HESVIC project

COOPERATION

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HESVIC	HESVIC is a three-year research project (2009-12) being implemented under the European Community Seventh Framework Programme (FP7). The project aims to investigate stewardship and regulation as it relates to governance of health systems in policy and practice through a comparative study of three Asian countries – Vietnam, India and China. The project uses maternal health care services as a case study of stewardship and regulation. The goal is to support policy decisions in the application and extension of principles of accessibility, affordability, equity and quality coverage of health care in the three countries.

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TABLE OF CONTENTS

ABBREVIATIONS AND ACRONYMS vii

CHAPTER 1. BACKGROUND OF THE PROJECT 1
1.1. Overview of key HESVIC research elements 1
1.2. Summary of HESVIC research 2
1.3. Purpose and structure of the research report 7

CHAPTER 2. METHODS 9
2.1. Design 9
2.2. Case studies 9
2.3. Data collection methods 10
2.3.1. Study sites 10
2.3.2. Data collection methods 13
2.4. Data management and analysis 15
2.5. Ethical issues 15
2.6. Personnel 16

CHAPTER 3. CONCEPTUAL FRAMEWORK 18

CHAPTER 4. INTRODUCTION TO THE COUNTRY CONTEXT 20
4.1. Socio-demographic status 20
4.2. The health system and maternal health services 21
4.2.1. Health system and maternal and child health network 21
4.2.2. Expansion of private health services 25
4.2.3. Maternal health care outputs and service delivery 26
4.2.4. Health sector financial inputs 28
4.2.5. Governance and the regulation environment in the health sector 30

CHAPTER 5. CASE STUDIES 36
5.1. Emergency Obstetric Care (EMOC) case study 36
5.1.1. Processes of Decision 385/2001 36
5.1.1.1. Policy environment 36
5.1.1.2. Administration 41
5.1.1.3. Implementation 43
5.1.1.4 Monitoring and evaluation 48
5.1.2 Regulation approaches 50
5.1.2.1. State command approach 50
5.1.2.2. Enabling approach 51
5.1.3. Actors 51
5.1.3.1. Description of actors 51
5.1.3.2. Actor power 59
5.1.4. Contextual factors affecting the regulation 62
5.1.4.1. Insufficient resources for providing EMOC services at different levels 62
5.1.4.2. District level reforms 67
5.1.4.3. Hospital autonomisation and marketisation in health care 68

5.1.4.4. Health insurance 70
5.1.4.5. Complexity of regulations 70
5.1.4.6. Health seeking behaviour: the selection of higher-level providers 71
5.1.5. Effects of the regulation on equitable access to EMOC services 73
5.1.6. Discussion 78
5.1.6.1. Process 79
5.1.6.2. Actors involved 79
5.1.6.3. Contextual factors 80
5.1.6.4. Governance 81
5.1.7. Conclusions 84
5.1.8. Recommendations 85
5.2. Antenatal care (ANC) case study 88
5.2.1. Introduction to the ANC regulation 88
5.2.1.1. The policy environment 88
5.2.1.2. Content 93
5.2.2. Processes 95
5.2.2.1. Formulation 95
5.2.2.2. Administration 96
5.2.2.3. Implementation of the regulation 98
5.2.2.4. Control of regulation implementation 102
5.2.3. Regulation approach 108
5.2.4. Actors 109
5.2.4.1. Description of actors 109
5.2.4.2. Actors' power 123
5.2.4.3. Actors' network 124
5.2.5. Contextual factors affecting the regulation 128
5.2.5.1. Policy and socio-cultural context: son preference and the small family policy 128
5.2.5.2. Poor political commitment 131
5.2.5.3. Abortion behaviour is different among regions 132
5.2.5.4. Features from the wider health and population system 133
5.2.5.5. Globalisation and marketisation in health care 135
5.2.5.6. Variation in local support to the ANC regulation 136
5.2.6. Effects of the regulation 136
5.2.6.1. Modest compliance with ANC regulation 136
5.2.6.2. Unintended effects of non-compliance with the regulation 140
5.2.7. Discussion 141
5.2.8. Conclusions and Recommendations 145
5.2.8.1. Conclusion 145
5.2.8.2. Recommendations 146
5.3. Grievance Redressal case study 148
5.3.1. Processes of the GR regulation 150
5.3.1.1. Formulation of the MOH instruction on solving complaints 151
5.3.1.2. Administration of the regulation 152
5.3.1.3. Implementation 153
5.3.2. Regulation approaches 168
5.3.2.1. State command approach 168

