

FINAL

Feasibility of the programme approach in the health sector in Vietnam

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Table of Contents

Abbreviations.....	iv
Acknowledgement.....	vi
Executive Summary.....	vii
1. Introduction.....	1
2. Macro economic conditions.....	2
3. The reform agenda.....	4
3.1. The CPRGS and the SEDP 2006 – 2010.....	4
3.2. The PRSC.....	4
3.3. The Public Administration Reform (PAR).....	6
3.3.1. PAR at the MoH.....	6
3.3.2. PAR review.....	8
3.3.3. PAR implications for a sector programme in health.....	8
3.4. Aid effectiveness initiatives.....	9
3.5. Public Finance Management.....	10
4. Key rationale and functions in programme support.....	13
4.1. The Paris Declaration on Aid Effectiveness.....	13
4.2. The Hanoi Core Statement and the disadvantages of the project mode of co-operation.....	14
4.3. Key rationale for a programme approach.....	16
4.4. Implementing a programme approach to the health sector in Vietnam.....	17
5. Achievements and challenges in the health sector.....	20
6. Overview of the health sector and its stakeholders.....	22
6.1. Domestic actors.....	22
6.2. External partners.....	23
7. The Government as programme implementer and provider of public services.....	26
8. Policy framework and planning procedures.....	30
9. Institutional capacities at the MoH.....	35
9.1. The planning processes.....	36
9.2. Information systems, monitoring and evaluation.....	38
9.2.1. A sector Performance Assessment Framework.....	39
9.3. Overall human resource capacity in the health sector.....	40
9.4. Decision making processes and dependency on others.....	41
9.5. Financial management at the MoH.....	41
10. A SWOT analysis of the health sector in Vietnam.....	44
11. A Vietnamese road map towards the programme approach in the health sector.....	48

13. Recommendations	52
13.1. General recommendation	52
13.2. Specific recommendations	52
13.3. Next steps	54

Literature list

People met

Annexes

- A. Terms of Reference
- B. Policy Coherence
- C. Consistency in the use of health indicators
- D. National Actors
- E. Case study on Tuberculosis
- F. Overview of ODA in the health sector
- G. The Planning process
- H. Case study Reproductive Health
- I. List of Regulations and Decrees
- J. Performance Assessment Framework
- K. Capacity study
- L. Code of Conduct and MoU Templates from Nicaragua
- M. Fiduciary Risk Assessment, EFA-programme in Education
- N. Code of Conduct, EFA-programme, Education
- O. Memorandum of Understanding, EFA-programme, Education
- P. Experiences from SWAps in other countries
- Q. Organisation Chart of MoH
- R. Case study HIV/AIDS

Abbreviations

ADB	Asian Development Bank
ARM	Annual Review Meeting
AusAID	Australian Agency for International Development
CBPHC	Community Based Primary Health Care
CCP	Community of concerned partners (HIV/AIDS)
CG	Consultative Group (Meeting)
CHC	Commune health center
CoC	Code of Conduct
CPRGS	Comprehensive poverty reduction and growth strategy
DOF	Department of Finance
DOH	Department of Health (at the provincial level)
DPF	Department of Planning and Finance at the MoH
DPI	Department of Planning and Investment
EC	European Commission
EPI	Expanded Programme on Immunisation
EU	European Union
GBS	General Budget Support
GDP	Gross domestic product
GFR	General fertility rate
GOV	Government of Vietnam
GSO	General Statistical Office
HCS	Hanoi Core Statement
HMIS	Health management information system
HPG	Health partnership group
HRD	Human resource development
HRM	Human resource management
ICD	International Cooperation Department (in MOH)
IEC	Information, education and communication
IMR	Infant mortality rate
INGO	International non-governmental organisation
JFA	Joint Financing Agreement
KNCV	Tuberculosis Foundation (in The Hague)
MARD	Ministry of Agriculture and Rural Development
M&E	Monitoring and evaluation
MCH	Maternal and Child Health
MMR	Maternal mortality rate
MoET	Ministry of Education and Training
MoF	Ministry of Finance
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MoU	Memorandum of Understanding
MPI	Ministry of Planning and Investment

MTEF	Medium Term Expenditure Framework
NGO	Non-governmental organisation
NIHE	National Institute of Hygiene and Epidemiology
NTP	National Target Programme
ODA	Official development assistance
PAF	Performance assessment framework
PAR	Public Administrative Reform
PARSC	PAR Steering Committee
PER	Public Expenditure Review
PFM	Public Finance Management
PGAE	Partnership Group on Aid Effectiveness
PM	Prime Minister
PMB	Programme Management Board
PMU	Project Management Unit
PPC	Provincial People's Committee
PRSC	Poverty Reduction Support Credit
RH	Reproductive health
RHAG	Reproductive Health Affinity Group
RTI	Reproductive tract infections
SBS	Sector Budget Support
SEDP	Socio-economic development plan
Sida	Swedish International Development Cooperation Agency
SPS	Sector Programme Support
STD	Sexually transmitted disease
SWAp	Sector Wide Approach
SWOT	Analysis of Strengths, Weaknesses, Opportunities and Threats
TA	Technical Assistance
TB	Tuberculosis
TFR	Total fertility rate
TWG	Technical working group
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAAC	Vietnam Administration of HIV/Aids Control (in MOH)
V-HAP	Vietnamese Harmonisation Action Plan
WB	World Bank
VHI	Vietnam Health Insurance
VHIA	Vietnam Health Insurance Authority
WHO	World Health Organization
VHSD	Vietnam health systems development (master plan)
VND	Vietnamese Dong

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Our closest co-operation has been with the Department of Planning and Finance at the Ministry of Health but we have also had several other valuable contacts and meetings with many other entities of the MoH. Several other ministries in the Government's administration, together with many other institutions under the Government, have helped us with valuable information, as have representatives of the National Assembly. We would also like to thank representatives of the three provinces we visited during the mission in Vietnam for their unconditional support to our work.

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Executive Summary

The assignment of this mission is to look at the feasibility of introducing the programme approach in the co-operation between the Ministry of Health in Vietnam and its development partners. Could the programme approach improve the level of efficiency further in the sector as compared to the impressive achievements already attained? The rationale for and key functions of the programme approach are presented in the report.

Backed by strong macro economic performance the Government of Vietnam works hard in different reform areas. The presentation of the new five year Socio Economic Development Plan includes a request for “modern” planning methods. Collaboration between the GoV and development partners at the macro level is concentrated to the World Bank’s Poverty Reduction Support Credit and the Partnership Group for Aid Effectiveness, both institutional arrangements with ambitious agendas and individual issues directly related to the health sector. On-going reform in the public administration and in public finance management are both hampered by different kinds of inefficiencies to move forward, even though general PFM systems stand out as strong in international comparison. The GoV’s high ambition in the area of aid effectiveness is reflected in the Hanoi Core Statement, a Vietnamese adaptation of the Paris Declaration for Aid Effectiveness to local conditions.

The impressive achievements in the health sector are presented in the report as are the challenges of quality care, demand and financing for the future. The Ministry of Health is dependent on a number of domestic as well as international actors. In government structures especially the MPI, the MoF and the MoHA control different procedures and resources in the sector. At present the Government suffers from fragmentation and a lack of information sharing in its decision-making and planning processes. This, and the position of the sectors in relation to Government cross-cutting institutions, has to change at the introduction of the programme approach. Collaboration with development partners in the sector is fragmented and mostly bilateral with the exception of a few sub-sector areas and the Health Partnership Group. However, the agenda of the HPG needs to change at the introduction of collaboration through programmes and not projects.

It has become increasingly difficult for the Ministry of Health to exercise its role as regulator and overseer of the sector, let alone coordinator of the various actors and interventions. The multitude of international agencies (bilateral, multilateral and non-governmental) makes the scene even more complicated. This calls for a collaboration that focuses on strategic planning in joint programmes.

With a few exceptions there is little involvement of development partners in the planning process for the sector. The current structure of and links between existing planning documents is not clear to development partners. The quality of the two main planning documents (the VHSD Master plan and the Five-year plan) leaves room for improvement. Issuing regulations and guidelines at the central level, and imposing norms and targets on the lower levels of the health administration, is an important feature of the Vietnamese tradition and way of operating and is at least as important as a planning tool. Introducing alternative planning procedures with local government administration also represents an important part of changing current instruments and ways of operating.

Internally at the Ministry of Health the current planning process is weak in relation the requirements of the programme approach, as are information systems and a number of other support systems. While the technical staff of the health sector is comparatively good in their professional competence, those involved in management tasks would need substantial improvements in their capacity. Several PFM-systems at the MoH would need improvements for an efficient application of the programme approach. Several of current weaknesses are directly linked to the division of mandate between cross-cutting Government institutions and the MoH and to the multitude of donor projects. A Performance Assessment Framework analysis for the sector should be carried out.

Several *Strengths and Opportunities* in Vietnam are conducive to the introduction of a programme approach: the high ambition on the aid effectiveness agenda, the strong general PFM system, the robustness of the health system, the GoV's reform intentions reflected in the SEDP, the improvements of the new planning documents in the health sector, donor interest in a change towards programme based co-operation and the existence of best practices outside and inside the health sector.

In relation to *Weaknesses and Threats*, difficulties to transfer the GoV reform agenda to the line ministry (i.e. the MoH) might be the strongest limitation to the introduction of a programme approach in the health sector. Other issues of concern are: weak management systems at MoH, the weaknesses of the PAR reform, a since long profoundly established project co-operation culture and a possible absence of political support to the introduction of this management system in the sector.

The report presents a road map to the programme approach in the health sector. Parameters included are a new and comprehensive planning instrument, the invitation to collaborate to implement a sector plan, the early confirmation of this collaboration through the signing of a Code of Conduct, the introduction of different institutional arrangements to support the process, the identification of costs and financial support to the plan, the arrangement of financing modalities (e.g. through a Joint Financing Arrangement reflected in a Memorandum of Understanding) and the need for a functional analysis and organised capacity strengthening.

The report concludes that there is a scope to introduce the programme approach in the health sector in Vietnam corresponding to the interests expressed by the GoV in the SEDP and in individual directives. While the way of planning and co-ordinating work through this approach should be applied for the *whole* sector, the different technical features of the programme approach should initially be applied only partly, in different sub-sectors organised as pilot projects. Using the same kind of modality, current planning procedures at provincial level should also be reviewed in a number of provinces. Capacity strengthening, introduction of a comprehensive and consistent sector plan, introduction and signing of a Code of Conduct for collaboration and introduction of institutional arrangements with joint representation should be considered initial priorities.

1. Introduction

The assignment of this mission is to look at the feasibility of introducing the programme approach in the co-operation between the Ministry of Health in Vietnam and its development partners. In the words of our Terms of Reference, (annex A to the report):

“ with particular attention to defining workable mechanisms that would allow donors and the GoV to *work together in a more efficient, harmonized and coordinated way* in order to achieve the health goals set out by the GoV ” (our Italic).

The issue of efficiency and effectiveness should be in the centre for any assessment of the feasibility to move from the very established project based co-operation modality in the health sector, to a programme based modality. We will argue that the GoV's administration has demonstrated efficiency in the political decision-making process and implementation of health policies and provision of health services throughout at least the last decade. The question now is: Could the programme approach improve this level of efficiency further? What is likely to happen on medium-term in the health sector and could the programme approach better support this development than the current dominating way of collaborating through projects? Previous attempts to introduce the programme approach have been put on halt for different reasons. Have the conditions now changed and if so, what has changed to make an introduction of the programme approach feasible?

There is a strong relation between an assessment of the answers to these questions and the on-going reform process in Vietnam, not least in the area of aid effectiveness where Vietnam stands out in international initiatives. Conclusions should also be made in relation to the impressive achievements in the sector and how this relates to the functionality of the administration as such, the broad areas of policy and planning frameworks and the actual capacity conditions at the MoH but also in the sector as a whole. This would include the existence or non-existence of sufficiently strong support systems to strengthen and make possible actual implementation of health policies. These systems are to be found inside the ministry but the MoH is also dependent on the policies of many other actors both inside the sector and outside, such as the MPI, the MoF and the MoHA. Is it likely that the MoH will have access to sufficient internal and external support to succeed in achieving the goals set out for the next five years? Could the programme approach help in this work? Are efficiency gains possible through initiatives not necessarily defined as a parameter of the programme approach?

Lessons learned are another vital part in an assessment of this kind. What are the experiences from the sector programme approach in other countries? Is this relevant to the Vietnamese context? Are there special pros or cons in the Vietnamese setting in general and the health sector particularly as far as programme based co-operation is concerned. This report provides some lessons learned from other countries.

2. Macro economic conditions

A sustainable macro economic development and a balanced fiscal situation are pre-requisites for any attempt to formulate a trustworthy poverty policy in any country: the very first conditions for the implementation of government programmes aiming at poverty reduction.

Vietnam displays in this respect a very strong position as compared not only to countries representing the same level of GDP/ capita, but also in relation to many other economically more developed countries, such as members of the European Union¹. Some figures:

	00	01	02	03	04
<i>Real GDP growth</i>	Annual average of 7 % for the last five years				
Government Debt ²	33 – 36 % of GDP during the period 00 – 04				
Budget deficit, % of GDP	2,0	2,8	1,5	2,0	1,4
Revenue, % of GDP	20,5	21,4	22,7	23,1	23,4

As a comparison could be mentioned that economic growth in the EU during the same period in average reached approximately 2 %, almost no EU country has a debt as low as 35% and that several EU countries, in fact especially the financially biggest ones, have a budget deficit of more than 3 % of GDP currently. Few countries at Vietnam's GDP/capita could display public revenue at more than 20 % (compare e.g. to richer countries in Latin America or as rich/poor countries in Sub-Saharan Africa). It should be noted that these achievements have been obtained in spite of a number of external shocks to the economy, amongst them the sharp rise in oil prices and the outbreak of avian flu.

Still, there are some fiscal weaknesses. The most worrying of these is the liability situation in State Owned Enterprises and Banks and the unclear regulations and practice from e.g. lower level administration in expenditure commitments³. All in all however, these restrictions do not pose a crucial threat to the in other respects very stable situation. Furthermore, transparency is increasing and the GoV is involved in several very broad based reform activities in public finance management, to be presented later in the report⁴.

This strong fiscal position⁵ of the GoV has several implications. The most important is financial self-reliance. Total ODA flow to finance budget expenditure ranged between 11 and 18% in 2004⁶; for the health sector only it is likely to be less than 5%. This financial strength, combined with the potential of an administration that has contributed to a reduction of the defined poor part of the population from 60% to less than 30 % in less than 15 years, reflects the fundamentals of a high level of GoV *ownership* of the on-going reform process; in turn a crucial component in a programme approach based co-operation.

¹ Figures in this chapter from the Program Document of the PRSC IV and the PER, both from 2005

² Debt attributable to budgetary expenditure

³ Public Expenditure Review 2005, Volume 1

⁴ There are several voices in international debate that claim that economic growth in countries like China and Vietnam is not sustainable since it does not sufficiently take into consideration depletion of the physical environment and growing inequalities in distribution of personal income

⁵ Even though the GoV itself continues to express dissatisfaction with the macro economic situation in the SEDP 06 – 10!

⁶ Joint Evaluation of General Budget Support 1994 – 2004, January 2006

3. The reform agenda

3.1. The CPRGS and the SEDP 2006 – 2010

The leading instrument in GoV reform initiative is the ten year Comprehensive Poverty Reduction and Growth Strategy. This document has recently been complemented by the new five-year Socio Economic Development Plan for the period 2006 – 2010.

The relation between these documents seems to be unclear to many external actors in Vietnam. The question presented to several people interviewed was if the new SEDP was to substitute the CPRGS or not. Not even the MPI was able to answer this question when asked.

In the SEDP the following relation is presented: “The five-year SEDP for 2006 – 2010 specifies the directions and tasks of the 10-year (2001 – 2010) strategy”.

However, hopes are that the introduction of the new SEDP would represent something more than just the definition of directions and tasks of the CPRGS, throughout its history perceived as biased toward instrumental planning and an investment led economic development. This hope of change of direction through the new SEDP comes out clearly in the Directive 33/2004 from the Prime Minister on the new SEDP, especially concentrating on a more outcome-focused planning and in this “the use of international methods and standards”, interpreted as e.g. methods relevant for poverty measurement and *targeting of assistance*.⁷ (our Italic). This new direction in planning and even indication of a new relation with development partners, represent a big leap in the possibilities to collaborate through the programme approach where one of the pre-requisites is the focus on results and the necessity for external partners to support the government’s programme and its intentions.

According to media information in Hanoi in February 2006, the intention behind the new five-year plan is to halve poverty one more time. The GoV recognizes the National Target Programmes as key instruments in this ambition. From a perspective of new planning procedures and a focus on programme based co-operation (including budget support as a funding modality) the question remains if the new directives give sufficient support for a shift from project to programme collaboration. How these issues apply to conditions in the health sector is further explored in detail later in this report.

3.2. The PRSC

The transformation of the new reform agenda for 2006 – 2010 to the new SEDP will guarantee a strong continued ownership to the process by the GoV. This will make it possible to uphold the close relation between the GoV’s reform initiatives and the overriding co-ordinating mechanism on the side of the development partners: The World Bank’s Poverty Reduction Support Credit the PRSC, now on its fifth credit to the country.

