hong Gai
Nguyen Thi Hai	Assistant Physician, Head of Ha Phong Commune Health

	Centre
Vu Thi Hien	Ass. Physician, Ha Phong Commune Health Centre
Luc Thi Lan	Midwife, Ha Phong Commune Health Centre
Van Boc	Doctor Assistant, Phuong Nam Commune Health Station
Ha Giang Province (general)	
Do Trong Quy	Vice Chairman, Provincial People's Committee
Hoang Xuan Du	Health Expert, Provincial People's Committee
Phung Cao Cuong	Director, Ha Giang Health Bureau (HGHB)
Nguyen Mong Ngoc	Deputy Director HGHB
Ngoc Mai Canh	Deputy Director HGHB
Luong Viet Thuan	Head of Planning Division HGHB
Dinh Hong Son	Head of Pharmaceutical Division HGHB
Hoang Dien Tuong	Expert, Planning Division HGHB
Nguyen Thanh Son	Expert, Finance-Accounting Division HGHB
Luong Van Son	Vice Chairman, Vi Xuyen People's Committee
Dong Van Huynh	Director, Vi Xuyen District Health Centre
Pham Van Kiem	Vice Head, Viet Lam Commune Health Station
Tuyen Quang Province (general)	
Mai Ngoc Chan	Director Tuyen Quang Health Bureau and Head of PMG
Nguyen Dinh Hung	Head of Planning Division, Tuyen Quang Health Bureau and PMG Secretary
La Dang Tai	Head of DMG, Na Hang District Health Centre
Nguyen Van Dung	Head of Planning Division, Na Hang District Health Centre and DMG Secretary
Loc Quang Ich	Head of Thuong Lam Commune Health Station/Regional Clinic
Swedish consultants	
Agne Andersson	former Chief Adviser – IPO
Melinda Öjermark	Senior Consultant, InDevelop, Uppsala
Sten Olsson	former Senior Adviser
Anders Wikman	former Chief Advisor – IPO
Agneta Lindsjö	Programme Officer, InDevelop, Uppsala
Olle Henriksson	former Financial Adviser – IPO

Annex 1

Terms of reference for the evaluation of Vietnam-Sweden health co-operation 1994–1999

1 Background

The Vietnam-Sweden Health co-operation dates back to 1972, when Sweden responded to a request from Vietnam to support the health sector in the post war period. The initial support consisted of the construction of two hospitals, later on the support developed to involve other areas of the health sector. From 1984, the support included assistance to Primary Health Care and provision of drugs. From 1990 the support was further increased to include support to Central Level Integration, Training Systems Support and Central Funds.

Swedish disbursements to the health sector from 1972 to June 1993 amount to 926 million SEK. Total Swedish disbursement to the health sector 1972–1999 is thus 1 115 MSEK.

An evaluation was carried out in 1992[22] to assess the results of the co-operation during the latest two agreement periods, July 1990–June 1993, as a base for adapting a new agreement to the economic reform in Vietnam. The evaluation concluded that most projects had been strongly influenced by the economic reform process (Doi Moi 1986). The projects had increased their rate of progress from 1986 to 1992 and all projects together had produced a large number of training activities for the health sector.

At the Annual Review in December 1999 Ministry of Health and Sida agreed to undertake an independent evaluation of the Health sector support. This evaluation, cover by these Terms of Reference, will focus primarily on the Agreement period starting from the 1 October 1994 and ending 31 September 1999, including the preparations leading up to this agreement. The evaluation will also take into consideration the changes made and initial experiences under the current agreement for the period ending December 2001.

The budget for the 1994–1999 agreement period was 250 MSEK while disbursements amounted to approximately 189 MSEK.

The overall objective of the development co-operation between Sweden and Vietnam during the period 1994–99 has been to support the development of a functioning market oriented economy. According to the planning document for Vietnam-Sweden Health Co-operation 1994–99, therefore, all objectives, strategies and activities of the health sector co-operation were to be consistent with this overall objective.