5.3.2.2. Client-oriented approach 168
5.3.2.3. Enabling approach 169
5.3.3. Actors 169
5.3.3.1. Description of actors 169
5.3.3.2. Actor power 186
5.3.3.3. The actor network 188
5.3.4. Contextual factors affecting the regulation 190
5.3.4.1. Lack of resources for GR work at all levels 190
5.3.4.2. Hospital autonomisation and marketisation in health care 191
5.3.4.3. Ineffective management of private practice 193
5.3.4.4. Different behaviour among Northern and Southern people 194
5.3.4.5. Corruption 195
5.3.5. Effects of the GR regulation 196
5.3.5.1. Introduction of clear procedures for solving GR case, with variation in implementation in different provinces and health facilities 197
5.3.5.2. Limited effects in improving quality services 198
5.3.5.3. Unintended effects 200
5.3.6. Discussion 201
5.3.7. Conclusion 209
5.3.8. Recommendations 210

CHAPTER 6. COMPARISON OF THE THREE CASE STUDIES 213
6.1. The regulation framework 213
6.1.1. Content 213
6.1.2. Regulation processes 216
6.1.3. Actors 218
6.1.4. Effects 224
6.2. Linkage between content – context – actors and effects 226
6.2.1. Good governance 226
6.2.2. Actors' power and potential 229
6.2.3. Contextual influences 231
6.3. Comparison of processes, actors and contextual factors for maternal health regulation with general health regulation 235
6.4. Recommendations 236

CHAPTER 7. CONCLUSIONS 239

REFERENCES 247

LIST OF TABLES

Table 1: Case studies and regulations....4
Table 2: EMOC services provided at different levels....5
Table 3: Overview of the research approach and case studies....10
Table 4: Mother and child health indicators of Bac Giang and Dong Thap provinces....12
Table 5: Key informants in the HESVIC study....14
Table 6: District health management model....22
Table 7: Health regulation framework....33
Table 8: Percentages of CHCs performing EMOC services....47
Table 9: Actors and roles in the EMOC regulation process....51
Table 10: Levels of power in EMOC service provision and potential of actors....59
Table 11: Summary of ANC actors' tasks and objectives....109
Table 12: Actor power in the process of Decree 104....123
Table 13: SRB trend by year and region in Vietnam 2001- 2009....129
Table 14: SRB by year in Bac Giang and Dong Thap, 2006-2010....129
Table 15: Violation of Decree 104 by publication institutions, 2009-2011....137
Table 16: Inspection results on prenatal sex determination and sex selection in health facilities in Vietnam, 2009-2011....138
Table 17: Compliance with Decree 104 by public versus private health facilities....139
Table 18: Number of GR cases at different levels in five years....154
Table 19: Percentage distribution of GR categories in the last five years....157
Table 20: Content of GR cases by health areas (%)....158
Table 21: Percentage distribution of authority for solving GR cases....160
Table 22: Percentage distribution of anonymous GR cases....160
Table 23: GR Actor analysis....170
Table 24: GR Actor power....186
Table 25: Actor analysis....220

LIST OF FIGURES

Figure 1: Map of Vietnam (source: Mapinfo Vietnam) 11

Figure 2: Conceptual framework for understanding regulation within the health system 19

Figure 4: Health expenditure in Vietnam over 10 years 1998-2008 (source: National Health Accounts) 28

Figure 5: Distribution of health expenditure in Vietnam, 2001-2008 29

Figure 6: Out of pocket spending in Vietnam, 2006 29

Figure 7: Hierarchy of legal documents in Vietnam 32

Figure 8: Timeline of regulation related to EMOC 38

Figure 9: Implementation process of EMOC functions 45

Figure 10: Distribution of key EMOC functions by district hospital locations 46

Figure 11: Actors involvement and relationships in the regulation process 61

Figure 12: Child sex ratio in Vietnam in 2009 89

Figure 13: National trend of SRB over time in Vietnam 91

Figure 14. ANC regulation timeline 93

Figure 15: ANC supervision/inspection procedure 103

Figure 16: Actor network of sex determination and selection processes in Vietnam 126

Figure 17: SRB by birth order, Vietnam 131

Figure 18: Timeline of the evolution of the GR regulation 149

Figure 19: Solving complaints process in the hospitals 156

Figure 20: Actor network of GR processes in the health system in Vietnam 189

LIST OF BOXES

Box 1: Research questions and sub-questions.....2
Box 2: GR case study in one district hospital in 2010 (35, 84-98).....165
Box 3: GR case study – Personnel handing the case.....180
Box 4: GR case study- Users' view.....182
Box 5: GR case study - Involvement of actors.....190
Box 6: GR case study - Unintended effect.....201