Co-operation takes place through the Steering Committee for the PRSC, led by the deputy Prime Minister for economic reforms and representing no less than 24 line ministries

⁷ The IV PRSC programme document, 2005

(including the MoH) and anticipated 15 donors for the PRSC V⁸. Total external funding has grown from 100 Million US\$ from the Bank and 23 Million from co-financiers in the PRSC I, to 100 Million from the Bank and 125 Million from co-financiers in the PRSC IV, the latter all in all representing 10 % of all ODA flow.⁹ Donors are entitled to participate in the PRSC dialogue, even without providing funds through GBS. This open approach from the GoV and the Bank and the growing funding through this mechanism positions the PRSC as the leading reform dialogue instrument between the GoV and development partners; in practice, the PRSC supersedes Consultative Group (CG) meetings as the most important dialogue occasion; or at least in formulation of the agenda of issues to discuss during CG meetings.

Sector topics chosen to be included in the PRSC matrix are obviously to be considered as priority areas for the GoV. In the health sector the following issues have been selected throughout the PRSC period in Vietnam:

- Introduction of Health Care Funds for the Poor at provincial level
- Establish these funds in all provinces, pay central government contributions
- Introduction of a HIV/AIDS strategy
- Introduction of a tuberculosis action plan
- Strengthening the regulation and pricing of pharmaceuticals
- Pilot a MTEF

The GoV's focus on these areas should be allowed to influence any further steps aiming at a more efficient way of co-operating with development partners. Experiences from these areas should be considered in assessments of what modalities to use in the co-operation between the MoH and development partners.

At the same time, the PRSC is currently not well aligned with other parallel on-going reform activities in Vietnam¹⁰. Co-ordination with activities under other aid modalities (read project financing) is not sufficient. Donor pledges should be changed to multiannual medium term commitments, some kind of MoU for the PRSC co-operation should be introduced to guarantee consistency with other reform activities, the agendas and mandates of different partnership groups and the PRSC dialogue forum should be streamlined and capacity issues more prioritised in the PRSC agenda.

This list of limitations proves that the difficulties in the continued reform process are more on the donor side than on the GoV side and that the introduction or expansion of a programme based collaboration would make it much easier for the GoV to follow through on its high ambition reform programme. At the same time, donors possess much valuable knowledge in the use of international methods and standards. The problem is thus linked to the organisation and structure of the co-operation (unfortunately also valid for PFM reform, see below!) and the funding modalities that are being used. The introduction of a programme based co-operation in the health sector would be one step in the direction of bringing different reform processes closer together.

⁸ Same document as 1 above

⁹ Joint Evaluation of GBS 1994 – 2004, January 2006

¹⁰ Same document as above under 3

3.3. The Public Administration Reform (PAR)

Over the past 5 years the main instrument for GoV administration reform has been the PAR process. The Prime Minister requested the development of a strategic and long-term PAR at the 9th National Party Congress of April 2001. Following a long period of preparation, Decision no. 136/2001 (September 2003) formally established the PAR Master Programme for the period 2001-2010.

The PAR Master Programme is a comprehensive and ambitious reform programme for the government and it extends through the key areas of government administration in its entirety. It has 9 specific objectives and is organised in four overall *focal areas of reform*:

1. Institutional reform
2. Reform of the organisational structure of public administration
3. Renovation and improvement of the contingent of cadres and civil servants
4. Public finance reform

The roles and responsibilities of government agents in executing the four focal areas of reform are set out in 7 sub-programmes headed by lead agencies either in pairs or individually: the lead agencies are the Ministry of Home Affairs (4 sub-programmes), the Office of the Government (3), The Ministry of Finance (1) and the Ministry of Justice (1). On central level, the Prime Minister heads the PAR process and is assisted by the Government PAR Steering Committee (PAR SC) to regularly orient and provide guidance on the implementation of the Master Programme. The lead agencies are in charge of formulating Action Plans on each sub-programme to be approved by the Prime Minister. There is a Programme Management Board (PMB) for each sub-programme charged with processing requests for projects within the framework of reform. The MoHA has a key role in its leading function in 4 of the 7 sub-programmes and responsibility for mobilising resources (both domestic and external) for the implementation of the Master Programme in co-ordination with MPI and MoF.

Based on the guidance provided by the Action Plans of the 7 sub-programmes and the PAR Steering Committee, each ministry, central government agency and the People's Committees of provinces and central cities should formulate and arrange the implementation of their own annual and five year PAR plans.

3.3.1. PAR at the MoH

The MoH works continuously on PAR implementation and co-ordinates its work and its interaction with MoHA and other ministries through its Cabinet. Work on the four focal areas of the PAR Master Plan is organised within the MoH in the form of projects for specific tasks.

For instance, in the public finance reform area there are currently three sub-projects on-going: (1) Increasing government budget for health care; (2) Developing and improving mechanisms and policy for mobilizing financial sources for health care; (3) Improving planning capacity and the financial reporting and information systems. For all three sub-projects in this area, the

DPF of MoH is the lead Department.¹¹ Progress to date is limited and most activities are in their start-up phases.¹²

The situation is similar yet more complex in the area of institutional reform. Lead department for most of the activities is the Legal Department, but several other MoH departments including the Department of Preventive Medicine, the Therapy Department and the Cabinet, have lead responsibilities in the implementation plan. Tasks are related to the development of individual decrees and drafting of laws, but progress to date is also in this area limited. Some decisions (namely decision no 3238/2004/QD-BYT and 4278/2004/QD-BYT) have been taken to spearhead the development and dissemination of legal documents, but the progress report states a few yet important constraints.¹³ These also re-appear in discussions with key personnel of the MoH (Cabinet, DPF, Dept. of Manpower and Organisation, Legal Department):

- Lack of capacity to evaluate administrative procedures so that adequate solutions can be proposed¹⁴
- Lack of resources for capacity training of staff
- Lack of human resources to enact decrees and implement institutional and organisational changes

These features are also closely linked to and explanatory of the MoH process of moving forward on reform. A variety of Departments within MoH are concerned with developing action plans for specified tasks under the said constraints. In turn, these are communicated to the Cabinet for co-ordination with, for instance, the MoHA and the sub-committee of a PMB that deals with the health sector. A proposal is then processed in an interactive manner and the period from first presentation to approval can be between 2 months to 3 years.

Despite co-ordination efforts, MoH and MoHA officials testify to a fragmented process where the risk of omissions or duplication increases with the number of actors involved and with an increasing lack of resources, both human and financial, to prepare PAR actions and proposals adequately. A MoHA official describes MoH as “not the best nor the worst” performer in preparing its cases to the PMBs under MoHA control. As the case may be, there is scope for facilitating in an integrated way MoH abilities to become a solid partner in the GoV PAR effort.

¹¹ There appears to be some overlap among the sub-programmes in the finance reform area. Comparing expected results, sub-projects 1 and 3 both aim to pilot a MTEF for health sector expenditure 2006-2010 within different time-frames. In fact, much of the work on Public Finance is carried out as part of PMF reform at MoF.

¹² MoH; Project – *Reforming health financing in the health sector*, 2005.

¹³ MoH; *Project – Institutional reform of the health sector*, 2005.

¹⁴ The report lists, importantly, the key areas where a lack of evaluation capacity is imminent:

“(a) Procedures on examination and therapy in state healthcare facilities, (b) Procedures on issuing license certificates on private medical and pharmaceutical practice; certificates to verify conditions for private medical and pharmaceutical practice facilities, (c) Procedures on providing registrations of foreign businesses operating in the field of drugs and raw materials for making drugs in Vietnam, (d) Procedures on issuing drug licenses in Vietnam and allowing drug imports into Vietnam, (e) Procedures on issuing registrations of foreign businesses trading vaccines in Vietnam, (f) Procedures on issuing licenses for vaccines to be circulated in Vietnam and permits for vaccines imports into Vietnam in case of emergency, (g) Procedures on issuing registrations on circulating chemicals, bacterial-killing products, micro-bacterial products in daily use and in health, (h) Procedures on issuing licenses for health equipments, which are domestically manufactured and permits for importing health equipments from overseas, (i) Procedures on announcing food quality and food additives. (k) Procedures on drugs and cosmetics advertising, which have direct impacts on the human health, organizing seminars, workshops to introduce drugs, health services, healthcare services by using traditional medicines, food, health equipments, vaccines, chemicals, bacterial-killing products in daily use and in health, (l) Procedures on foreign investment in the health sector (healthcare services and therapies by using traditional medicines and drugs).”

3.3.2. PAR review¹⁵

In May 2005 the PAR SC Secretariat conducted a comprehensive review of the implementation of the PAR Master Programme during the previous five years. While recording some advances, the main message of the report is that of slow progress and an inability as yet to apply appropriately directives on lower levels of the administration.

One overall aspect standing out in the review account is the challenge of changing mentality necessary for the transformation of Vietnamese public administration from a command system to a market system with a socialist orientation. In a planned economy, civil servants are trained to be regulators, whereas in the new orientation envisaged by the PAR, civil servants should turn into facilitators. No matter how skilled the individual in the legal frameworks regulating administrative functions, unless a basic shift in attitudes towards service provision and a view of the public as clients is achieved, reform progress will remain slow.

There is also a slowness in organising the top leadership of reform, which has hampered implementation and development of action plans by line ministries and other agencies. It has taken substantial time for several PMBs to form and act on their mandate. For instance, the PMB on sub-programme 1 took three years to form and secure funding for its initially approved projects.

The review also notes the need to co-ordinate donors to better contribute to PAR implementation. Fragmentation among donor projects is severe and the review points out that different donors sometimes propose multiple similar interventions to the same institutions; with high transaction costs and duplication of efforts as a result. There is scope for assisting the GoV on PAR implementation in a more concerted way.

3.3.3. PAR implications for a sector programme in health

In terms of a programme based approach, the PAR represents an opportunity to support a GoV led and directed reform effort. PAR is described by the GoV as the main government reform process underpinning all other reform efforts.

Support of a line Ministry in its efforts to move forward on PAR has the potential to delineate and focus PAR implementation for that ministry. Regarding MoH, the interlinkage and dependency of MoH to, in particular, MoHA, MPI, and MoF for PAR implementation calls for an integrated effort on the part of MoH to which the donors can contribute.

Joint TA may serve to stimulate and strengthen MoH capacities to (a) co-ordinate its reform efforts, and (b) to provide resources for a necessary review of administrative procedures that should underpin PAR action proposals. A concerted effort contributing to the MoH PAR implementation plan may serve to create the necessary organisational space for real co-ordination, and for planning to be executed and priorities to be set from a solid evidence and evaluation base in direct response to the constraints stated by the MoH.

¹⁵ PAR Master Programme Review 2005 (English translation).

Additionally, a joint programme can support the vast training needs of a changing health administration. Donors have a comparative advantage in addressing the shift from a *regulating* to a *facilitating* civil service cadre. Not only do they benefit from experiences gained elsewhere, but also from their own national resource bases that have experience in developing training schemes in this regard.

Finally, it is important to acknowledge and make use of efforts currently being implemented to support the PAR initiative. For instance, the PAR MP Review makes reference to a MoHA-UNDP project now working with the PAR SC Secretariat to develop a computer based system to give support to the implementation agencies. The system is deemed fruitful by the GoV and should be taken into account.

3.4. Aid effectiveness initiatives

Vietnam has not only signed the Paris Declaration on Aid Effectiveness but also taken the unusual step to transform it into a set of rules adapted to local conditions expressed in the Hanoi Core Statement (HCS). Attached to the Statement – committing both the government and its development partners to the core principles of the Paris Declaration – is not only a list of indicators but also an Action Plan with identifiable outputs and activities planned to take place. Responsible institutions are also identified.

Both the indicators and the action plan itself reveal a high ambition in implementing the Paris Declaration agenda. For instance, one objective is to channel at least 50 % of all donor funds through the GoV's PFM systems by 2010, compared to the current 12%.

The GoV and its development partners also work through a Partnership Group for Aid Effectiveness. Conclusions from the group were high at the agenda of the CG meeting for Vietnam in Hanoi in December 2005. Documentation from the group¹⁶ spells out clearly that “the emerging challenge that must be addressed in the coming years is to put the tasks identified in the SEDP into action.”

The table of content for the Partnership Group is impressive and completely aligned with the intentions of the HCS. Areas covered are:

- Alignment to country strategies and plans
- Aligning to government systems
- Improving efficiency of ODA implementation
- Developing program based approaches (to be further explored later in this report)
- Working jointly
- Managing for results

All initiatives from the GoV and the Partnership Group on Aid Effectiveness are very consistent to the Paris agenda and should definitely be supported from the point of view of introducing a programme based co-operation between donors and the GoV. If realised, all topics on this agenda as expressed in the documents presented above, would strongly support any attempt of introducing this kind of working modality, also in the health sector.

¹⁶ Working together to Improve Aid Effectiveness for Supporting Sustainable Development in Vietnam, Partnership Group for Aid Effectiveness, December 2005

Bringing the progressive macro scenarios (macro economic development, the SEDP – PRSC dialogue, the PAR process and the Aid Effectiveness dialogue) together as very clear achievements, it is at the same time this team’s impression that the impact of this impressive reform agenda is clearly divided within the GoV’s administration. On the one hand all cross-cutting management functions and their counterpart organisations – like the MoF, the PM’s office, the MPI, the Steering Committee on the PRSC, etc – are all highly aware of and supportive to the agenda and its goals. On the other hand, these initiatives have so far had very limited impact on conditions and working methods at horizontal ‘line structures’, such as the MoH, still struggling with weak support systems and few initiatives from the donors’ side to truly harmonise and align to government systems. There are a number of reasons to this that will be presented in the rest of the report. Already in this part it could however be concluded that one of the most important tasks for the GoV and its leading partners in the future is to build a bridge between very relevant and ambitious cross-cutting reform initiatives and the possibility to implement them in reality through structures like the MoH.

Before health sector conditions are described more in detail, the status and reform of general public finance management systems in Vietnam will be presented.

3.5. Public Finance Management¹⁷

Vietnam represents strong public finance management (PFM) systems in comparison to other countries at the same level of economic development¹⁸. The pump and heart of the system is the on-line treasury management system under the State Treasury. Some observations:

- The State Budget Law provides all actors with a clear framework for the budget process. Backed by the Decision 192 (later replaced by Decree 130, requesting all administrative agencies to implement financial autonomy mechanisms) and the Decree 10, efficiency in budget preparation has increased e.g. through more focus on results. The ambition to decrease and limit the numbers of detailed regulations has not always worked out well due to many years of implementation of a much more strict set of rules. In richer provinces Decree 10 has led to higher cost-efficiency while poorer provinces have not managed to take advantage of the new situation. As mentioned, the planning process has not changed as fast as the budget process.
- The introduction of a pilot MTEF (e.g. in the health sector) has the ambition to change this situation through a more integrated planning and budget process, taking into consideration both planning pre-requisites and all financial resources available in the sector at the same time. The first MTEF presented for the health sector has some deficiencies, though. It remains unclear how the very rapid cost increase during the MTEF period has been calculated and whether calculations can be assumed to be linear in relation to existing resources or dynamic in relation to anticipated reform in individual expenditure areas. The latter would be unlikely considering the limited access to these kinds of calculations internally at the MoH. The size of the financing gap could also rapidly change. This is to a large extent depending on donor alignment

¹⁷ Most information in this section from ”Vietnam Public Finance Management Diagnostic Study funded by the EC, 2004, interviews during mission and previous visits to Vietnam

¹⁸ DFID judges the quality of the systems as ”medium” The problem with this kind of assessment for developing countries is that the comparison is based on very good operating systems, rarely a fact in these countries. In such a comparison the rate will almost by default always become “medium” or “poor”.

and involvement in MoH and GoV reform, where new ways of co-operating and new funding modalities could change both funding provision from the donors and ambition from the GoV. It also remains unclear whether the resource envelope for the sector is calculated based on a top-down calculation by the MoF of available resources in the health sector or not. The introduction of a three year MTEF cycle reflects insensitiveness to conditions in Vietnam. Both political and financial medium term planning is based on the five year cycle and it would be more than natural that the MTEF was adapted to this fundamental planning and political decision-making period in the country.

Irrespective of initial shortcomings, the MTEF will on medium term substantially strengthen the planning and budget process and for the first time be the instrument that seriously addresses the problem that the budget is divided between recurrent resources (under the MoF) and investment financing (under the MPI).

- Transparency in the budget system is rapidly improving and from last year the whole budget is publicly available.
- Accountability structures are growing stronger. Through disbursement of block grants, instead of control of numerous different line items and more concentration on results, different State and Government accountability organisations have more time to look at efficiency and financial control. The State Audit of Vietnam is formally independent from the GoV since the beginning of this year. More accountability power is being transferred to the National Assembly.
- The budget execution system is strong through the treasury management system. All payment requests have to run through this system at both central and sub-national level. Accounts are reconciled with payments through the Treasury's own bank system but for investment resources not until year's end with records kept at implementing agencies (such as the MoH). The electronic system makes it possible to transmit accounting statements all the way from districts to central level on daily basis. Treasury regulations have been substantially specified and there are no liquidity shortages in the payment system.
- Procurement regulations are much improved, but application still makes it necessary to introduce special regulations to minimize misuse of funds.