The main objective for the health sector co-operation outlined in the 1994 agreement was *"to improve policy work and capacity building in the health sector with particular emphasis on activities aiming at appropriate direction and quality of services and to advance equity in access to and utilisation of services"*.[23] The agreement specified eleven different areas targeted for support, and planning documents contain

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[22] SIDA 1992/3 Doi Moi and Health; Jan Valdelin et al.

[23] Agreement between the Government of Sweden and the Government of the Socialist republic of Vietnam on Health Co-operation October 1, 1994 - December 31 1999, dated 24 October 1994.

separate sets of objectives for each area, which are further developed in the Annual Plans of Operations.

Implementing agency was the Ministry of Health (MOH). A ministerial unit, the Vietnam-Sweden Health Co-operation Management Office (CMO) with technical assistance by InDevelop Uppsala AB, has managed the support.

The areas of support were;

1. Health Policy,
2. Drug Policy and Control,
3. Support for Disadvantaged Areas,
4. Central Hospital,
5. Primary Health Care Unit, (phased out in 1997)
6. Maternal and Child Health, (phased out 1996)
7. Training Systems Support (evaluated during 1999 before being closed out)
8. Health insurance (planned, but never took off)
9. Support for Public Health Training (planned to be included from 1996, but never took off)
10. Support for Aid Management and Co-ordination started during 1998 with the assistance of SIPU
11. Support to the Co-operation Management Office

A decision to restructure the co-operation was made in June 1996, based on the experiences made thus far. The main changes included a plan for phasing out some of the areas, as well as modifications of areas to be continued. In addition, changes and modifications have been made over time to better adapt the objectives and content of the support to the prevailing circumstances,

In accordance with the agreement, Ministry of Health carried out an in-depth analysis during 1997.[24] The main conclusions were that "the result analysis report gives much impressive and considerable quantitative information as regards to the implementation. However, as the objectives of the areas were not shown in quantitative and measurable terms from the start of the period, it was not possible to assess if the objectives had been reached. Further it was not possible to see if the achievements really were attributable to the co-operation or weather they should have occurred anyway".[25]

2 Main focus of the Evaluation and issues to be covered

The main purpose of the evaluation is to summarise key experiences and determine important *lessons* to be learned from the co-operation. Its conclusions will thus provide guidance for the modelling of the future co-operation.

The evaluation shall be based on a review of existing documents and relevant literature, and interviews with key stakeholders of the co-operation.

[24] Result Analysis Report on Vietnam Sweden Health co-operation 10/1994–6/1997 revised on November 13th 1997

[25] Agreed Minutes dated 3–4 December 1997

The main focus of the evaluation will be on the following issues:

- The *relevance* of the Swedish support over time in relation to Government's health policy, current development processes in the country – the health sector in particular, the health situation of particular target groups, Sida's health policy and initiatives of other donors. This includes the question of how the VSHC has contributed towards better surveillance and monitoring of the health care system as a whole, and thereby enhanced the relevance of government (and aid) interventions.
- Achievements with respect to *capacity building* – a core objective of the co-operation. The evaluation team shall assess the progress of the policy making and method development, institutional and management capacity and the impact of training activities in the program. It shall provide an analysis of the results achieved, lessons learned, positive as well as negative. The analysis shall also relate to possible impact on the policy work and the service delivery capacity within the areas.
- Impacts in terms of addressing *equity concerns* in health policy and delivery of services. The evaluation shall pay particular attention to dimensions relating to poverty alleviation and socio-cultural aspects such as gender and ethnic-specific issues.
- Lessons related to the *management of aid* – i.e. the efficiency of various aid instruments and organisational modalities for channelling Swedish support, dealing primarily with questions of ownership and cost-efficiency. This includes assessing the mechanisms for planning, execution, follow up, management and administration of the VSHC, covering how the various actors (GoV, MoH, Sida/Health, Swedish Embassy/DCO, Consultancy companies, etc) have performed their various roles and duties. In this analysis, the evaluation shall give special attention to the distribution of roles and responsibilities between the different actors. The evaluation shall thereby elaborate on the organisational set-up of the VSHC, and to the extent possible relate to experiences within other donor-funded programmes.