ABBREVIATIONS AND ACRONYMS

AFS	Administration of Food Safety
AMS	Administration of Medical Services
ANC	Antenatal care
APM	Administration of Preventive Medicine
BG	Bac Giang
C-section	Caesarean Section
CHC	Commune Health Centre
CSO	Civil Society Organisation
DCPFP	District Centre of Population and Family Planning
DCPM	District Centre of Preventive Medicine
DHO	District Health Office
DPC	District People's Committee
DT	Dong Thap
EMOC	Emergency obstetric care
GOPFP	General Office of Population and Family Planning
GR	Grievance Redressal
HESVIC	Health system stewardship and regulation in Vietnam, India and China
HN	Hanoi
HRH	Human resources for health
HSPH	Hanoi School of Public Health
LET	Law on Examination and Treatment
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MET	Medical Examination and Treatment
MMR	Maternal Mortality Ratio
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs

MPI	Ministry of Planning and Investment
NA	National Assembly
OBGYN	Obstetric and Gynaecology
PCPFP	Provincial Centre of Population and Family Planning
PHD	Provincial Health Department
PMM	Professional Medical Management
PPC	Provincial People's Committee
RHC	Reproductive health care
SBA	Skilled birth attendants
SCNA	Standing Committee of the National Assembly
SRB	Sex ratio at birth
TA	Technical assignment
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation

CHAPTER 1. BACKGROUND OF THE PROJECT

1.1. Overview of key HESVIC research elements

'Health system stewardship and regulation in Vietnam, India and China' (HESVIC) is a multidisciplinary and multi-partner project, implemented over the period of three years (July 2009–June 2012) with financial support from the European Commission's Framework Programme 7 (FP7).

This project aims to investigate regulation as it relates to the governance of health systems in policy and practice. It aims to do so by developing an integrated[1] approach to governance and regulation in the area of maternal health in Vietnam, India and China. The effect of regulation on equitable access to quality health care represents the core of the HESVIC study. However, in order to identify the effects of regulation, the study addressed other factors affecting access to health care, such as the substance and structure of the regulatory environment. Understanding the features of maternal health practice will form part of the understanding of current approaches, practices and capacities with respect to regulation. We hope that the findings of the study will support policy decisions towards the principles of accessibility, affordability, equity, and quality coverage of health care in the three study countries.

HESVIC has involved three Asian and three European partners. India, China and Vietnam led with the research sites with paired partners in the Netherlands (KIT), Belgium (ITM; Scientific Co-ordinator), and the UK, (The Nuffield Institute for International Health and Development, Leeds; Co-ordinator). The results of the larger HESVIC study will be based on data analysis and outcomes of all three country studies.

The Hanoi School of Public Health (HSPH) led the study in Vietnam. The HESVIC partners reached a consensus on the selected case studies reflecting different areas of

[1] The word 'integrated' refers to integrating multiple research disciplines and to vertical integration, meaning that regulation will be scrutinised from the policy making level to the user's level (D1.1. page 5).

maternal health services or an area of regulation applied within maternal health care. These are Emergency Obstetric Care (EMOC); Antenatal Care (ANC); and Grievance Redressal (GR). These cases studies were conducted in each of the three countries Vietnam, China and India.

The scope of the study was defined by one overarching research question, which was applied to all three countries, and a set of sub questions. These research questions are presented in Box 1.

Box 1: Research questions and sub-questions

Overarching question: How does regulation, and through it governance, affect equitable access to quality health care?

RQ1. What approaches and processes exist for regulating maternal health care and how do they operate in practice?

RQ2. Who are the actors involved in the regulation of maternal health care; what are their roles and power relations?

RQ3. What are the effects of regulation on equitable access to quality maternal health care?

RQ. What are the differences or similarities between regulation of maternal health care and health care in general?

RQ5. How could regulation be improved to enhance equitable access to quality maternal health care?

1.2. Summary of HESVIC research

Maternal mortality rates (MMR) in Vietnam over the last two decades have shown a steady decline from 165/100,000 in 2000 to 69/100,000 in 2009. However, the MMR in remote areas and mountainous regions is still three to ten times higher, at 411/100,000 than that in mainland region, where it stands at 45/100,000 (1). The main causes of

MMR in Vietnam are haemorrhage, eclampsia and sepsis. For all these, delay in obtaining the necessary interventions at a health facility is a very important factor. Current research suggests that the main reason for inequitable access to quality maternal services is the unavailability of EMOC services, and especially so in remote and difficult regions.