In this, some functions are more important to the sector than others and to the possibilities for development partners to align with GoV PFM systems in a programme approach co-operation. Examples: While debt management (still not fully functional) does not represent a core PFM area to sector programming, budgeting, accounting and payment do. The budget process is constantly improving and the core area of accounting and payment is subject to interventions through the so called TABMIS initiative; in reality an introduction of an IFMIS system (an Integrated Financial Management System). However, given the functionality of the Treasury system already in Vietnam, the rationale for introducing a completely new and unknown database system remains unclear and could in fact be strongly counterproductive. The more efficient and much more understandable alternative would be to continue improving the current system, well known to all actors in the GoV administration.

From a fiduciary point of view and increasingly from a development point of view, there are no obstacles for development partners to use all GoV PFM systems, with the additional proposal that complementary procedures should intermediately be used in procurement and auditing to minimize fiduciary risks. From this point of departure there is no reason to explore alternative funding mechanisms to budget support as a funding modality to the reform agenda in Vietnam even though the presentation of alternative models is included as a request in our

Terms of Reference. Whether PFM systems overall are sufficiently developed to support the introduction of a programme approach co-operation in the health sector remains a different question that will be further explored in chapter 9 of this report.

Also in relation to PFM, it comes out clearly that GoV reform activities pave the way for far reaching alignment from the donors. As already mentioned in section 3.2, the problem in continued PFM reform lies instead with the donors and the co-ordination between different interest groups:

PFM reform in Vietnam is supported by different donors and groups of donors (especially those that co-finance the PRSC), representing different institutional settings. One of these is the Multi Donor Trust Fund financially supported by the GoV (through the MoF), the World Bank and the so-called Like Minded Donor Group, that comprises a group of bilaterals donors (Sweden, Denmark, the Netherlands, Germany, Canada, Finland, Norway, Australia, Switzerland and the UK).

Although some progress in PFM reform has been accomplished through this Trust Fund, there is harsh criticism on its achievements¹⁹:

- The Fund has not operated in accordance with the intentions to build MoF capacity
- The Fund has not succeeded in building GoV capabilities to drive the government's own reform agenda
- Operations have not been consistent with the aid effectiveness agenda
- There are no prioritisation or allocation criteria for activities financed through the Fund

The situation reveals a sharp split between on the one hand the World Bank view on PFM and PFM reform and on the other hand the views of the likeminded group standing closer to the GoV reform agenda and the idea of GoV ownership to this process.

Continued PFM reform is necessary to further improve the systems and sustain already obtained gains. This can not be jeopardized by yet another example of poor co-ordination between donors and unwillingness of some of them to submit to GoV leadership and GoV formulated reform agendas. The continued introduction of programme support will depend on the possibilities to continue on the PFM reform path. Development partners that can not accept GoV points of departure in a very favourable reform environment should not claim that they support the process. The recommendation from the review team mentioned in the footnote below to change the modality of support to the Multi Donor Trust Fund should be followed through.

¹⁹ "Mid Term Review of the Multi Donor Trust Fund in support of the Public Financial Management Reform Initiative", Like minded Donor Group and the EC, February 2006

4. Key rationale and functions in programme support

This chapter sets out to discuss the key rationale for programme based approaches and their applicability in Vietnam. It will go on to outline key steps in the development of a sector programme for the health sector.

4.1. The Paris Declaration on Aid Effectiveness

The Paris Declaration on Aid Effectiveness is the main internationally recognised agreement on what the development community can do to improve aid effectiveness and contribute better to the achievement of the Millennium Development Goals (MDG). The signatories of the Paris Declaration have determined to support and adhere to five core principles²⁰:

- Ownership: Partner countries exercise effective leadership over their development policies, and strategies and co-ordinate development actions.
- Alignment: Donors base their overall support on partner countries' national development strategies, institutions and procedures.
- Harmonisation: Donors' actions are more harmonized, transparent and collectively effective.
- Managing for results: Management of ODA should be carried out from the results side: first looking at the desired outcomes and impacts, and only then determine inputs and activities.
- Mutual accountability: to establish joint evaluation and planning cycles based on government systems.

The Paris Declaration uses the term programme based approaches (PBA) to describe the preferred relationship and organisation of government donor co-operation.. The OECD defines PBA as:

“a way of engaging in development cooperation based on the principles of coordinated support for a locally owned programme of development, such as a national development strategy, a sector programme, a thematic programme or a programme of a specific organisation. Programme based approaches share the following features: (a) leadership by the host country or organisation; (b) a single comprehensive programme and budget framework; (c) a formalised process for donor coordination and harmonisation of donor procedures for reporting, budgeting, financial management and procurement; and (d) efforts to increase the use of local systems for programme design and implementation, financial management, monitoring and evaluation.”

The key points are: agreement on one plan and budget (for a particular sector or part of that sector), simplified procedures using Government systems wherever possible, one set of result indicators and follow-up of results and Government in control.

Prior to the Paris Declaration, several low-income countries that receive external support to the health sector had already ample experience in introducing and maintaining a sector-wide approach to health sector development. Already in 1997, Cassels and Janovsky pointed out that the key point in understanding the idea of sector-wide approaches is that the focus of

²⁰ <http://www1.worldbank.org/harmonisation/Paris/FINALPARISDECLARATION.pdf>

dialogue between governments and donors shifts up a level: from the planning and management of projects, to the overall policy, institutional and financial framework within which health care is provided (Cassels and Janovsky, 1997).

Cassels (1997) distinguished four distinct key components of a health SWAp:

1. Development of a comprehensive national health strategy and subsequent medium-term implementation programmes
2. Creation of resource envelopes to cover the cost of implementation of medium-term and annual POW's; indicating govt budget, donor contributions, private contributions
3. Common management arrangements, such as basket funding, pooling of TA, standardised procurement mechanisms.
4. Joint implementation of sector reviews.

Meanwhile, work has progressed and especially the issue of alignment has been worked out much better. Although there is no official definition of what a SWAp is, today it can probably best be described as an approach in which (Waddington and Girma Teshoma, 2005):

- a. All significant funding (from the government, donors and other sources) supports a shared, sector wide *policy, strategy and implementation plan* which have clear sector targets and which are focused on results.
- b. A *medium term expenditure framework* or budget supports this policy, strategy and plan.
- c. Government provides *leadership* in a sustained partnership with donors and other contributors, including the non-governmental sector.
- d. *Shared processes* and approaches for implementing and managing the sector strategy and work programme are agreed, *including reviewing sectoral performance* against jointly agreed milestones and targets.
- e. There is commitment to move to *greater reliance on Government* financial management and accountability *systems* as well as implementation systems.

Annex P provides examples and lessons that can be learned from some experiences in other countries that have introduced the sector-wide approach.

4.2. The Hanoi Core Statement and the disadvantages of the project mode of co-operation

In many respects, Vietnam and its development partners find themselves in a unique position. Unlike in many other development countries, there is an ongoing government led process in Vietnam for donor harmonisation and alignment with national priorities manifested by the Hanoi Core Statement (HCS)²¹. The HCS is, as mentioned in chapter 3, a joint commitment between the Government and the donor community for improving aid effectiveness. It is based on and derives its content and direction from the Paris Declaration on Aid Effectiveness. It contains a clear framework of objectives, verifiable indicators, and a Vietnamese Harmonisation Action Plan (V-HAP) created and led by the GoV with the explicit aim to support the implementation of HCS. Dialogue between the government and the donor community is conducted within the Partnership Group on Aid Effectiveness (PGAE).

²¹ See e.g. www.aidharmonization.org

This accord between the GoV and the donor community is strongly bent on achieving greater effectiveness through *programme co-operation*. As is the case with the Paris Declaration, the HCS sets out a number of progress indicators that are designed to measure increasing use of programme approaches, such as; ODA to be integrated into GoV planning (Indicator 1), donors to base support on GoV strategies (Indicator 2), donors to avoid implementing structures (specific reference to PMU's) parallel to the government's (Indicator 3), the GoV to lead comprehensive capacity building programmes with co-ordinated donor support (Indicator 4) and so on.

The PGAE monitors closely the progress of HCS indicators and concludes that there is progress. Increasing levels of ODA are provided jointly, the most notable cross-sectorial programme is the Poverty Reduction Support Credit, but there are also examples of joint sector programme support in the education and forestry sectors. There is a slowly increasing number of joint analytical reviews and a slowly decreasing number of individual donor missions. The PGAE also notes a number of initiatives to improve progress towards HCS indicators (among which this very study is mentioned).

While being clear on progress towards co-operation in line with the HCS, the PGAE and V-HAP are not so clear about what situation they want to avoid or get away from. A brief introduction to the shortcomings of the alternative to a programme based approach – the project based approach – is in place.

The Paris Declaration on Aid Effectiveness and the Hanoi Core Statement spring from an increasing frustration with development efforts not generating desired results in terms of social and economic impact. A central finding made across the development community and developing partners is that working in a project mode weakens partner administrations and fails to stimulate ownership and sustainability on a global level. Already in 1998 Forrester and McLoughlin²² made a summary of the characteristics of a project-mode-situation that still remains one of the most comprehensive and convincing:

- There is no clear framework or focus within a particular sector to prioritise activities and to allocate project resources;
- The availability of short term foreign support distorts domestic policies and spending priorities;
- A range of fragmented, independent and possibly competing projects tend to dissipate government capacity while diluting the impact of scarce resources;
- Without a clear analysis of sector priorities and available resources, duplications and omissions, in the form of funding and coverage gaps, are likely;
- Separate and often parallel systems to account for and manage different agency projects require additional staff time and make comparative analysis and coordination difficult;
- Inconsistent arrangements for accounting, reporting and auditing demand further staff time and a level of foreign technical support.

This summary is an indication of substantial transaction costs being associated with the project mode. Several studies also show that working in this way is counterproductive to the development of overall (sector-wide) monitoring mechanisms and results-based management. This is so because to be operating efficiently, these mechanisms demand a level of overview and strengthening of existent sector administrations that projects fail to provide. Perhaps the

²² Forrester and McLoughlin, *Sector Wide Approaches and Financial Accountability*, p. 2, Dublin 1998.

most important reason for this inability is that projects in themselves perpetuate fragmentation (compartmentalisation) and thereby obstruct the *exchange of information* throughout the system. Without access to consistent reliable information, evidence based decision and policy making is made extraordinarily difficult.

In the case of the Vietnam health sector, this study finds these traits strongly manifested. Hundreds of projects are run more or less parallel to the regular administration through PMUs and lack integration with MoH planning processes on all levels.

4.3. Key rationale for a programme approach

The HCS is based on the principles of a programme based approach to development co-operation. Reading the V-HAP and studying the 14 indicators of HCS may not, however, give the reader a clear view of the target, namely to move from non-coordination to coordination, and what that entails more precisely. To explain this, a brief introduction should be provided.

(i) The basic point of departure for programme approaches is that *donor support to partner governments should be provided jointly*, meaning a move from bilateral agreements and dialogues, to inter-agency government agreement and dialogue, where the joint condition is the key to remedy the shortcomings of the project mode. It is paramount to understand that the “joint” requirement means precisely that: joint funding, joint reporting, joint financial mechanisms, joint analyses, joint follow-up and joint agreement. The “joint” concept is crucial both in the process of harmonisation between donors and in alignment to government systems and procedures:

The articulation of the “joint” feature has led many to assume that the intention of the Paris Declaration is to move towards creating one massive programme in each country to support the PRS or similar in the form of GBS. But this is a misreading of the Declaration, and of the HCS. The intention is instead to *support jointly the strategies and plans of the partner government*. That may include provision of budget support as a funding modality but also, as in Vietnam, support to sector and sub-sector strategies and what they entail.²³ Luckily for the donor community, in Vietnam the government in its HCS has outlined just what it does entail.

A very important aspect of the programme approach is that it can be introduced partly in a sector to cover only one or a couple of sub-sector areas initially, if this is considered necessary or appropriate. In these cases however (for instance in the case of the health sector in Vietnam) it would be important to remember that this partial application should be linked to a policy dialogue on *the whole sector*, corresponding to the one normally introduced in a SWAp. Even if actual application of the features of the programme approach only covers parts of the sector, the policy dialogue should hence still be upheld to include a *sector wide* approach.

²³ For instance, it may be in the interest of the government not to include every UN or NGO activity into the government administration strategy because of the need for supporting civil society balancing and putting pressure on administrations to operate better. Such an intent would, although not made explicit, be in line with PAR intentions of re-modelling the way public administrations operate.

4.4. Implementing a programme approach to the health sector in Vietnam

A few other aspects are important in the establishment of a sector programme support (SPS). Experience shows that programmes are vulnerable in their initiating stages. The new mode of co-operation demands inter-agency dialogue, harmonisation of procedures and alignment with government systems on a level previously unknown to the partners. Firm frameworks are advised to guide all actors into the new relationship.

Primarily, the relationship between the government and the donors must be defined. This is best done in the form of an agreement – *a Code of Conduct* – outlining in a detailed way how the partners should co-operate and what they commit to.

The first key point of the CoC is to establish the framework for co-operation between development partners and the Government: All external parties active in the programme (that could constitute a whole sector or one programmatic area of the sector) agree to submit to the policy, strategy and plans (objectives) of the programme area and will refrain from supporting any other activities outside the Government's plan or try to establish bilateral agreements outside stated objectives. Other important features of the CoC are the establishment of the institutional set-up of the work and definitions on the annual planning cycle including occasions for the Annual Review Meeting (ARM) as its focal point (see annex P). This is the main instrument for a joint dialogue on programme priorities involving the government and its partners. In turn, the ARM must be based on a key joint review document²⁴ that, according to pre-set criteria, establishes,

- the current status and development of the sector,
- the progress of the joint sector programme, including its contributions to sector performance, financial input and impact, institutional strengthening and progress towards harmonisation, alignment and results-orientation, as a point of departure for joint discussion and agreement.

In defining the institutional set-up for monitoring of the implementation of the sector plan it would also be important to identify which actors that should be invited to participate. As a rule of thumb only actors in the sector should participate in regular monitoring discussions in e.g. the Health Partnership Group or the suggested Working Group in chapter 13. However, interdependency with many cross-cutting government institutions and development partners represented in macro reform (such as PRSC Steering Committee meetings, leading representatives in PFM and PAR reform, etc) is strong and external stakeholders to the sector should regularly be invited to present development in these dialogue foras and answer to question in relation to individual issues of concern to the sector. Much value would be added if MPI, MoF and MoHA could regularly participate in HPG meetings.

The next step is to ensure support of the system that should inform the government donor dialogue. As suggested above, also the Annual Planning cycle has its pivotal point, its hub; *the monitoring mechanism*, from which follow-up analyses and dialogue points should be drawn.

In addition to the CoC, agreements to work under a common programme approach often includes a Memorandum of Understanding, a Joint Financing Arrangement (JFA) between the

²⁴ A Joint Review Mission, JRM, is a common term in use.

Government and development partners that are prepared to provide budget support as a funding mechanism. This MoU / JFA should in principle only regulate the technical aspects of the transfer and channelling of these funds. Unfortunately it very often also regulates other issues on the planning document or presentation of results or other topics that in reality touch on the interests of all parties involved – also those not providing budget support but using other financing mechanisms – and therefore ought to be regulated in the CoC that relates to *all* external partners supporting the sector.

Attached to this report are the CoC and MoU of the health sector programme in Nicaragua in annex L. These examples are considered applicable as points of departure for partners in the health sector in Vietnam because they include all principally important aspects and make clear the separation between the CoC – *a framework for the co-operation of all parties in the sector* – and the MoU – *establishing financial arrangements for parties providing joint financial support to the sector*.

Also attached for reference (in annex O and N) is the CoC and MoU of the Education for All programme at the Ministry of Education in Vietnam. The CoC is too weak in this example, not even regulating the basic facts that all donors should submit to the objectives of the programme and refrain from supporting anything else in that sub-sector area. The MoU follows the so called ‘Nordic + Group’ model to a large extent²⁵ (this template is a bit over-regulating – reflecting donors’ disproportional interest in control of financial flows - but it nevertheless provides clarity and possibilities for international comparison).

In summary, three steps are deemed key to the establishment of a (health) sector programme in the following order:

1. Development of *joint key agreements* in the form of a CoC and a MoU;
2. Establishment, within that agreement, of an *Annual Planning cycle* as the main focus of joint government donor dialogue on (a) sector performance, strategy and priorities, and (b) programme implementation progress and results through *joint reviews*;
3. Establishment, within that agreement, of a *joint monitoring mechanism* that at the same time contributes to a comprehensive health sector performance assessment framework.

Partners should only enter into a joint programme agreement on a sub-sector on the assumption that they embark on, and endorse in principle, a process towards expanding the joint programme approach to cover the entire sector and encompass all donor funds. The Annual Planning cycle should be the vehicle through which a step-by-step plan is developed to attain this goal.

Note, however, that that there is little need to hasten this overall process or, even less advisable, to make it self-sustaining within the context of health sector support. Instead, it should be linked closely with the overall V-HAP – a direct follow-up of the Hanoi Core Statement – deriving its priorities and goals from that process in close co-operation with the GoV. This calls for close interaction with the ministry in charge of that process, the MPI, and to involve the MPI in the Annual Planning cycle to determine the way forward on harmonisation. In particular, MPI is in a position to assist in the direction of the process and

²⁵ The Nordic + Group is a co-operation between 8 bilateral donors – including the Netherlands and Sweden - on e.g. the templates for a Joint Financing Arrangement for the provision of both General Budget Support and Sector Budget Support.

point to experiences from other levels of GoV donor interaction, e.g. on the SEDP to guide the programme partnership.