Based on an analysis and assessment of the above, the evaluators shall discuss the likelihood that benefits and achievements generated by the support are sustained beyond the time of the support – i.e. the survival of the different projects if external funding was to be discontinued. Important factors and conditions for sustainability shall be identified and discussed.

During the years the Swedish development co-operation in the health sector has changed. Today the support is directed towards a reduced number of areas focusing on broader terms of co-operation, e g policy and institutional development. The evaluation shall review shifts in content, approaches and modalities and asses different development methods/"aid instruments" used during the co-operation period.

Based on the assessment and current trends in the health sector recommendations should be given for Swedish future health collaboration.

The type of analyses outlined above will distinguish between the different areas. As and when relevant for understanding the issues above, aspects of how the different areas have been selected, designed, changed over time, implemented and monitored shall be analysed.

In principle, all areas in the co-operation during the agreement period 1994-99 period are included in the study to give a complete picture of the co-operation, but the areas continuing in the current agreement shall be given highest priority, relative to the ones that were phased out or closed down before October 1999.

The remaining areas of support are; Health policy, Drug policy and control (including safe and rational use of drugs), Support to Disadvantaged Areas, Aid Management and Co-ordination and the Project Management Unit.

4 Methodology

The programme has a long history and the evaluation will cover a period of approximately 6 years. The support has during these years been modified. The programme, as discussed in many reports, is scattered and the entire program did not initially have an intention to create linkages or interactions between the different areas. This has however later been discussed and efforts made to increase the relationship between the areas. In order to provide a viable, just and realistic picture of the achievements of the programme, a selection of methods for the evaluation is needed as the areas have slightly different approaches.

Prior to the mission, the team leader is therefore requested to visit Hanoi and jointly with Sida and MOH agree on a work plan for the evaluation. This includes modalities of contacts with key persons in Vietnam as well as the timing of project visits, teamwork and consultations with MOH and Sida.

The evaluation shall be made in close collaboration with the Ministry of Health. The comments from Ministry of Health have been included in these Terms of Reference. It is proposed that the Ministry participate in the identification of national consultants, however the T/L makes the final decision during the planning visit to Vietnam.

As part of the assignment a seminar shall be carried out in Vietnam to present the findings of the evaluation before the Evaluation Report is finalised. The seminar shall be held 19 January 2001.

In carrying out the assignment, the team shall be guided by the Swedish objectives for development co-operation, the country strategy for co-operation between Sweden and Vietnam as well as the following four Sida action programmes and guidelines:

- Sida poverty programme
- Sida's action programme for promoting equality between women and men in partner countries
- Sida's Policy on sustainable development
- "Justice and peace" – Sida's programme for peace, democracy and human rights
- Guidelines for the application of LFA in project cycle management

The evaluators shall work as an independent team, but in close consultation with the Embassy, which together with MOH will assist in identifying relevant informants and project documents, and provide logistical support. The recommendations made and the opinions expressed by the team shall be those of the team and shall not be regarded as emanating from or binding upon Sida or the MOH.

The team is expected to act independently in the planning and implementation of the assignment. This will also encompass direct contacts with the Ministry of Health and other actors involved in the Sida's health sector support.

For having, a full picture of the situation in which the programmes are working it is expected that the team visit the provinces, districts, communes and villages, hospitals, drug quality control laboratories, schools and institutions that have been benefiting from the co-operation. The Embassy and/or Health Division may join the team during visits and field trips as observer.

During the assignment the team shall meet and interview, but is not necessarily limited to, representatives of the following groups;

- Ministry of Health
- Officials from the Areas and related institutions
- Officials at province / district / commune level
- InDevelop Office in Uppsala
- LTA
- Staff at the Embassy
- Staff at Sida in Stockholm
- Beneficiaries

5. Composition of the team

The evaluation team will comprise of 4 international and 2 Vietnamese consultants of whom one is appointed as team leader. The team leader should have experience in evaluation assignments with good knowledge of Sida's policies, approach and working methods. The following team expertise is required;

1. Expertise on health systems development with knowledge and experience from health policy, institutional and organisational development, management and project management.