Results from the HESVIC Vietnam desk study indicate a number of barriers that affect access and utilisation of health care among vulnerable groups. These include: (i) geographic barriers, including distance and transportation to health facilities; (ii) financial barriers related to economic status; (iii) socio-cultural barriers related to behaviours and attitudes of both health staff and family members, and to customs and cultural/language barriers; (iv) barriers caused by the provider situation, including the availability and quality of health care services; (vi) barriers caused by the user situation, including gender, education and awareness of diseases (2).

The HESVIC study attempts to answer the research questions through a critical approach to three dimensions of selected regulations. These include regulation processes, the role of and interactions between actors involved in regulation, the influence of the health system and wider contexts upon a regulation, and the link between all these elements and regulation effects. These are described by the conceptual framework of the study. In terms of case studies to investigate the research questions, the Vietnam team selected the following three:

- EMOC: The specification of technical assignments for EMOC services and its regulation, addressing problems and achievements related to the availability and quality of EMOC services, especially at district hospitals and commune health centres.
- ANC: Prohibition of prenatal sex determination and sex selection and its regulation, addressing problems and achievements related to restricting the availability of sex determination and sex selection procedures during ANC visits.

- Grievance Redressal: Processes of GR and its regulation, addressing problems and achievements related to solving complaints in health facilities with regard to maternal health services.

Under each case study, one main regulation was selected for in-depth study (see Table 1)

Table 1: Case studies and regulations

EMOC	Decision 385/2001: Technical assignment of RHC services among levels in the health system, enacted by the Ministry of Health (MOH, 2001)
ANC	Decree 104/2003/NĐ-CP: Guidance for implementing the Population Ordinance *(Article 10 related to prohibition of sex selection procedures*), enacted by the Prime Minister and Government.
GR	Instruction 44/2005: Regulation on solving complaints, enacted by the Ministry of Health (MOH, 2005).

EMOC

Regulation 385/2001 was issued by the Ministry of Heath to ensure the availability of quality reproductive health services in general and EMOC services for different health levels. It specified a list of non-mandatory technical assignments among different levels in the health system (both public and private). Specific services specified at each level are highlighted in Table 2.

The commune health centres (CHCs) are allowed to provide five basic EMOC functions/services, with the exception of vaginal assisted delivery due to a concern over the inability to treat complications in a timely manner at these facilities. The district hospitals are supposed to provide comprehensive EMOC (six basic functions including assisted vaginal delivery, plus C-section and blood transfusion).

Table 2: EMOC services provided at different levels

Levels	CHC	District hospitals
Basic EMOC Services	IV/IM antibiotics	IV/IM antibiotics
	IV/IM oxytocics	IV/IM oxytocics
	IV/IM anticonvulsants	IV/IM anticonvulsants
	Manual removal of placenta	Manual removal of placenta
	Removal of retained products	Removal of retained products
		Assisted vaginal delivery
Comprehensive EMOC services		C-section Blood transfusion

Despite the technical criteria, recent surveys show that only a limited number of district hospitals and CHCs provide comprehensive and basic EMOC services. This constitutes a barrier to availability of quality EMOC services, hindering access to EMOC services generally for local women. Furthermore, hospitals are now under pressure to become autonomous, which means that hospital directors need to protect the reputation of their hospital, make efforts to attract patients and generate their own incomes. An increasing marketisation of the public health system is likely to threaten patient well being (3). The study of Regulation 385/2001 is aimed at answering the question why comprehensive and basic EMOC are not implemented in the health facilities. This was undertaken

through a review of its processes, procedures and approaches, the actors involved, as well as contextual factors that have affected the degree of success of the regulation.

ANC

In Vietnam, the imbalanced sex ratio at birth (SRB) has been increasingly recognised as an issue by policy makers. This is not only due to the fact that since first documented, there has been an increasing trend towards sex selection, but also because of an understanding that it is a combination of socio-cultural, user's and provider factors that can lead to an imbalanced SRB. These include decreased fertility, son-preference and the increasing availability of prenatal sex determination. To address the problem, in 2003, the Government issued regulation 104/2003/ND-CP as guidance for the implementation of the Population Ordinance. In the regulation, all prenatal sex determination and selection services and behaviours were banned (as stated in article 10) in order to reach a balanced SRB. This applied to both public and private sectors. However, since the regulation took effect, there has been no evidence of decreasing imbalance of the SRB in Vietnam. The study of the processes and elements involved in this regulation aimed to investigate why the regulation appears to have failed to achieve its intended objectives.