5. Achievements and challenges in the health sector

Vietnam has recorded impressive achievements in terms of development of its health infrastructure in the public sector (input), increased health service production (output) and improvements in people's health status (outcome). Table 5.1 shows just some of the impressive past achievements in core health indicators. The grass-roots health system has been strengthened such that all communes now have health workers, with about two-thirds of the commune health centres having a physician among its staff, 93% of communes having a midwife or paediatric/obstetric assistant and nearly 80% of all villages and hamlets having active commune health workers²⁶. The curative system has expanded, resulting in high rates of service utilisation (an average of 1.9 curative consultations per capita in 2004) with a steep increase in specialist interventions and application of modern medical technologies. Meanwhile, 70% of the provinces and major cities have a traditional medicine hospital and about half of all other hospitals have a traditional medicine unit or department. However, service utilisation levels and bed occupancy rates at primary and secondary levels of care remain relatively low and lag behind those at tertiary and quaternary levels of care which show signs of serious congestion.

Table 5.1.: Past trends in core health indicators *

	Indicator	1990	1999/2000	2004
1	Life expectancy (yrs)	65 (1994)	67	73.1
2	IMR (per 1000)	45.1 (1994)	36.7	18.0
3	CMR (per 1000)	62	42	28.5
4	Low birth weight (%)	9.5 (1996)	7.3	5.8
5	Malnutrition in children <5 yrs (%)	43.9 (1996)	33.8	26.6
6	MMR (per 100,000)	160	95	85
7	Fully immunised children (%)	95.1 (1996)	96.6	96.5
8	Communes with physician (%)	n/a	51.05	67.8
9	Communes with midwife or paed/obs ass. (%)	n/a	87.9	93.0
10	Villages with commune health worker (%)	n/a	75.7	93.3
11	Drug expenditure per capita (USD)	n/a	5.4	8.6
12	Confirmed polio (cases)	n/a	Eradicated	Eradicated
13	Neonatal tetanus (cases)	n/a	142 Eliminated	46 Eliminated
14	Leprosy (new cases)	n/a	1,477 Eliminated	858 Eliminated

* Source: MOH, Health statistics yearbooks 2000, 2002 and 2004

The drug supply system has improved much, with 40% of drug consumption now being covered by locally produced drugs²⁷. In addition, Vietnam is self-sufficient for four out of six antigens that are being used in the national immunisation programme.

Several preventive health programmes have recorded noticeable achievements in bringing epidemics under control (cholera, bubonic plague, malaria) and eradicating or eliminating diseases (polio, neonatal tetanus, leprosy). Nutritional status has improved considerably. Some ailments and mortality trends remain stagnant, though, (e.g. tuberculosis) or they go in

²⁶ Source: The MOH (draft) Five-year Plan for People's Health protection Care and Improvement 2006-2010 (24 January 2006, available in Vietnamese only).

²⁷ Source: The MOH (draft) Master Plan for Vietnam Health Systems Development to 2010 (draft).

the wrong direction, such as HIV/AIDS, traffic accidents, cardiovascular disease, diabetes and neoplasms. Clearly, Vietnam has all the typical features of a society that is undergoing a rapid demographic transition²⁸. What distinguishes the country from other countries with similar levels of economic development are, amongst others, its low level of infant mortality (estimated at 18 per thousand live births) and its relatively low fertility rate (2.2 children per woman), which is associated with a high contraceptive prevalence rate (76%, all methods combined).²⁹ Nonetheless, there are sharp disparities both between and within geographic regions/ provinces. While the former disparities are being monitored quite closely, the latter are not. Several of the reproductive health indicators remain worrying (obstetric complications, induced abortions and/or menstrual regulations, infertility) and the quality of care in general leaves much to be desired, especially at the primary and secondary levels of care and in the most disadvantaged parts of the country.

The main challenges with which the Vietnamese health sector sees itself confronted are: (a) addressing social problems and inequity in an environment of growing income differentials, (b) strengthening health sector support systems that would improve the quality of service provision, (c) increasing the demand for health care, with appropriate financing mechanisms, (d) containing cost escalation, and (e) addressing threats related to globalisation. All of these are explicitly referred to by the Party's Politburo in its Resolution no 46-NQ/TW of February 23rd, 2005 on people's health protection, care and promotion in a new context and will be further analysed in chapter 8 of this report. The recognition of these challenges should be viewed in perspective of the call in the SEDP for "modern" planning methods. This reflects an insight with the GoV that new methods are needed to control and meet remaining problems. In such a shift, the programme approach represents a useful management tool.

²⁸ The term 'demographic transition' refers to the change of a population from high birth and death rates to low birth and death rates; it usually happens in phases.

²⁹ www.globalchange.umich.edu/globalchange2/current/lectures/pop_socio/pop_socio.html

6. Overview of the health sector and its stakeholders

As a major stakeholder in the Vietnamese health sector, the State plays the role of policy maker and regulator, as well as that of planner, implementer and financier of a large part of the health services rendered. It is important to recognise, though, that the health sector is much wider than the State or just the Ministry of Health.

6.1. Domestic actors

Annex D provides an overview of all domestic actors in the sector. It is noted that there is no unique power centre for the health sector in Vietnam. Several State actors are involved in priority setting and decision making, which has implications for the planning possibilities of the MoH. Clarity about the exact roles and responsibilities of each actor is important when introducing a programme approach to a health sector partnership between the government and donors. It should also be recognised that the linkage and mutual dependency of different government institutions outside the health sector define the *inter-sectoral* nature of certain public health issues, such as HIV/AIDS (see case study in Annex R) and avian influenza, but also reproductive health (see case study in Annex H).

While the Ministry of Health does play an important role in the sector, its working relations with the Ministry of Planning and Investment (MPI for everything that has to do with investment and capital expenditure, including ODA) and the Ministry of Finance (MoF for everything that relates to recurrent budgets and expenditure) are key to the whole planning cycle and budgeting process. Chapter 8 will elaborate this further. Other government departments that are important for the health sector are the Ministry of Home Affairs (MoHA, for administrative reforms and human resources), the Ministry of Culture (for public campaigns and mass mobilisation), and line ministries, such as Education and Training (MoET; for all training programmes) and Ministry of Agriculture and Rural Development (MARD; for specific inter-sectoral programmes, such as food security and avian influenza control).

Apart from the State and the technical roles and capacities of the Ministry of Health and other ministries, it is important to recognise that Vietnam is rather unique in the world in that the country has a very strong command structure to mobilise people behind nationally agreed priorities and targets. This has made it possible to achieve very good results, for instance in the domain of immunisation and in the control of epidemics (including SARS and avian influenza, recently). The involvement of the Party and mass organisations has repeatedly proven to be a key determinant of the success of any intervention.

In addition, the accountability lines of the GOV administration towards the National Assembly and the People's Councils at provincial, district and commune levels are quite clear. Nevertheless, the mechanisms are not fully functional in practice. The emerging trend towards decentralisation and the emerging role of local People's Councils in overseeing policy implementation are worth strengthening. Some UN agencies and international NGOs that are involved in advocacy issues already work with the Assembly, the Party and mass movements. This is the case, for instance, in the domain of HIV/AIDS, which many people still largely perceive as a 'social evil' that would only affect distinct groups in society.

Two groups of (private) non-state actors are often overlooked – both by the State and by part of the international community, despite their official policies – as health service providers and potential co-implementers of national programmes; yet they play an important role, at least potentially, in strengthening health sector performance. Firstly, there has been of late an emergence and increase in activity of civil society organisations and local (not-for-profit) NGOs. Medical associations, patient interest groups and organisations that focus on specific health issues, such as quality of care, reproductive health and HIV/AIDS, need to be given the space to develop their niche and articulate their specific contribution towards achieving nationally agreed objectives and targets.

Secondly, the expansion of private for-profit companies – be they health service providers, local manufacturers (of drugs, vaccines, medical equipment) or consultancy firms – cannot be ignored. Nor should the ongoing commercialisation of health services within the public sector be overlooked³⁰. Although the Government of Vietnam is opposed to private activities and private payments in the public sector, it is a fact that public services and commodities to some extent have been commercialised³¹ and hence limited insight into the effects on the achievement of national targets.

This has implications for the role of the State, which may have to find a new equilibrium in the various roles it performs. In particular, it may need to concentrate more on its policy formulation role and that of regulator, while reconsidering its role as health service provider and programme implementer. Chapter 7 will elaborate this further.

While any firm statements about the roles and responsibilities of various stakeholders would require a comprehensive institutional assessment of the sector, it is fair to state that at present the Government suffers from fragmentation and a lack of information sharing in its decision-making and planning processes. Official documents implicitly do acknowledge this and point at the State's slow response to adapt to a rapidly changing environment³².

6.2. External partners

One of the challenges, therefore, is for the international community to assist the government – both the Ministry of Health and its fellow ministries – in articulating these new roles and finding a new equilibrium.

However, external support to the health sector in Vietnam is highly fragmented and puts an enormous administrative burden on the State. Annex F provides an overview of the nature and volume of external support. More than 20 bilateral and multilateral agencies and lending institutions in the health sector account for less than five percent of total ODA to Vietnam (all

³⁰ The term 'commercialisation' has a wider connotation than privatisation. The essential characteristics of commercialisation are (Mackintosh, 2003): (a) the provision of health services through market relationship to those able to pay; and the phenomenon that cash income and/or maximising profit dictates investment and the production of health services; and (b) the financing of health services through systems of individual payment or private insurance.

³¹ See for instance Sepeheri et al. (2005).

³² *Resolution no 46-NQ/TW of 23rd February by the Politburo on People's health protection, care and promotion in a new context*, for instance, states that: "the State management in the health sector remains with many problems; some health policies are not in line with the current context, but they are slowly adjusted or modified."

sectors combined), with the volume of ‘health ODA’ accounting for less than five percent of total health sector expenditure (all sources combined). There has been a commendable effort to classify 240 known projects in the health sector into 16 ‘programme areas’, but this still does not allow an easy insight how ODA relates to the national health sector strategy and the established Vietnamese nomenclature of sub-sectors and national target programmes. In their design it is often not clear how individual projects relate to the national sector or sub-sector policy; yet many projects have the ambition to contribute to policy development. International agencies introduce new projects through their own bilateral consultations with the relevant Government departments, with some examples of projects that are supported by two or more agencies (e.g. through the PRSC facility; see section 3.2). Most agencies have negotiated and concluded their own bilateral programmes of cooperation with the Government covering periods of three to five years. Independent evaluations of individual projects do take place, but there is little transparency and rarely any joint decision making whether to continue, modify or terminate a particular intervention. Independent joint evaluations involving several external parties that support a particular sub-sector are rare.

The situation is even more diffuse in the case of (registered) international NGOs (INGOs), almost 400 in total (all sectors combined), of which more than a quarter (108 organisations) are active in health (see annex F). Reliable estimates of the volume of human and financial resources made available by these INGOs are not available; and despite the expertise and good track record of several of these organisations it is not clear at all how they contribute to national priorities and the achievement of national targets.

Annex F also describes the various platforms that are in place for government-donor and donor-donor coordination in the health sector. There is no mechanism in place, though, for international agencies to account for their actions and results towards the government and/or the people of Vietnam. While the established platforms do play an important role in sharing information and avoiding duplication of efforts, they have so far not succeeded (or to a very limited extent) in moving towards better alignment of external aid with government policies, priorities and procedures. Nor have they been instrumental in working towards a situation that external aid strengthens national systems that are conducive for an efficient implementation of health programmes and the delivery of quality health services for as many people as possible. This is because the majority of the externally supported projects deal with service delivery themselves and have the tendency to create and maintain their own planning cycles and management procedures that are more in line with the established routine of the donor agency than with national procedures.

There are at least two noticeable exceptions, though, where external technical assistance has helped to formulate national policy and where financial support is now well aligned with the respective sub-sector programmes: these are the national target programmes for immunisation and tuberculosis control respectively. Annex E presents more detail about the origin and main features of the tuberculosis sub-sector programme support.

With such a multitude of external parties, it is clear that not only is the State unable to take a leading role in aid coordination and fulfil its formal obligations³³, it is also not able to entertain the high level of ambition of the many external parties wishing to engage in a policy dialogue with the Government or to scale-out the interventions that they claim have proven

³³ The government has issued instructions and the MOH has issued special circulars about the management of external aid: see Annex F.

successful. Since the sector itself is so diverse and already involves such a large number of domestic actors (as demonstrated above), it is quasi impossible at this stage to introduce a true sector-wide approach to health development that would be sufficiently comprehensive.

The Health Partnership Group (HPG) has so far served mainly as an information exchange network. Chaired by a representative from the MoH, it has the potential to initiate a true coordination mechanism and move towards alignment of external aid with government policy, priorities and procedures as part of a programme approach. This would require the sharing of Government's policy and strategic plans (see Chapter 8) with external agencies, engaging in a policy dialogue with these same agencies and extending invitations to support a comprehensive plan for health sector development, specific components of such a plan or separate sub-sector plans. The international agencies, on the other hand, would need to give up on their conventional way of doing business on a bilateral basis and adhering to their own agency-specific procedures. As the leading joint policy body in the monitoring of the implementation of the sector plan, the HPG would need clear and consistent instructions on what issues could and should be included in the agenda of its meetings. They should be of strategic value and reflect the further development of the overall policy environment rather than individual donor concerns and their individual relation with the MoH.

Some of the technical working groups (TWG) that are linked to the HPG³⁴ are not as yet led by the relevant Government departments³⁵. This is an anomaly that needs to be rectified, since it would enable the Government to better guide development partners in the respective (sub)sectors. The establishment of technical working groups in areas that are not restricted to any particular health programme or type of service delivery, such as for instance HMIS and health financing³⁶, is to be commended. They may serve to articulate national policies and strategies for the strengthening of health sector support systems, which are rather weak in Vietnam (see Chapter 8). Other support systems that could benefit from international expertise through the formation of a TWG are: human resource management, human resource development (incl. training), public finance management internally at the MoH and procurement of supplies and services.

³⁴ See Annex D for the complete list.

³⁵ This is the case, for example, for the TWGs that deal with reproductive health and child health issues.

³⁶ The Terms of Reference of the health financing group have just been adopted (at the HPG meeting of March 2nd, 2006) and the group is expected to start functioning soon.

7. The Government as programme implementer and provider of public services

In its *Socio-Economic Development Plan (SEDP) 2006-2010*, the Government of Vietnam has taken on the ambitious task to protract the reduction of poverty. A reduction by half from 22 percent of the population to 11 percent is envisaged and planned for³⁷. This is likely to be achieved less easily than the reduction in poverty that was achieved during the last decade. Quality aspects now need to be introduced in the process. People targeted will be more difficult to reach with planned activities, costs per person will be higher and resource allocation formulas need to be introduced that effectively take into account specific local circumstances. These arguments for a shift of implementing tools are further qualified in the Government's (draft) *Master Plan for Vietnam Health Systems Development to 2010*³⁸. In short, the health sector is in need of management tools to enhance efficiency and effectiveness in its operations.

The Government of Vietnam has been and is the prime resource for the implementation of the national health policy and the achievement of its objectives and targets. In doing so, it relies heavily on regulations, decrees, norms and plans issued at the central level for nationwide implementation. *Government Decree no. 49/2003/ND-CP of May 15th, 2003, on the functions, responsibilities, powers and organisational structure of the Ministry of Health*, stipulates that:

“The MOH is the Government body that exercises the State management over public health care – including epidemic prevention and control, examination and treatment of diseases, functional rehabilitation, traditional medicine, preventive health care, health cosmetics, food hygiene and safety, medical equipment and all public services controlled by the Ministry – and it exercises the representation of ownership to the State capital in the state enterprises under the Ministry's management as stipulated by law.”

The organisational structure of the MOH comprises 16 departments that are depicted in Annex Q. One cluster of departments, such as the Dept. of Therapy, the General Dept. of Preventive Medicine, the Dept of Reproductive Health and the Dept of Food Safety and Hygiene, deals with specific health or disease-related matters and oversees service delivery in their respective domains (or sub-sectors). These are also the departments that host some of the National (health) Target Programmes (NTPs).

The other cluster of departments is involved in building and maintaining the support systems that are necessary for the ministry to oversee and strengthen the health sector: Dept. of Planning and Finance, Dept. of Human Resources and Manpower, Dept. of Legislation, the Inspectorate, Dept. of Science and Training, Drug Administration (DAV), Dept. of Medical Equipment and Infrastructure, Health Insurance Dept., Dept. of International Cooperation.

³⁷ The figures are based on the new poverty line.

³⁸ Two of the three principal concepts for the development of the master plan are: (1) health systems development towards equity and efficiency, by ensuring the balanced development of high-tech and grassroots health care and the harmonious integration of preventive, promotive, curative and rehabilitative services and between traditional and modern medicine; (2) health systems development consistent with national socio-economic development, by mobilising multiple resources and increasing the responsiveness to changing disease patterns.

Most of these departments are not related to any specific set of health services or national target programme and they serve as a kind of ‘oil that makes the engine work’. They are much less visible than the first cluster of departments. Unlike the NTPs, they do not attract any additional government resources, outside their core funding, which would allow them to redirect resources to the provinces and build capacity at that level for the actual implementation of national policy. The principal instrument for this second cluster of departments is either to issue legislation, decrees, norms and plans, for application by provincial departments, districts and individual health institutions; or apply regulations issued by others, such as for instance on financial management.