2. Expertise on pharmaceutical and policy issues related to rational and safe use of drugs, drug law development, drug quality control and management of drug quality control laboratories.

3. Expertise on public health care, with experience from primary health care programme in development countries including gender specific issues.

4. Expertise on rural community development, participatory methods (PRA) and communication.

The Vietnamese consultants, besides having general knowledge about health sector development in Vietnam, should cover, in particular, issues related to ethnic minorities and equity issues in health policy development. The Vietnamese consultants shall facilitate the planning of the mission, and carry a special responsibility for identifying and reviewing relevant documents in Vietnamese and identifying persons to interview. EU guidelines for cost norms for national consultants shall be applied.

All the team members shall have considerable experience of practical application of the logical framework approach, LFA, and preferably knowledge in Sida's working methods. It is a condition that at least one international team member has the experience from work in Vietnam for having an understanding of the environment in which the support has been implemented.

6. Time frame

The assignment is planned to take place from mid- September to mid-November 2000, and includes the following milestones:

Preparatory visit by the team leader to Vietnam:	29/8–6/9 2000
Mission to Vietnam:	26 September–13 October 2000
Draft evaluation Report:	3 November 2000

Comments from the Embassy and Sida:	within 3 weeks before presentation in Vietnam

The team leader shall arrange for a seminar in Vietnam to report on the main findings of the evaluation. The seminar shall be held 19 January 2001.

Final report:	within 3 weeks after seminar in Vietnam.

7. Reporting

The evaluation report shall be written in English and should not exceed 50 pages, excluding annexes. Format and outline of the report shall follow the guidelines in *Sida Evaluation Report – a Standardised Format* (see Annex 1). Subject to decision by Sida, the report will be published and distributed as a publication within the Sida Evaluations series. The evaluation report shall be written in Word 6.0/95 for Windows (or in a compatible format) and should be presented in a way that enables publication without further editing.

The separate summary and a completed Data Work Sheet shall be submitted to Sida along with the (final) draft report.

Annex 2

Lists of documents

Planning documents

- Planning Document for Vietnam Sweden Health Cooperation 1994-1999 10 October 1994
- Insatspromemoria; stöd till Vietnams hälsosektor 1994/95–1998/99,
21 September 1994

- Memorandum of understanding on the development cooperation between Sweden and Vietnam for the period 1 July, 1994–December 31, 97, 20 April 1994.

Agreement and Contracts

- Specific agreement between the Government of Sweden and the Government of the Socialist republic of Vietnam in Health cooperation October 1, 1994–December 31, 1999

- Contract for Consulting Services between the Ministry of Health, Vietnam and Indevelop Uppsala 10 October 1994, including TOR and annexes.

Agreed Minutes

Agreed Minutes from Annual and Semi-annual reviews

- Annual review 30 Nov.-–1 Dec. 1995
- Semi-annual Review 4–5 June 1996
- Annual review 11–12 December 1996
- Semi-annual Review 3 June 1997
- Annual review 3–4 December 1997
- Semi annual review 2 June 1998
- Annual review 6 May 1999
- Annual review 7 December 1999
- Semi-annual review 6 June 2000

Annual plan of operations

Annual Plans of Operations (APOs) have been elaborated for each Area for the following periods:

- 1/10/1994 –31/12/1995
- 1/01–31/12/1996
- 1/01–31/12/1997
- 1/01–31/12/1998
- Addendum to APO 1998 for the period: 1/01–30/6/1999

Evaluations and Result analysis

- SIDA Jan Valdelin et al. 1992/3 Doi Moi and Health. Evaluation of the Health Sector Cooperation programme between Vietnam and Sweden

- C Schuftan Evaluation of TSSA 1994–1998

Result Analysis report on VSHC 10/1–6/1997. Revised on November 13th 1997. Including background documents from each Area