It is important to point out that these departments do not attract much support either from international agencies; yet they experience much extra pressure *because of* external aid. The Department of Planning and Finance is the most striking example: with a limited staff establishment it is responsible for both the national planning and budgeting process as well as the elaboration (and monitoring) of a multitude of bilateral programmes of cooperation with external agencies. While it is unfortunate that these appear to be two separate processes, it is not too bold a statement to say that the latter responsibility (working with international agencies) prevents the department to fully exercise the former one (national planning and budgeting) and that this affects the formulation and implementation of national policy in a negative manner. While some of the departments belonging to the second cluster seem to have managed to fulfil their role reasonably well without substantial external support, others would definitely benefit from technical assistance that could bring in international experience from other countries for local adaptation to the Vietnamese situation. There has been no systematic review so far of the needs for such types of assistance.

In addition to the 16 departments in the MOH itself, there are 45 units that are subordinated to the ministry, comprising of hospitals (22), specialist/resource institutes (15) and training institutions (8). These are the state enterprises referred to in the above quote that either have a national function in a particular domain or sub-sector³⁹ or a regional function in which they represent the MOH in a certain geographical part of the country⁴⁰. The mandates of these units and their roles vis-à-vis implementation of national policies may be defined on paper, but the actual activities are not always in line with their mandates, nor with their potential role in the fast changing environment. The study team found, for instance, that several of the above institutes tend to diversify their activities, combining the delivery of health services, with training, research, consultancy work and in some cases the production of medical supplies. They do this in an effort to adjust to the changing environment in which they operate and which is characterised by a changing disease profile, new epidemic threats and the increasing commercialisation of health care services, and which also offers new opportunities for international collaboration and external support. While this diversification in activities in itself is not bad, it may lead to unnecessary duplication and disturbing overlap. An example is in the domain of policy research: the roles of the MOH and its various departments, the Health Policy Unit of DPF and the Institute of Health Policy and Strategy in the policy making process are not clear, resulting in a duplication of efforts, a lack of quality control and

³⁹ The National Institute of Nutrition, for instance, hosts the national target programme to reduce child malnutrition; the National Institute of Hygiene and Epidemiology (NIHE) plays an important role in the national immunisation programme.

⁴⁰ Some institutes combine both functions: e.g. the Pasteur Institutes in Ho Chi Minh City and Nha Trang that are on the one hand involved in the production of vaccines for the entire nation, and on the other hand provide regional laboratory services and oversee the immunisation programme in their respective regions.

insufficient translation of research results into policy formulation and implementation⁴¹. Furthermore, there are also other GoV hospitals and clinics not submitting to the MoH or lower level administrations.

As a result, the picture of who does what in the health sector becomes increasingly blurred. The study team noted that the organigram of the Ministry itself, for instance, is not widely available, even within the Ministry itself, and it is basically unknown by many people. Thus it has become increasingly difficult for the Ministry of Health to exercise its role as regulator and overseer of the sector, let alone coordinator of the various actors and interventions. The multitude of international agencies (bilateral, multilateral and non-governmental), most of which work with several partners at a time and at different levels of the health system, and some of which implement projects themselves rather than supporting national/local implementing organisations, makes the scene even more complicated.

Provincial health authorities are given high financial autonomy by decree. In practice, however, national resources are scarce and have to be distributed to meet ambitious objectives and targets that are centrally defined and that leave little room for individual provinces and districts to allocate resources on the basis of local disease profiles and priorities. Financial autonomy has advantages for richer provinces that have a user fee surplus to reallocate. For most of the poor provinces the expectation that they should finance part of their activities by generating their own resources further adds to their financial deficit. Moreover it may turn out a perverse incentive to invest in the expansion of curative services (with the intention to generate more revenue) for which there is insufficient demand, rather than in preventive measures and health promotion that do not provide any financial revenue. Without an extra effort to improve the quality of health services at the primary level of care, it is not very likely that the demand will increase and the cost of delivering health services can be covered. Hence there is a need for rationalising the various policy instruments and financing mechanisms so as to ensure that they do not work out in a contradictory manner. Such policy measures and financing mechanisms are not specific to the conventional disease-related health programmes and the ‘cluster one departments’ of the MOH; they are typically the domain of ‘cluster two departments’, in charge of planning and finance, human resources, legislation and others.

At the international level, the World Health Organisation makes a plea for governments to see to it that national health systems are designed in such a way as to best achieve three universal objectives⁴²:

- a. Improving the health of the population
- b. Responding to people’s expectations and
- c. Providing financial protection against the cost of illness.

All three objectives matter in any country, irrespective of how poor or rich it is, or how its health system is organised. The best way of achieving them and the specific implications for policy will vary according to the country’s financial capacity and the cultural and organisational features of the health system. Although in many countries the Ministry of Health itself engages in the delivery of health systems, it may not always be best placed to do so. While the Government of Vietnam in particular is seen to be playing a very prominent role in the delivery of health services, it is important to note that private *financing* on health in

⁴¹ Valdeline J., Huyen T. Dao and G. Krantz (2005): Cooperation at the crossroad – More of the same, or making a difference? Evaluation of the Vietnam-Sida Health Cooperation on Health Policy and Systems Development 2001-2005. MOH/Sida, November 2005.

⁴² See www.who-int/health-systems-performance/ or the World Health Report 2000 (WHO, 2000).

Vietnam amounts to around 70% of total health expenditure (as opposed to 29% that is covered by the government), with the vast bulk of this private expenditure (87%) coming out of people's pocket at the time when they obtain the service⁴³. This means that a great deal of the total volume of health services is being funded through private co-financing arrangements but with the majority of services carried out by public institutions.

It seems appropriate for the Government, as well as for the development partners that support the health sector, to concentrate on policy development, strategic planning and strengthening support systems that will ensure that policies are implemented and objectives are met, regardless of (but not ignoring) who provides the services. After all, and as argued in Chapter 5, the Government has proven to be very effective in expanding the network of health service providers, mobilising broad public support for priority interventions and curbing health indicators in the right direction. The availability of international support for health sector development – both in terms of finance and technical expertise – should be capitalised upon to assist the GoV and other national actors in implementing priority programmes and delivering quality health services in a more efficient manner. For this purpose, the introduction of the programme approach as a management tool would be very instrumental.

⁴³ World Health Report 2005, presenting data of 2002.

8. Policy framework and planning procedures

Vietnam's health policy has been articulated in various key documents, most important of which is Resolution no. 46-NQ/TW of February 23rd, 2005 by the Central Political Bureau of the Party on *People's health protection, care and promotion in a new context*. This Resolution calls for (further) reform and development of the health system in line with "equity, efficiency and (the country's) development orientation". As the Party is based in all government bodies and the National Assembly, whose members oversee the functioning of the health system and approve the national health budget every year, there is quite a strong domestic consensus in policy orientation and strategy. The health policy (Resolution 46) clearly has a pro-poor orientation and is consistent with the SEDP 2006-2010 (and the CPRGS).

Two priorities that transpire clearly from Resolution 46 are: quality of services and access (in that order). The Resolution has seven main orientations which reflect the key issues that are associated with the actual trends in disease patterns, and which pay attention to both technical interventions (curative, preventive) and social action.

Following Resolution 46, the MOH produced a (draft) *Master Plan for Vietnam Health Systems Development to 2010 with a vision to 2020*, which comprises seven strategies that do not entirely concur with the seven orientations of Resolution 46. The Master Plan for VHSD clearly has a strong investment perspective and a much more curative orientation than Resolution 46, focussing on the development of infrastructure at the provincial, district (priority) and commune level. The plan has not been costed and it awaits formal approval by the National Assembly in the course of 2006.

From the VHSD Master Plan, a set of sub-sector master plans are currently being developed:

- a. Master plan for the development of the curative care network – to be approved by the Prime Minister; comprising of three special investment projects:
 - construction/rehabilitation of district hospitals (already approved⁴⁴),
 - construction/rehabilitation of commune health centres (in progress),
 - rehabilitation of provincial and specialist hospitals (in progress)
- b. Master plan for preventive health care
- c. Master plan for human resource development
- d. Master plan for the development of the pharmaceutical sector⁴⁵.

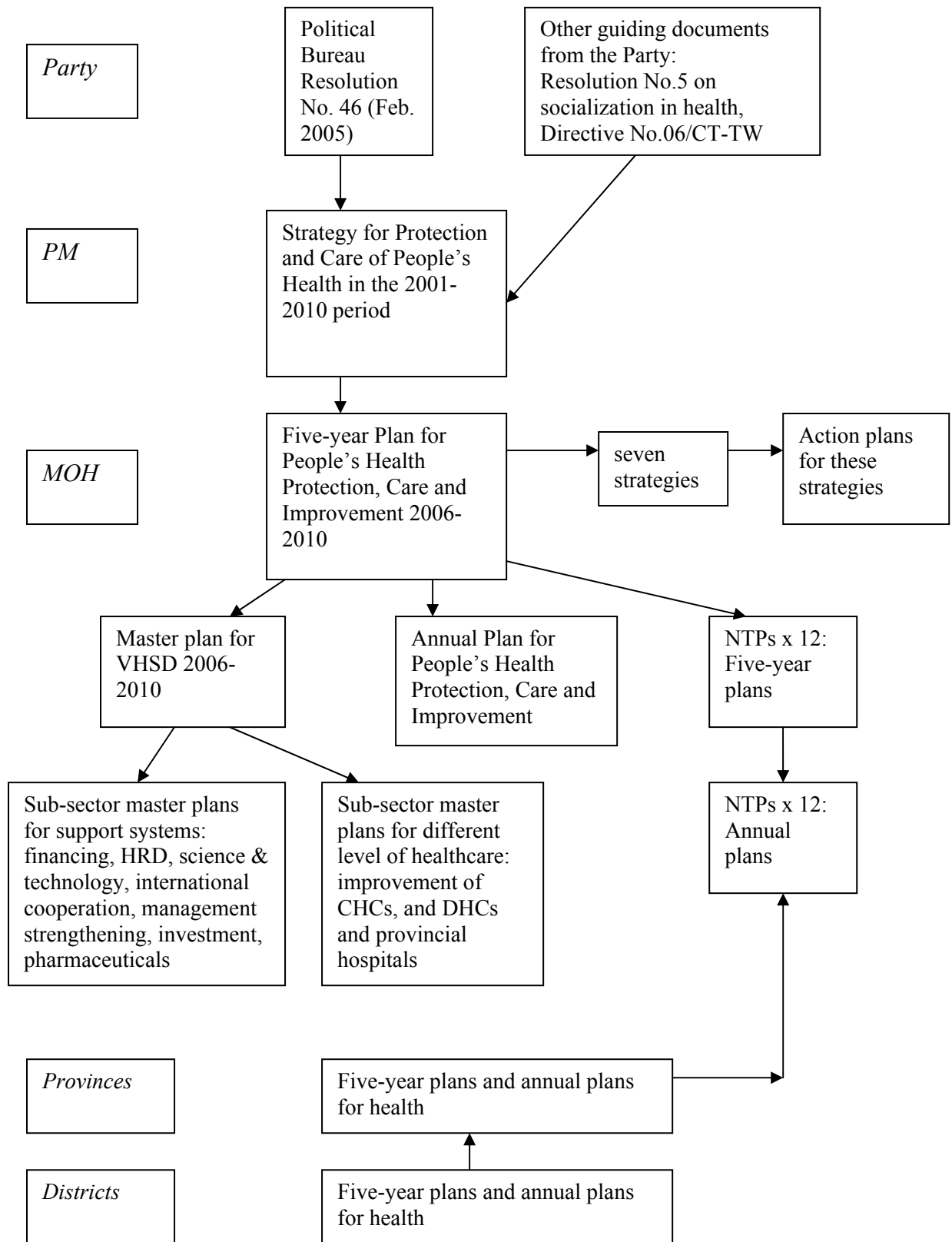
The Master Plan for VHSD and the sub-sector master plans that are derived from it, has to been seen in conjunction with the brand new five-year *Plan for People's Health Protection Care and Improvement 2006-2010* (draft, 24 January 2006⁴⁶), which is broader since it comprises the entire scope of Government health activities. The feasibility of the plan is questionable, though: while the total budget needed to implement the plan has been calculated at 197,934 billion VND (about USD 12.5 billion over five years; or USD 2.5 billion per annum), less than half of this amount has been secured from domestic and external sources, leaving a financing gap of around 100,000 billion VND.

⁴⁴ Decision no. 225 by the Prime Minister in Sept. 2005.

⁴⁵ The latter three sub-sector master plans will require approval by the Minister of Health.

⁴⁶ This document is available in Vietnamese only for the time being.

Figure 8.1: The National Health Planning Process



The Master Plan for VHSD and the five year Plan for People's Health Protection, Care and Improvement form the macro-framework for health programming in the next five years and as

such constitute a big step forward compared to the situation prior to 2005, when the national 10 years *Strategy for Protection and Care of the People's Health in the 2001-2010 period*⁴⁷ was the main guideline. It relied on 11 broad strategic orientations that did not give sufficient direction to the more specific planning exercises that the various MOH departments and national programmes started to undertake between 2000 and 2005 and which has led to a multitude of strategies and plans. Today there is a great deal of confusion – not least among the international community – about the hierarchy of the various plans and how one plan relates to the other. As one of the most priorities actions, the MOH would need to clarify the status of its two main strategic documents, in which ideally the various sub-sector master plans, national target programmes and programmes to strengthen support systems will fit (see chapter 13 on Recommendations and Next Steps).

Annex B provides an overview of the structure of the main policy and strategic documents and a comparison of the core indicators that are being proposed. The exact relation of the VHSD Master Plan and the Five-year plan is not entirely clear, but at least the two documents are quite consistent in the use of core indicators.

The main shortcomings of the two planning documents can be summarised as follows:

- a. They do not have a sufficiently coherent structure in terms of objectives, strategies, expected results and required resources.
- b. They have a strong focus on infrastructure development, with much less attention being paid to improvement of the quality of health services.
- c. While there is some attention for the strengthening of support systems - such as human resource development (HRD), financing and management - other support systems that cut across the various sub-sectors and NTPs receive little or no attention at all. For instance: comprehensive planning, human resource management (HRM), procurement systems (of services and supplies), monitoring and evaluation (M&E, HMIS), inter-sectoral collaboration and health sector governance. Annex G elaborates further on this, arguing and visualising how such support systems facilitate the implementation of national (sub)sector policies and plans.
- d. The plans focus on health service delivery by Government institutions, and reduce the role of mass organisations and other civil society organisations largely to mobilisation of the people behind national targets; the potential contribution of the private for-profit sector and the phenomenon of commercialisation of care in the public sector get very little attention.
- e. The national plans do not sufficiently acknowledge that there are large disparities between provinces – in terms of capacity and health sector performance – and that some provinces will find it easier to meet national targets than others. While the planned decentralisation and in particular Decree 10 on the financial autonomy of public institutions appears beneficial for provinces that have a strong position to generate their own income, their pro-poor implications are contested (see Chapter 7). The Government and donors try to compensate less well resourced provinces by a higher budget allocation, but it is doubtful whether this will be sufficient without additional measures.
- f. Estimates of the resources that are required to implement the plans are either not provided (in the case of the VHSD Master Plan; although such estimates are expected for the four sub-sector plans) or not realistic (in the case of the Five-year plan).

⁴⁷ Decision no 35/2001/QD-TTG of March 19th, 2001, by the Prime Minister.

The international community has not been involved in the development of these plans; as a matter of fact, the study team found that very few of the main development partners had taken knowledge of the VHSD Master Plan and none of them was familiar with the Five-year plan. This is not entirely surprising because of the fact that the former document still awaits approval by the National Assembly, while the latter one (also a draft) was just about six weeks old at the time of the mission. A mature partnership, however, could imply that the Government, in particular the Ministry of Health, works with (selected) international agencies in the compilation of its national strategic plan. If the Government is of the opinion that it is capable of formulating the plan in conjunction with domestic parties (including civil society representatives), rather than international parties, it would still be appropriate to be transparent about the process and invite external agencies to pledge financial support, either to the plan as a whole or to specific parts of it. This is in fact what happens in at least two sub-sectors: the national immunisation programme and the national programme for the control of tuberculosis (see Annex E). The MoH and its political leadership will need to extend such an invitation to several more of its development partners if the intention is to base sector wide dialogue on a programme-based cooperation in the future.

In some sub-sectors, especially those with multiple actors that have different interests and (hence) the largest fragmentation, such as in the domain of HIV/AIDS, the need for a programme-based approach is big. The multidisciplinary and cross-sectorial nature of HIV/AIDS related issues, makes it however difficult to apply a sector view on this disease as Annex R tries to argue.

Meanwhile, the Five-year plan does give an indication of the financial commitments that the Government has already secured from various donor agencies and lending institutions⁴⁸. The manner in which ODA is presented (divided in four categories of projects: health care and treatment, preventive health, local/regional health projects and ‘implementing projects’)⁴⁹ is not conducive to a good understanding of how these projects will help in addressing the national priorities and achieving the set objectives and targets.

Lastly, another weakness is that donor contributions – little as they may be in some cases – are often not reflected in sub-sector or provincial plans, since (a) they are not always explicitly solicited, (b) development partners are often not involved in the elaboration of the plans, and (c) project introduction and planning usually happens on an individual basis (not as part of a larger sub-sector) and is largely limited to bilateral interventions. Thus, several of the sub-sector plans are not comprehensive and it is not quite clear how the external resources made available contribute to the achievement of the national objectives and targets. Again, the examples of immunisation and TB control are exceptions that are worth taking note of.

In the case of the National Programme for Tuberculosis Control, a comprehensive five-year programme has recently been elaborated by the National Hospital of Tuberculosis and Respiratory Diseases (the host institution of the programme) with some external technical support from KNCV (made available through the Royal Netherlands Embassy) and WHO. It

⁴⁸ The total amount for externally supported projects is close to VND 13 billion for the five-year period (about USD 820 million), and an additional VND 16 billion for investment projects that draw on the state budget and ODA combined.

⁴⁹ See the appendix Sectoral demand for budget in the period 2006-2010 in the Five-year plan.

takes into account the results of the joint review⁵⁰ of the programme, which constituted the TB component of the National Health Sector Project co-funded by the World Bank and the Netherlands Government. The new five-year programme (2006-2010) specifies the resource requirements for each of the six main objectives (and associated 'service delivery areas') and by year, as well as the amounts committed by the three main financiers (GOV, the Royal Netherlands Embassy and the Global Fund) and the financial gap that remains to be filled. The indicators and set targets against which the programme will be reviewed have been specified as well. In short, the programme provides all the necessary elements of a sub-sector approach with the exception of a joint financing arrangement. Nevertheless, some important challenges remain, one of which is the integration or combination of TB control and HIV/AIDS control activities. The relationship between the two national programmes is not clear and they seem to operate in parallel, in spite of the fact that in reality the two diseases are strongly associated, with many TB patients infected with HIV, and require similar approaches towards case finding, laboratory testing and treatment.

In conclusion, with a few exceptions, there is little involvement of development partners in the planning process for the sector as a whole or for sub-sectors. As a result, donor commitments to a corresponding *programme* are uncertain, which limits the likelihood that the plans will effectively be implemented. The quality of the two main planning documents (the VHSD Master plan and the Five-year plan) leaves room for improvement. Two important weaknesses are: (1) the lack of a perspective on the strengthening of health sector support systems other than infrastructure development, such as planning, health financing, human resource management, M&E/HMIS, etc., which are required to make it possible at all to implement any national five-year plan and deliver quality health services; and the lack of a vision how international aid (finance, technical assistance) could be instrumental to strengthen such support systems; and (2) inadequate translation of five-year strategies and master plans into operational annual plans, with realistic targets, concrete activities and a realistic resource envelope.

In addition to that, it is important to note that the established routine of issuing regulations and guidelines at the central level, and imposing norms and targets on the lower levels of the health administration, is an important feature of the Vietnamese tradition. This certainly restricts the possibilities to alter the existing planning process and will affect any attempt to introduce more flexibility. This will need to be explored further when planning for a programme approach towards strengthening specific sub-sectors or health sector support systems. Introducing alternative planning procedures with local government administration also represents an important part of changing current instruments and ways of operating.

⁵⁰ This review was supported by several agencies: CDC (Atlanta), Medical Committee Netherlands-Vietnam (MCNV), KNCV Tuberculosis Foundation, Royal Netherlands Embassy, World Bank and WHO.

9. Institutional capacities at the MoH

This chapter deals with the institutional capacity of the health administration system and how it can be strengthened in the context of sector programme support. Identification of needs must take note of i) existing system strengths, ii) the reform agenda of the government, and iii) the comparative advantages of donor input.

As repeatedly stated elsewhere, macro health indicators for Vietnam over the past decade have shown steady improvement. The health administration system has shown strengths in targeted programmes such as that of immunisation, and in the control of epidemics (including SARS and avian flu, recently). The system has functioning vertical command structures with a high executing capacity.

However, as pointed out by the Vietnamese government in Resolution 46 by the Politburo on Health (23 February 2005), there is a need for improving the health administration on several accounts. The resolution makes it clear that while overall health indicators have improved, the administration's capacity for addressing the changing needs of the population requires strengthening, particularly from an administration viewpoint. Regarding reformation of the system, Resolution 46 affirms that in recent years "the health system has been stagnant in reforms... [and] it has not adapted to the development of the socialism-oriented market economy and changes of the disease pattern".

The recognition from Vietnamese authorities of weaknesses in the health administrations should be the starting point for GoV – donor programme co-operation. Two sources are of paramount importance to identify and recognize the government's intended efforts to reform the health sector; (1) the PAR process on health – currently the "health financing reform" and "institutional reform of the health sector", and (2) the Master Plan of the Vietnamese Health Systems Development to 2010 (the Master Plan to 2010).

In these documents the GoV make reference to a strong mechanical element to the executing capacity of the health administration that needs reform.⁵¹ Measures suggested include clarification of legal frameworks to safeguard decentralisation efforts, reformation of management systems and training of staff cadres.

As one response, there is a recognised need to improve the flexibility and quality of the administration's management capabilities, i.e. its ability to react to changes in disease patterns, to reach vulnerable populations and ensure the financial sustainability of the care system. This includes an ability to adapt to the real impact of action programmes during the course of their implementation. As has been presented in chapter 3, the PAR process has so far contributed little added value to the reform agenda in the health sector.

⁵¹ For instance, budget allocations on provincial level are still often made according to a system introduced in 1998 (fixed rate per hospitable bed) deemed to be inappropriate. Confer the Master Plan for Health Sector Development to 2010 (Draft May 2005), pp 12-13; 14.

In particular, the Master Plan to 2010 is a valid response to Resolution 46 and the PAR process's call for reform.⁵² It identifies needs both in training and in management capacities. Key areas⁵³ include:

- strengthening health planning capacity to better delineate short- and long term health plans;
- improve quality of the monitoring and evaluation systems;
- improve knowledge on state management and regulatory framework among health workers;
- strengthen recording/reporting system so as to provide needed reliable information for decision making processes.

Responding in these key areas of improvement is closely linked to strengthening the *planning processes* of the MoH. Planning represents a critical part of the demand side to existing information and monitoring systems, and the supply side to the policy and decision-making functions of the Ministry. It is therefore rational for a programme partnership to focus on strengthening the planning processes of the MoH and to develop existing information and monitoring systems.

9.1. The planning processes

The planning processes are at the heart of MoH abilities to formulate, execute and monitor activities. Supporting them would, simultaneously, (1) strengthen the internal management capacities of the MoH and thereby the GoV reform agenda and (2) provide for a government lead in supporting the inter-agency dialogue that should guide programme co-operation (cf. chapter 4). Note that it is no coincidence that Indicator 1 of the HCS aims to “integrate ODA into mainstream planning” of the GoV. This is because in order to make programme co-operation efficient, government processes must define co-operation content and take the lead, and the heart of those processes are represented by GoV planning procedures.

While recognising the strengths of existing MoH planning processes, it is equally important to define what can be made better. In recurrent reviews of sector performance both by Vietnamese authorities and outside observers the planning processes reappear as a topic of concern. As a supporting framework for policy and decision making, the planning processes are critical. Current co-operation projects implemented or financed by UNDP, UNFPA, UNICEF, and Sida,⁵⁴ all make references to the need to strengthen health planning and the systems that support planning, mainly through information bases, but also in terms of human capacities.

As mentioned above, the MoH is aware of this need and the Master Plan to 2010 indicates the overall direction of systems support. Underlying the needs expressed by the Master Plan, the MoH has also summarised the fault lines of the planning processes. Already in the Vietnam Health Report 2002, MoH states that:

⁵² Note, however, that the MoH only has partial decision-making power over some of its defining parameters including staffing, organisational division, and salary structures; and thus only responds partially to the demands expressed in the PAR implementation plan and Resolution 46.

⁵³ Cf. the Master Plan to 2010, section 3 V – *Management solutions*, p. 46.

⁵⁴ UNICEF, the SAVY assessment 2003-2004; UNDP, Country Programme for the Socialist Republic of Vietnam 2006-2010 (articles 10-28); UNFPA, Support to strengthen the capacity for integrated population and development planning 2002-2005; Sida, Valdelin J., Huyen T. Dao and G. Krantz (2005): Evaluation of the Vietnam-Sida Health Cooperation on Health Policy and Systems Development 2001-2005. MOH/Sida, November 2005.

- Monitoring of the implementation of plans is poor – there are no unified procedures and staff are under-qualified – and as a consequence there is no basis for timely adjustment of plans

- There is no general information bank for planning

- Incoming information is not timely and often unreliable

In consequence of these characteristics, systemic conditions of MoH planning processes risk producing fragmentary, unfocused and overlapping plans that may provide for cross sectoral gaps, weak association between related plans, and little involvement of lower administrative levels⁵⁵.

Planners both at central (DPF) and provincial levels testify to these conditions in interviews. A key constraint regards the availability of information and good time series of statistics for planning purposes, and analytical capacities and resources to process information. Another is a lack of interaction between central and local levels in planning, and a frequent reference is made to planning being undertaken under great time constraints.

Our assessment is that MoH planning abilities throughout the health administration are hampered by organisational as well as capacity (skills) limitations. There is a need not only to develop central but also provincial planning, and in particular the associations (information sharing, joint planning and feedback systems) between the various layers of the system.

In terms of organisation, planning and research, tasks are delegated vertically and largely on an individual basis. Centrally, planning tasks are distributed across the 10 divisions of the DPF in a complex pattern, and many other departments are engaged in making their own plans and strategies. Mandates to conduct planning lies centrally with all MoH Heads of Department, and the horizontal co-ordination functions do not appear to be specified other than the DPF nominally assuming overall responsibility. However, being asked expressly about the existence and implications of planning taking place outside DPF, and sometimes even inside, DPF unit heads are sometimes unaware of their contents.

One explanation for this pattern is that planning is mainly viewed as a carefully delineated response to a specific objective with a related budget line, which expansion it is the primary purpose of the planner to promote. This provides for a limited view of (a) the larger context into which a particular plan is fitted, and (b) the need to use performance information to establish the priority of the planning objective in relation to other priorities.

Another equally important factor behind this situation is the unfortunate involvement of the DPF in the management of tens (if not hundreds) of individual donor funded projects; as a result, it is constantly occupied with the task to deliver different kinds of individually profiled requested information to these external financiers at the cost of not being able to carry out regular planning work.

It would be safe to suggest that there is scope for integrating these processes better and thereby expanding the organisational range of planning: turning from individual to group planning exercises and so increase specialisation and allowing more time and information transparency to surround the processes. From a programme support perspective, this would include a more holistic and analytic approach to information processing, thus supporting the *managing for results* element of the HCS agenda; making close links between planning and a

⁵⁵ Provincial and district administrations typically being involved passively by providing data but not engaged in dialogue or co-operation on plan implementation

transparent evidence based performance framework. A shift of focus necessitates a corresponding shift from development partners: moving from individual projects to common programme collaboration.

In terms of human capacities, looking more carefully at the DPF, it is noteworthy that it has mostly Med. Dr's in its ranks; DPF has three health economists and no statisticians, no physical planners, no performance auditors. There is scope for expanding the range of individual capacities involved in the planning processes. In the short term, international and national TA can serve to supply additional skills, but in the longer term MoH needs to cater to these needs within their cadres. Again, supporting HR development of MoH planning capacities would be a core objective for a programme based approach in line with the HCS; advocating an integration of ODA into existing GoV/MoH planning (HCS indicator 1).

9.2. Information systems, monitoring and evaluation

Deeply entangled with strengthening the planning processes is the need to improve information management at MoH. Consistent and comprehensive data is lacking, quality of data is at least uneven and there is no systematic use of data as a planning and decision-making tool. This is a key constraint. Information flows are the fuel of the planning process and one basic requirement for its proper functionality.

Data collection processes in the health are suffering from incoherent reporting formats and standards, both according to GSO and MoH/DPF. Overall, the information coverage is incomplete. For instance, private sector activities are largely unaccounted for except for the occasional government inspection. Several initiatives are ongoing to remedy the situation. Inside the DPF, units are working on software solutions (MEDISOFT) and directives for information collection and recording at hospitals and elsewhere in the health care system.

Outside the MoH, particularly with the GSO – but also at MoF, MPI and MoHA – major strengthening processes are ongoing in data collection. The Social and Environmental Statistics Division at GSO – in charge of health statistics – has been supported through a number of projects including, lately, the project in “support of socio-economic development monitoring” by the UNDP with DFID funding⁵⁶. UNICEF works together with GSO in this area as well. Initiatives are also ongoing, within the framework of V-HAP, to introduce reporting and monitoring frameworks on which the government and donors alike can agree.⁵⁷

Also with the MoH there are a number of projects that, in different ways, deal with planning, information, monitoring and evaluation systems. However, these projects are predominantly oriented towards specific (donor individual) tasks, and do not address the totality of a broad systematic information base for the health sector.

At this point it should be noted that while there is no comprehensive and consistent information base available, there is no shortage of health indicators. To explain this briefly, it means that information needs to be organised in order to provide an *information base* that can

⁵⁶ The project “Support to socio-economic development monitoring”. See also the UNDP Country Programme for the Socialist Republic of Vietnam 2006-2010, p 4.

⁵⁷ Cf. the VAMESP II, where led by FERD/MPI a core team of donor and GoV representatives is currently working on an information system that can be institutionalized in 2006 and that donors can align to. See PGAE - *Working together to improve aid effectiveness for supporting sustainable development in Vietnam*, Report 2005.

serve as an effective input to planning and decision making processes. If, for instance, current figures show inconsistencies (and figures normally do) there is a need for an analysis offering some explanation – perhaps in the form of a limited survey if the inconsistency is severe – so as to inform the decision-maker. In a similar way, there is a need for advanced interpretation and analyses skills in order to provide explanations to complex result patterns of a series of interventions. In both cases, policy and decision-makers cannot be expected to do the analysis themselves but need supporting systems to provide them. This is where the planning processes of a modern administration come in to organise, process and provide analyses of existing information.

So given the existence of information, what is needed is a coherent indicator framework and analysis capacity capable of determining what these indicators mean in relation to national health priorities and programmes so as to inform the policy and decision-makers of the health sector⁵⁸.

There are two basic elements to support the information systems in the health sector. One is to strengthen information collection processes, and the other is to support information management; processing, analysis, and usage for decision-making purposes within the health administration at all levels. Improvement of information systems in the sector should be considered a priority activity (see Chapter 13).

9.2.1. A sector Performance Assessment Framework

To address both collection and management constraints, a sector programme may consider as a first step organising the establishment of a comprehensive performance assessment framework (PAF) for the health sector. Specifically, a health sector PAF developed at MoH would serve as a much needed management tool for a learning process on the use of information in planning and decision-making. All units within central MoH associated with the planning processes would benefit from using an evidence base for planning and need technical assistance to that end. Furthermore, as discussed in chapter 4, the PAF would be underpinning the Annual Planning cycle of the health sector programme and its Joint Review Missions. An outline and detailed purpose of a health sector PAF is presented in annex J.

MoH planning units are in need of the information base and skills to use information for decision making purposes. The PAF would answer to the first requirement, and provide the basis for capacity strengthening in relation to the second requirement. This includes all the 10 units of the DPF and also disease related departments (confer chapter 7) often concerned with developing their own specific implementation plans, for instance related to the NTPs.

The main priority for support of information processing is this group of departments and units of the MoH that deals with planning. More specifically, the main units of the DPF should be targeted so that all planning processes can be integrated and make use of the overview that should be made possible through the DPF. The Department of Statistics of the MoH is a particular case and its strengthening probably involves a substantive expansion or other measures so that it can serve as a hub for PAF management. Its exact role should be determined by a study to establish a PAF (cf. again annex J). If any one unit of the DPF should at least be a priority, it is the Equipment Unit to rationalise the investment processes

⁵⁸ Such analyses should be able to establish the interrelationships between indicators in a “results chain” format. Cf. DAC guidelines on monitoring for results in *Managing for development results principles in action: sourcebook on emerging good practice*, (OECD/DAC December 2005).

and their integration in to planning and calculation of other resources. Investment in health is a concern to the GoV, and it is possible that the absence of a comprehensive information system on existing equipment contributes to the GoV assessment in Resolution 46 that “the Government’s investment in health is low and the allocation and utilization of resources are not rational and of poor effectiveness”.⁵⁹

9.3. Overall human resource capacity in the health sector

HR in the health sector can be divided into two major types: the professional/technical staff and management staff in the first group, quite dominant in number, mainly involved in delivering health services; and the other group, much smaller in number, that is mainly involved in management tasks at both macro (MoH) and micro level (hospitals, health units). While the technical staff of the health sector is comparatively good in their professional competence, those involved in the management tasks would need substantial improvements in their capacity to do a good job. This weakness can be explained by both the fact typical for the whole country of Vietnam that it is in transition from command economy to market economy and thus expertise in market oriented management is generally lacking. And also by the fact - specific for the health sector - that most of the management personnel in the health sector have a medical background and only few have an additional degree or professional training in management science or economics. The only courses every civil servant in the health sector has to attend are the ones on public administration and on political training that is given to every other civil servant in the same form with the same content, regardless of their specialization and background. These courses are commonly assessed as superficial, formal and are rather needed for promotion purpose (in both salary grades and position) rather than for the knowledge or skills it provides. Management training and skills are also often provided within the framework of donor projects, but they are usually subject-specific rather than on general management and only accessible to those who participate in the project, who will not necessarily use or need the acquired skills later in their work.