Regulations and Stipulations

- Guidelines for Planning Reporting documentation etc. revised June 1996

- See Annex 2G in Annexes to the Final report of the cooperation

Periodic reports

- Programme Status reports 30 April each year
- Draft Annual Progress Report 15 November each year
- Annual Progress Report 28 Febr. each year

Audits

- Price Waterhouse Audit of the VSHC for the year ended 31 Dec.1996
- Price WaterhouseCoopers Audit of the VSHC for the year ended 31 Dec.1997
- Price WaterhouseCoopers Audit of the VSHC for the 18 months period ended 30 September 1999

Final reports

- Final report of the cooperation, Ministry of Health March 2000.
- Final report of the Consultant, June 1999.
- Financial final report 30 March 2000.

Reports of the Consultant

Inception Report
Report 3 months after each "Plan of Operation"
Long-term adviser Yearly reports (can be obtained from InDevelop Office) List of LTA consultants App. 4 Final report of the Consultant,
Long-term adviser End-of-Contract reporting (can be obtained from InDevelop Office)

Reports from CMO and the Areas

- Back-ground reporting for Progress Report, Status Reports and Result Analysis from each Area
- Reports from the Senior Advisers visits, see list App. 5 Final Rpt. of the Consultant
- Reports from study trips abroad
- Short-term Consultants reports app.6 Final Rpt. Cons.
- Comments on short term consultation reports

Other documents

List of documents are also found in the:
- Annexes to the Ministry's' Final Report on the Cooperation and in the
- Final Report of the Consultant.

Letters
Follow-up Memos of various issues

General Background documents

DRAFT Vietnam Health Sector Review, 3 November 1999 (for information – Not for quotation)

O. Bring, Christer Gunnarsson and A. Mebourne. Utrikespolitiska Institutet. Vietnam: Demokrati och mänskliga rättigheter. (Also available in English)

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Department for Cooperation with Non-Governmental Organisations and Humanitarian Assistance

00/36 **The Swedish Consultancy Fund in Mozabique.** Karlis Goppers. Department for Africa

00/37 **Assessment of Lessons learned from Sida Support to Conflict Management and Peace Building: Final Report.** SIPU International AB, Stockholm, Centre for Development Research, Copenhagen, International Peace Research Institute, Oslo
Department for Cooperation with Non-Governmental Organisations and Humanitarian Assistance

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State of the Art/Annotated Bibliography. Ninna Nyberg Sørensen, Finn Stepputat, Nicholas Van Hear
Department for Cooperation with Non-Governmental Organisations and Humanitarian Assistance

00/37:2 **Assessment of Lessons learned from Sida Support to Conflict Management and Peace Building: Annex 1-5, Case Studies.** Ivar Evensmo, Hilde Henriksen Waage, Joakim Gundel, Jennifer Schirmer, Björn Bengtson, Barbro Ronnmö, Dan Smith
Department for Cooperation with Non-Governmental Organisations and Humanitarian Assistance

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Department for Latin America

00/39 **Programa de Capacitación en Economía para Funcionarios de la República de Cuba. José Antonio Cuba**
Department for Latin America

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Department for Natural Resiurces and the Environment

00/41 **Water and Environment Project in Estonia, Latvia and Lithuania.** Bastiaan de Laat, Erik Arnold, Philip Sowden
Department for Eastern and Central Europe

01/01 **Rural Development and Democratisation in Russia and Estonia. An evaluation of Sida's support to the three projects in Russia and Estonia.** Paul Dixelius, Camilla Gramner, Dan Hjalmarsson.
Department for Eastern and Central Europe

01/02 **Project for Development of Social Work in St Petersburg 1998-2000.** Nils Öström, Dmitri Gavra.
Department for Eastern and Central Europe

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Phone: +46 (0)8 698 5163
Fax: +46 (0)8 698 5610
Homepage:http://www.sida.se

SWEDISH INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
S-105 25 Stockholm, Sweden
Tel: +46 (0)8-698 50 00. Fax: +46 (0)8-20 88 64
Telegram: sida stockholm. Postgiro: 1 56 34–9
E-mail: info@sida.se. Homepage: http://www.sida.se