So in general, acquiring new and improving management skills (strategic planning and management, management of work processes, HR management, financial and budgetary planning and management, marketing, organizational development, etc.), is essential for health sector personnel, particularly for those working in MoH and holding the important positions, to adapt to and meet the demand of the changing context of the country.

This goes in line with the current PAR process and directions, in which improving capacity, particularly in the area of (public) management stands among the major programs and is considered critical and decisive for the improved performance of the public administration (even though progress in this reform area so far has been limited).

The needs to improve human resources, both in their professional competencies as well as in the management capacity with particular focus on strategic and operational planning and management, decentralization and performance monitoring are clearly stated in the Master Plan, the Five-year Plan and the PAR plan for the health sector. However, what is further needed is a concrete action plan on HR development and capacity building for the health sector, which should be able to specify types of training for specific target groups in a good

⁵⁹ This assessment is reinforced by the Master Plan for health to 2010 reporting of insufficient and inadequate medical equipment from “a sorry mix of origins”, p. 11 (English version).

timing structure. Such a plan needs to be included in a work plan for the introduction of the programme approach.

9.4. Decision making processes and dependency on others

As a ministry, MoH has the role of state management in the health sector. This means it is there to formulate and support implementation of health related laws, resolutions and decisions set out by the Party, the National Assembly and the Government. It has an advisory role in making/preparing these documents to be approved/promulgated by the higher bodies and an executive role in implementing the promulgated documents/policies. To do so, it relies on its given authority to issue decrees, decisions and regulations. However, the ministry, like any other ministries, is quite limited in certain authorities. These include for example the authority to change its structure and organization, to decide on personnel size, to appoint ministerial ranks, or even to try innovate reforms in certain areas such as planning.

In the example of changing structures at the MoH, it is MoHA that appraises the proposed changes and makes recommendations to the PM for decision-making. In case MoH has a recommendation on the change, they will need to work very closely with and convince MoHA of the need for the change so that MoHA, as an agency mandated for recommending structural changes, can further influence the PM and the GOV in their decision. The process might vary between 2 months to 3 years.

MOH has to strictly follow staff management regulations set out by MOHA. It receives quota for number of personnel to be engaged during the year and does not have the right to change the quota. Similarly, the Minister him/herself can not decide on the salary schemes for the ministry, but strictly follows the rules set out by MOHA and MOF in relation to each post decided.

When it comes to planning, MOH also seems to be quite dependant on MPI for instructions on the methodologies, format and content. Innovative actions to reform the planning process, for example the use of a different format, such as a logframe matrix to present a plan, might present a challenge in itself to MPI and might get rejected as it would not fit the overall planning frame. However, MPI seems to be more aware of the need to reform its planning process toward more result and outcome orientation rather than focusing too much on input and output targets and thus tends to look for more effective planning tools such as the logframe approach. If this shift in approach continues, this will lay a very good foundation for a much needed planning reform at the MOH.

9.5. Financial management at the MoH⁶⁰

The ambitious intentions behind the PFM reform agenda previously presented do not seem to have influenced the every day operations at the MoH so far. General improvements of procedures and systems – like the streamlining of the budget process including the reduction of the number of classifications and line items in the budget and the much improved liquidity situation at the Treasury – are of course changes that will ultimately affect the situation at the MoH.

⁶⁰ Previously listed documentation on PFM, papers elaborated during missions and interviews at the MoH

However, in terms of PFM systems as *management tools* supporting the introduction or implementation of the programme approach, much work remains to be done. An assessment of the feasibility in relation to the necessary status of PFM systems at the introduction of a programme based co-operation, presents the following picture:

Treasury: Treasury systems are centralised and there are no liquidity restrictions. Approval of disbursement of funds is instead slow due to cumbersome procedures. Fiduciary risks are small as in the possibilities to reallocate budget support funds to other expenditure areas, further restricted by the reality of fungibility of funds from different sources. Development gains in transfer of donor funds through the Treasury system are high, impacting on both common disbursement arrangements to the same programme and the severe transactions costs at the MoH caused by project proliferation

Budget and budget structures: Even though at least two donor funded reports on sector financing⁶¹ propose a programme based budget structure, the structure of the economic classification at MoH, the only one used in the budget, completely follows the guide presented by the MoF, representing a mixture of classical line items (such as water and fuel) with programmes (such as health insurance). An attempt to align with GoV budget procedures in a programme based co-operation would necessitate the introduction of a programme based budget structure.

Accounts and financial reports: Accounts are presented at least every quarter in the budget structure. In addition and interestingly, Consolidated Financial Accounts at year's end are presented in a very different complementary structure to the budget structure, in fact formulating the first step on the road of introducing a programme base budget. Budget items are in these accounts presented as i) overall expenditure and revenue presented by source of income, ii) a full cost-item base structure, iii) expenditure in relation to ODA (pre-supposes traceable aid) and a general heading of iv) others.

In a matrix structure to this, expenditure (and revenue) is classified in i) a number of administrative areas like Economic services, Administration but also e.g. University, ii) Infrastructure investment, iii) a division in Curative and Preventive Care, together with Family planning and Other Health Services and iv) division in diseases and other items like Food Safety and Drugs to match with NTP defined areas.

This structure of the Annual Accounts could be interesting from the perspective of the programme approach and should be further explored to see if these structures introduced to serve the NTPs, also could be used as a base for programme based budgeting..

Audit and audit functions: Internal audit functions at the MoH currently do not answer to the internationally recognized parameters of the PEFA analysis (Public Expenditure and Financial Accountability) Capacity is weak both in HR and methodology used.

Procurement: Procurement procedures at the MoH are currently fragmented between different departments and entities of the ministry, jeopardizing a streamlined approach to tendering and procurement of services and goods. The introduction of a programme approach could benefit from the issuing of the GoV's new Ordinance on Procurement in December 2005, valid from April 2006, enforcing a more unbiased procurement procedure and higher demands on those

⁶¹ Report on Health Funding/Financing 2006 – 10 and Research report on developing comprehensive health financing plan

presenting bids. Also, the ministry would benefit from the introduction of a Procurement Department, which would stipulate common rules and procedures.

In summary and in relation to a fully fledged programme based co-operation between the MoH and development partners, the weakest parts of the PFM systems at the MOH are the same as in other Government ministries, i.e. audit and procurement. All areas need to be analysed more in-depth for an introduction of the programme approach. PFM conditions in the provinces should also be further analysed. This discussion could be well supported from previous analyses and experiences in the education sector at the introduction of the Education for All Programme⁶². Even though the system to a large extent is uniform, there are still individual situations that only apply to lower level administrations. For instance, experiences from the EFA programme suggest that possibilities to track expenditure and receive financial reports improve substantially if pilot initiatives are linked to a NTP sub programme under the MoH. The fiduciary risk assessment from the education sector is annexed to the report (annex M).

⁶² "TBS Programme for Education For All Implementation (TBS-EFA) in Vietnam: Fiduciary Risk Assessment", April 2005

10. A SWOT analysis of the health sector in Vietnam

Based on the findings reported so far in this document and derived from several sources of information, this chapter presents the most important issues in the health sector in Vietnam in the form of a SWOT analysis (strengths, weaknesses, opportunities and threats). It should be noted that the parameters presented below relate to various actors of relevance to the sector, for instance institutions like MPI, MoF, MoHA and others. This implies that the success of a programme based approach is partly dependent on decisions that are beyond the control of the MoH.

Strengths

	<i>Level</i>
<ul style="list-style-type: none"> • At the macro level, there is a favourable reform climate: instructions to and intentions behind the SEDP for 2006 – 10 are supportive to new ways of planning and follow-up on results achieved; they favour the move towards programme based support. 	<i>GOV</i>
<ul style="list-style-type: none"> • The GoV demonstrates high ambitions in poverty reduction; not only as political goals but also through mechanisms like norms for allocation of regular budget resources, special pro-poor programmes and support to poor people in health insurance 	<i>GOV</i>
<ul style="list-style-type: none"> • The macro economic situation is strong, even compared to high income countries. 	<i>GOV</i>
<ul style="list-style-type: none"> • The political situation is stable. 	<i>GOV</i>
<ul style="list-style-type: none"> • The Public Finance Management system is very strong compared to other countries at the same GDP/capita; it is further improving through broad reform initiatives. 	<i>GOV</i>
<ul style="list-style-type: none"> • The GoV's strong decentralisation policy gives broad possibilities for lower level administration to formulate individual strategies to implement health services. 	<i>GOV</i>
<ul style="list-style-type: none"> • There is an overall national policy framework for the health sector. 	<i>MoH</i>
<ul style="list-style-type: none"> • The health system has some strong features, most importantly the strong apparatus to implement centrally defined sub-sector programmes and achieve the related targets; the important progress in many health indicators is a clear reflection of this. 	<i>MoH</i>
<ul style="list-style-type: none"> • Some of the recent planning documents of the MoH reflect the improvements in general planning, in line with the SEDP. 	<i>MoH</i>
<ul style="list-style-type: none"> • The GoV has the potential to successfully mobilise resources in situations of (health) emergencies if there is a political will to do so (e.g. avian flu). 	<i>MoH</i>
<ul style="list-style-type: none"> • Many important donors in the health sector demonstrate a strong will to move to programme based cooperation. 	<i>Donors</i>
<ul style="list-style-type: none"> • There are already some good examples of (close to) programme based collaboration (tuberculosis control, immunisation) with strong political commitment, international technical assistance and a common policy framework. 	<i>MoH + donors jointly</i>

- The strong poverty reduction commitment from all parties involved *Jointly*

Weaknesses

- The national reform agenda and the intentions in the HCS have not been implemented in the health sector as yet, or only to a very small extent, in spite of the strong commitment at macro level. This reflects weak co-ordination between cross-cutting institutions responsible in the reform process and the sectors. *Level
MoH*
- Strategic (medium-term) planning at the level of the MOH is weak, with little involvement of non-government actors or donor agencies; there is not a single (overall) implementation plan or established routine of identifying and quantifying the resources that are needed to implement the health sector policy. *MoH*
- Responsibilities for the provision of health services are highly fragmented between various government agencies and departments. *MoH*
- The health system at lower levels reflects weaknesses in information feedback and utilisation of opportunities to reallocate resources. (stronger in rich provinces, weaker in poor provinces). *MoH*
- The present capacity and support systems (amongst them M&E) at the MoH are too weak to allow a straight and comprehensive implementation of the macro reform agenda in the health sector as a whole. *MoH*
- Several PFM subsystems at MoH require strengthening, e.g. auditing and procurement. *MoH*
- The already existing fragmentation in the provision of health services is being further aggravated by donors' project approach. *Donors*
- Some donors do not seem to be well informed about MoH policies and plans. *Donors +
MoH*

Opportunities

- The GOV has a high ambition on the Aid Effectiveness agenda and this process has been institutionalised in collaboration with development partners. *Level
GOV*
- The uniform system of the administration where introduction of new features, such as the programme approach, could impact broadly and relatively fast. *GOV*
- The new five-year planning cycle has just started. *GOV*
- The decentralisation policy and the possibilities it will create in the medium term to strengthen the impact of a programme approach. *GOV*
- There are opportunities to learn from good examples (best practices) in other sectors (education, transport) and in other countries. *GOV*

- There are opportunities to learn from good examples (best practices) with programme support in particular sub-sectors at the MoH. *GOV*
- Broad donor support to the GOV's Aid Effectiveness agenda. *Donors*

Threats

- The reform agenda is to some extent slowed down by poor synergy between different reform programmes. *Level GOV*
- PFM reform does not sufficiently consider and build on existing systems that are quite strong. *GOV*
- The PAR reform is moving too slowly and does not include all necessary parts of deconcentration of decision-making and control of resources from MoHa to MoH. *GOV*
- The strong dependency of MoH on policy initiatives by other government departments (MoF, MIP, PM, others). *GOV*
- Risk of further already acknowledged and recorded corruption⁶³ *GOV*
- The decentralisation policy and unrealistic expectations from health insurance could increase inequity and reduce the impact of poverty policies; it could jeopardize medium- and long-term financing of the sector. *MoH*
- Interest among individual stakeholders at MoH and in provinces in a continuation of project support, which would strengthen their own respective structures rather than (sub)programmes as such; this represents a classic type of resistance to the introduction of programme support. *MoH*
- A continued biased resource allocation in favour of investments, with insufficient attention for their recurrent cost implications and for quality of care issues. *MoH*
- No full understanding and partial political commitment at the MoH to sector programme support, for the time being; in reality a killing factor if it is true. *MoH*
- The PFM reform is to some extent slowed down by differences of opinion on the donor side. *Donors*
- Continued resistance from certain core donors in the sector to the programme approach *Donors*
- For certain sub-sectors (e.g. HIV/AIDS, malaria): a large amount of additional funding through 'vertical' global funding mechanisms that come with their own management arrangements. *Donors*

Among the numerous issues listed in this SWOT analysis, several can be singled out that are particularly relevant for *the introduction of a programme approach in the health sector*.

⁶³ Extensive information on the corruption situation in Vietnam can be found in the study "Report of the survey on corruption in Vietnam", Committee for internal affairs of the communist party of Vietnam, November 205 (draft)

Several *Strengths and Opportunities* are conducive to the introduction of a programme approach: the high ambition on the aid effectiveness agenda, the strong PFM system, the robustness of the health system, the GoV's reform intentions reflected in the SEDP, the improvements of the new planning documents in the health sector, donor interest in a change towards programme based co-operation and the existence of best practices outside and inside the health sector.

In relation to *Weaknesses and Threats*, we think that the difficulties to transfer the GoV reform agenda to the line ministry (i.e. the MoH) might be the strongest limitation to the introduction of a programme approach in the health sector. Other issues of concern are: weak management systems at MoH, the weaknesses of the PAR reform, a since long profoundly established project co-operation culture and a possible absence of political support to the introduction of this management system in the sector.

Building on the above SWOT analysis of the most relevant issues in the Vietnamese context, the next chapters propose a road map towards the introduction of the programme approach in the health sector and will then draw conclusions on the feasibility and chances of success of such an approach.

11. A Vietnamese road map towards the programme approach in the health sector

Based on the principles of the Hanoi Core Statement and the international experience with programme based approaches elsewhere (presented in Chapter 4), the specific conditions inside and outside the health sector in Vietnam (described in Chapters 2 to 9 and summarized in the SWOT analysis in Chapter 10), a road map is proposed towards the introduction of the programme approach in the health sector. This road map consists of six steps that are meant to achieve more effective and efficient collaboration between the government and its partners – both domestic and international:

1. The MoH formulates the agenda for entering into a new way of cooperation in the health sector and opens up the dialogue with its partners about the strategic framework(s) and implementation plans that it envisages for implementing its sector policy and/or sub-sector policies. It invites comments and suggestions on draft master plans and multi-annual plans, which are as comprehensive as possible, taking into account the roles and resources of all actors. Interested international agencies respond to such invitations and comply with the proposed timeframes for submitting their inputs.
2. The MoH takes the lead in developing and presenting medium-term expenditure frameworks/financing and cost analyses for the sector plan or individual sub-sector plans, showing the ‘resource gap’ that would need to be filled through external assistance.
3. The MoH calls upon donors interested in supporting the implementation of sector/sub-sector policies and plans, willing to fill in (part of) the resource gap through *different* kinds of aid and financing modalities. The MoH initiates a written *Code of Conduct* that stipulates the *jointly* agreed planning, monitoring and implementation procedures and development partners’ obligations to support this process. Through the signing of the CoC, development partners commit themselves to refrain from bilateral and closed agreements with the MoH. The HPG is a suitable forum to initiate the CoC and monitor adherence to it. In addition, a much smaller and more operational Working Group (headed by DPF, reporting to the HPG) will carry the responsibility to guide and monitor implementation of the road map towards the programme approach.
4. The MoH, in conjunction with *development partners willing to provide (sector) budget support*, develops a *Joint Financing Arrangement* that articulates the agreed procedures for budgeting, accounting, transfer of payments and audits, based on the existing GoV financial management system.
5. The MOH proposes and agrees with its development partners how the (sub)sector strategy and annual work plan (AWP) will be implemented, managed, reviewed and adjusted (in case there is a need for adjustment), and how to consolidate this in a set of *common management arrangements*. These will – among many other things - propose the selection of performance indicators, targets and mechanisms for performance monitoring. Ideally, all these arrangements should already be regulated in the Code of Conduct (see 3 above).
6. The joint GoV/MoH – donor *Working Group*, chaired by the DPF, initiates a functional analysis of the capacity in the sector (or sub-sectors concerned) to identify weaknesses and develop a plan for capacity strengthening and technical assistance. This is not necessarily the last step: it should start as soon as possible.

It should be remembered that the main feature of the programme approach is the intention of concerned parties to *jointly* discuss and agree on the different steps included in the Government's planning cycle, aligned to Government procedures and systems: from planning to discussion on results. In this financing arrangements and financing mechanisms are important to consider but do not represent different stages on the road towards a fully fledged SWAp. Sector co-operation could in principle be based on project support only, even though, as has been presented, the provision of sector budget support is highly recommended in Vietnam and would represent many advantages. Co-ordinated and common procedures as the most important pre-requisite for the SWAp would also imply that the Code of Conduct is a more important document to establish at early stages of this process, compared to the JFA.

12. Conclusions

In the introduction to this report we put the questions if the programme approach could support the ongoing initiatives to review government procedures and enhance efficiency and quality in the use of public resources. In a balance between opportunities and limitations on the path towards a more efficient and effective way of utilising resources in the health sector, it is the team's opinion that there are good opportunities to improve the situation through initiatives that include the introduction of a programme based way of co-operating, but also through other initiatives.

It is our impression that the GoV is well aware of the need for a change in planning procedures, planning instruments and management tools and that this represents a significant change compared to conditions at previous attempts to introduce the programme approach. This comes out clearly in the newly introduced SEDP and the current health sector five year plan, as well as in Resolution 46. The formulation of the HCS indicators is another evidence of this awareness. Collaboration through the PRSC dialogue and the on-going PFM and PAR reform agenda, all point in the same direction.

The SWOT analysis in Chapter 10 displays Vietnam's relative strength in many of the fundamentals that would be supportive to the introduction of the programme approach. It should also be remembered that many of the topics labelled as "threats" in the SWOT analysis are issues that are on the agenda in most developing countries (in fact many of them are on the agenda in most countries of the world), while there are plenty of examples of countries where the strengths that characterise the Vietnamese health system are much less prominent. Still, most development partners that are active in Vietnam are already engaged in a programme based collaboration with these other countries.

One of the most fundamental conclusions from our analysis is that conditions in the health sector are not as favourable as at the macro level. A key initiative would therefore be to open a dialogue between "macro" representatives and sector representatives from both the government and development partners on how to translate the progressive reform agenda on the macro level into tangible implementation tools in the sectors, including the health sector..

The cross-cutting reforms presented in this report represent one of the strongest motives to move ahead and introduce the programme approach in the health sector. Without the kind of management model represented by the programme approach, it will become difficult for the GoV to materialize the intentions presented in government documents mentioned above and formulated in ongoing reform work. Intentions for the health sector on medium term necessitate a shift in planning procedures.

The programme support presupposes a close relation between government representatives and concerned development partners. In the health sector this calls for a change of attitude. While the MoH needs to be more inviting towards donors in the formulation phase of policies and multiannual and annual plans and in the presentation of results and shortcomings, donors should learn to accept the GoV's agenda and refrain from bringing in their own favourite agenda themes (that are often dictated by their HQ policies but which do not necessarily fit local priorities). Donors must also move from a principle support of the HCS, to concrete steps to materialise the agreed aid effectiveness initiatives. This means in practice: alignment with government's PMF systems, from planning to audit, with complementary procedures for

the time being in some areas, for fiduciary reasons. Donors must be prepared to set aside resources to accomplish this shift in their working relations with the government.

It is the team's impression that many donors as well as managers in key positions at the MoH want to do precisely this. What we have not been able to find out during this assignment, though, is the extent of political support to the process. From experience, a lack of political support in this kind of reform in reality represents a killing factor to any attempt to introduce the programme approach. A shift to budget support will undoubtedly mobilise resistance, also in this sector, also in this country. Having a say over their "own" projects represents advantages to many managers in the sector and strong incentives not to support any steps towards programme or budget support. Without clear political signals that the shift should and will take place, this kind of (sometimes organised) resistance will prevail.

As in any introduction of the programme approach, the planning process is important. In the Vietnamese setting and specifically at the MoH we think that it is even more important than in other countries as an instrument to influence almost all parameters that determine the actual provision of health services. Our conclusion is that initiatives for supporting the Planning Department at the MoH are crucial, even in the absence of any programme approach. The DPF needs (initial) external support to succeed in achieving the goals set out by the GoV for the next five year period.

An especially important factor in this kind of efficiency effort, is the relation to lower level actors. It would be crucial for the MoH to include and utilise knowledge from different stakeholders at local levels in the process of introducing the programme approach, for different reasons. One is the centralising effect of the programme approach, strengthening the powers and position of central planning functions. This needs to be balanced through active involvement of local actors. Another reason is to safeguard the possibilities to include the knowledge and competence of these local actors in the new planning process. The local position could be strengthened in different ways, e.g. through invitations to participate in Annual Review Meetings and representation in the institutional arrangements of the programme approach, such as the HPG.

The local level also needs frameworks and opportunities for continued promotion of innovations and new modalities as pre-requisites for efficiency improvements. This calls for the possibilities to introduce new planning procedures also at this level (See recommendation in Chapter 13).

We find capacity at the MoH unevenly distributed and the ministry in great need of stronger support systems so as to balance with the vertical command structure and the corresponding way of planning and implementing programmes. We think that the introduction of a performance assessment framework to support planning, combined with different capacity strengthening initiatives, would improve this situation.

13. Recommendations

13.1. General recommendation

All involved stakeholders should now take advantage of the broad common interest and the favourable conditions in moving to a programme based cooperation between the MoH and its development partners.

We are aware that the MoH is dependent on clear signals from structures like the MPI to go ahead with this agenda. At the same time we find that all formal requisites already exist and that the GoV has signalled very clearly, for instance through the instructions supporting the implementation of the new SEDP, that this shift is not only possible but necessary. We also find that the MoH could move ahead with actions that do not need the approval of other institutions

We therefore recommend that the MoH invites development partners for the sector as a whole (with the DPF as counterpart) and specifically in different sub-sectors (corresponding to the departmental structure of the ministry) to work in accordance with the prerequisites of the programme approach as this has been described step by step in chapter 10. This presupposes the willingness and ability of the MoH to take the lead in this process.

13.2. Specific recommendations

A massive and complete shift to a programme based cooperation throughout the MoH and involving the entire sector is not feasible for many reasons, one being the fact that there is no unique and agreed comprehensive intervention framework as yet. The weaknesses in administrative support systems at the ministry in combination with the deeply rooted project-based cooperation throughout the sector, with its strong impact on relations and every day working procedures, represent too strong limitations to such a sudden and comprehensive shift.

Instead we recommend a number of pilot approaches:

- i) We recommend that a *service delivery area* that involves a certain package of health services (could be disease related or thematic) be selected as a sub-sector for a pilot intervention to work according to the parameters of the programme based approach as presented in chapter 4. Apart from service delivery areas (malaria, TB, etc.), *health sector support systems* can be selected for such pilot interventions as well (e.g. HRM, HRD, health financing, procurement of commodities, infrastructure development, ...)

The selection of the pilot interventions should be based on the following criteria:

- Linked to a particular service delivery area or to one of the support systems.
- Defined as a service delivery area or support system that is largely managed inside the MOH by a particular department (or national institute).

- An existing policy that could be adjusted to a framework acceptable for both the ministry and donors involved.
- An existing dialogue forum for discussion on the implementation of the agreed programme and all issues related to this.
- At least three donors in the sub-sector that are willing to move to a programme based co-operation, including an eventual shift to provision of budget support.
- A management team at the department/institution involved that is willing to take the lead in the process and develop planning, monitoring, follow-up and result reporting cycles and procedures for common application.
- Willingness of this management team to accept technical assistance in this process; as well as willingness of donors to provide funds for such technical assistance, that would be expected to work under the leadership of the regular management at the chosen department.
- Poverty orientation.

In this pilot we would also like to suggest a more flexible allocation of budget resources to the MoH, for the ministry to allocate ordinary budget resources from the MoF and from donors more freely in accordance with the intentions and priorities of the pilot. The selected area could also increase horizontal collaboration and network development and contribute to a reduction of fragmentation of services.

- ii) We further recommend support to a small number of provincial health administrations to strengthen their conventional planning procedures and to utilise management tools already introduced (decentralisation initiatives, possibilities to raise funds, etc) and those implicitly supported through the new SEDP (“modern planning”). The purpose should be to enhance efficiency in resource consumption through new planning instruments and procedures.

These provinces should be selected based on the following criteria:

- At least one rich province and at least one poor province.
- Application of the same sub-sector area as for the pilot at central level.
- At least a couple of existing donor projects from the same donors involved in the pilot on central level.
- A willingness from this provincial management to integrate the planning process to cover all existing resources.
- Strong coherence in management (criteria: ability to meet deadlines in the annual planning process, ability to supervise and report in time, corruption index position if available and willingness to accept transparency in information handling).

- iii) We finally recommend that technical assistance resources at the MoH are (re)allocated to support the Department of Planning and Finance (DPF) in an attempt to change the current planning procedures of the MoH, especially in relation to development partners, and to establish the programme approach dialogue for the *whole* sector. The objective of the technical support should be to institutionalise a process where *all* external involvement in the sector is discussed in accordance with policy and planning procedures established by the ministry. This means that discussions are held with all donors engaged in a specific programme area (a sub-sector or a support system), and at the same time based on

a commonly acknowledged policy and planning document. DPF should formulate the agenda for dialogue occasions between the ministry and development partners based on principle issues in the planning cycle, and not on issues formulated by and referring to the needs of individual donors. This support should not be linked to a PMU. The individual technical assistants engaged should operate fully integrated within and under the leadership of the management of the DPF.

In this work the potential and abilities of support systems previously presented in the report should be assessed and subject to strengthening. Based on the performance assessment framework annexed to this report (annex J), a work programme to strengthen the planning process should be identified.

13.3 Next steps

Following our second period of work in Vietnam in May 2006, we suggest the following immediate initial actions on the road to establishing the programme approach as the dominating management modality at the MoH.

List of prioritized actions at the Ministry of Health in Vietnam for the introduction of the programme approach.

Steps	Activity	By whom	Milestones	Comment
1. Capacity assessment and strengthening	Assess the requirement for additional technical capacity to help introduce the programme approach (implement the road map)	MoH/DPF with support of interested DPs	Brief report outlining the capacity gap	<i>Assessment to focus on DPF's capacity</i>
	Prepare a proposal for technical assistance and present it to DPs for (common) funding	MoH/DPF with support of interested DPs	Proposal prepared; common fund established	<i>Common fund to be dissolved once budget support is introduced</i>
	Procure technical assistance (using the common fund)	MoH/DPF	TA mobilised	<i>Both short-term and long-term TA is required</i>
2. Strengthen internal information systems	Conduct a review of the adequacy of current information systems at the MoH for strategic planning & resource allocation	MoH/DPF to initiate, with support of interested DPs	Review conducted	<i>This may be initiated before the long term TA is in place; it will inform the choice of core indicators and common procedures for monitoring sector performance that should be defined in the Code of Conduct</i> <i>See the study report sections 9-9.2.1 and annex J</i>
	Prepare a proposal for strengthening information systems	MoH/DPF	Proposal adopted and implemented	<i>See the study report sections 9-9.2.1 and annex J</i>

3. Sector policy and strategic frameworks	Fine tune and clarify the national health planning process internally (MoH) and towards DPs	MoH/DPF, through the HPG		<i>cf. fig 8.1 of study report</i>
	Further pursue the elaboration of comprehensive master plans: for the whole sector and for particular sub-sectors and support systems	MoH/DPF, in conjunction with relevant MoH depts and DPs	Master plans adopted	<i>See selection criteria below</i>
	Introduce the process of integrated planning & budgeting in one or more provinces on a pilot basis	MoH/DPF, in conjunction with selected province(s)	Integrated provincial plan & budget adopted	<i>See selection criteria below</i>
4. Expenditure frameworks	Elaborate medium-term expenditure frameworks for the selected sub-sectors; update annually	MoH/DPF, in conjunction with relevant MOH depts and the MoF	Sub-sector MTEFs finalised	
	Pursue annual updates of MTEF for the sector as a whole	MoH/DPF	MTEF finalised	
5. Establish a Code of Conduct	3.1 Elaborate a Code of Conduct, for signature by GoV and <u>all</u> DPs. The CoC should include agreement on common	HPG, led by DPF	CoC signed; bilateral negotiations	<i>See study report section 4.4 and annex L</i>

	procedures and planning and review occasions throughout the annual planning cycle.		stopped; PMUs phased out	
6 a. Introduce institutional arrangement at the MoH for the programme approach	3.2 Establish the Working Group (as presented in the attached diagram) headed by DPF. The Working Group should initially consist of representatives from the MoH and other signatories to the Code of Conduct. The Working Group will guide and monitor implementation of the road map to the programme approach; it will eventually monitor implementation of the sector (master) plan and sector performance as a whole	MoH to establish, DPF to lead, with participation of selected DPs	Working Group functional	<i>Working Group will report to the HPG</i>
<i>6 b. Introduce institutional co-operation between development partners</i>	Establish a dialogue mechanism (platform) for DP amongst themselves (with agreed ToRs and clear relation with the Working Group and HPG)	DPs, with rotating chair	Platform functional	<i>Platform will provide input to the Working Group and to the HPG</i>
<i>6c. Rearrange current institutional arrangements</i>	Review current regulations and the agenda of the Health Partnership Group and establish regulations and procedures that answers to the HPG as a policy decision-making group to the programme approach	MoH/DPF in collaboration with DPs	New regulations and procedures	
<i>7. JFA between GoV and interested DPs</i>	Enter into Joint Financing Arrangement between GoV and DPs willing to provide (sector) budget support	DPF to initiate, with involvement of MoF	JFA signed and implemented	<i>See study report section 4.4 and annex L</i>
	Monitor adherence to JFA; adjust when necessary	Specific institutional arrangement for the JFA only		

Criteria for the selection of sub-sectors to support the elaboration of comprehensive master plans:

- a. There should be one single MoH entity (a department or national institute) that is recognised and mandated to develop policy and provide strategic guidance in the sub-sector.
- b. The MoH entity should currently be strong enough to take leadership and initiate a policy dialogue with the major development partners on a multilateral (rather than bilateral) basis.
- c. There must be some kind of policy paper and/or strategic framework in place that is reasonably comprehensive and that does not have any controversial/contested elements that would prevent external parties from aligning with government policy. This is to ensure that the pilot can move fairly quickly beyond step 1 of the road map.
- d. There should be more than one major external agency providing technical and/or financial support to the sub-sector.
- e. It is not a requirement that the sub-sector be restricted to health (in other words: sub-sectors with strong inter-sectoral features, such as HIV/AIDS, do qualify for a pilot).

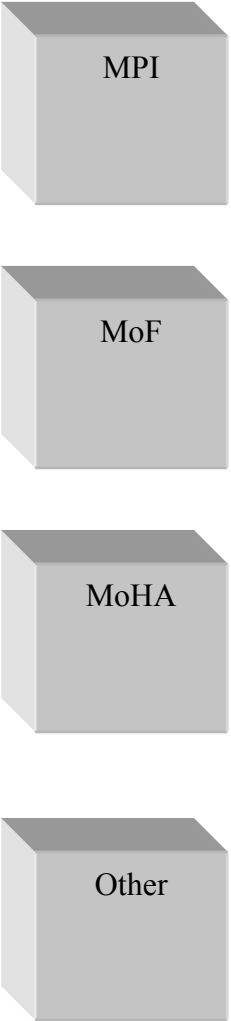
Criteria for the selection of pilot provinces to introduce integrated planning & budgeting:

- a. The leadership of the provincial department of health (DoH) should be interested in participating in the pilot in conjunction with MoH/DPF
- b. The provincial department of health (DoH) should have a fully established DPF section in place (no vacancies, stable staff)
- c. The province should have a proven record in sound planning & budgeting in at least one or two sub-sectors
- d. The province should have national (target) programmes operational in sub-sectors that are chosen for the sub-sector pilots
- e. At least two provinces; preferably one relatively rich province, and one relatively poor province.

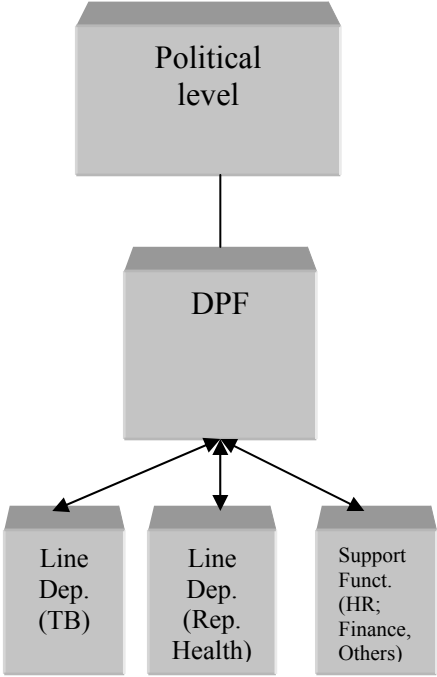
The institutional arrangement for the programme approach in the health sector in Vietnam. Proposal

(should be read in relation to activities throughout the annual planning cycle, identifying the Annual Review Meeting as the core review and planning occasion)

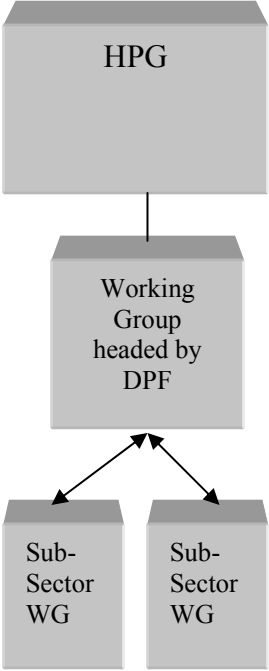
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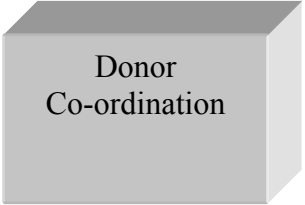
MoH



MoH/DP



Dev. partners



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