GR

The Vietnam Government issued the law on complaints and denunciation (Law on Grievance Redressal) in 1998 and amended it twice in 2004 and 2005. However, the health sector is an area in which there are many competing interests between patients and providers, and all of these cannot be addressed using the generic law on GR. In order to ensure the application of citizens' rights in resolving complaints about the health services, the MOH issued the regulation QD 44/2005 on solving complaints in 2005. To date, no report has been published on how this regulation is being implemented in practice. Our study of the processes of regulation 44/2005 aimed to investigate how the regulation on GR has been applied in Vietnam. We explored the factors which may affect these processes in order to yield policy recommendations for improving patients' equity in addressing problems and complaints.

Overall, HESVIC research aimed at exploring how these three regulations, and through them governance, affect equitable access to quality health care. Three specific questions were explored: (1) Whether the governance of the EMOC regulation contributed to improving EMOC services in district hospitals and commune health centres; (2) Whether the governance of the ANC regulation contributed to a compliance with the law by not disclosing the sex of the foetus to clients; and (3) Whether the governance of the GR regulation was effective for patients making complaints about services they received in hospitals in Vietnam.

Although there are different definitions of governance, in Vietnam 'governance' is generally interpreted as effective 'State Management' (4). Good governance is considered by the Ministry of Health as including the proper management of information, standards, participation, accountability and transparency in the overall management process. 'Consensus' governance is also included and emphasises co-operation and collaboration, aspects that are unique to the Vietnamese system (5). The HESVIC study explored the different principles of governance, with an emphasis on good governance including information management, standards, accountability and incentives. The participation of different actors was investigated using the nexus of 'actor–network–power' analysis.

1.3. Purpose and structure of the research report

As a country report, this document aims at understanding the achievements and problems of maternal health care in Vietnam. This will involve describing the regulation, its control and design, and finally its administration and implementation. The report will also identify actors and factors that may have facilitated or prevented a regulation from being effective. This will be done in order to understand the extent to which social, political, economic and cultural factors have been influential for actors and for the trajectory of the three regulations selected for study.

This report is composed of seven main sections:

1. Background of the project
2. Methods
3. Conceptual framework used by the country research team
4. Introduction to the relevant country context
5. Case study analysis
6. Comparative analysis across the case studies
7. Conclusion and recommendations

Following this introductory section, the next section will discuss methods used in the study covering site selection, sampling methods, data collection, management and analysis and ethical issues. This will be followed by a description of the conceptual framework used by the Vietnam research team. Following this, there will be a brief introduction to the country context, and the relevant regulations, which encompasses some features of policy, health services, the social and cultural contexts and the prevalence and nature of the problems that the study of the regulations seeks to address. This will be followed by a substantial section on the case studies. For each case study, details about regulation processes, actors involved and contextual factors are described, and an analysis presented of the regulation processes with theoretical insights, followed by conclusions and recommendations.

The case studies are followed by a section specifically exploring a comparative analysis of regulations in Vietnam, across the case studies and with reference to the literature, in which the content, processes, actors, and contextual factors affecting the regulations of each case study will be synthesised, compared and contrasted. The final section of the report provides readers with the overall conclusions concerning regulation processes in Vietnam, together with recommendations for improving regulation processes and governance in the country.

CHAPTER 2. METHODS

2.1. Design

This study is a multi-method, retrospective comparative study of three case studies of maternal health policy processes. Table 3 summarises the research approach. In Vietnam, the three case studies were identified, and two provinces chosen for study which represented variation in terms of geographical as well as socio economic factors. The data collection period ran from August 2010 to August 2011. As detailed below, methods included reviewing 300 documents, conducting 165 in-depth interviews, holding a verification workshop with key informants, and participating in two Country Research Advisory Group (CRAG) meetings for verification of report results.

To enable comparisons of findings to be made between the three study countries, similar research design, methods, tools and analysis procedures were implemented in each study country. The research design was structured around three phases: Phase One – Preliminary data collection and data analysis; Phase Two – Main data collection; Phase Three – Main country-specific and comparative analysis and follow-up.

This incremental approach enabled Phases Two and Three to be informed by the results of the previous Phases. These inputs range from modification of data collection tools, to developing further inputs based upon findings from preliminary analysis. All stages of the research were informed by relevant literature from the fields of health policy, health services, and research methodology.

2.2. Case studies

Table 3 sets out the features of the three case studies chosen for the study.

Table 3: Overview of the research approach and case studies

Case studies	EMOC	ANC	GR
Research topic	Equitable access to quality EMOC services	Prohibiting sex determination techniques	Patient's equity in making and solving complaints
Regulation	Decision 385/2001: Technical assignment of RHC services among levels in the health system (MOH 2001)	*Article 10 on prohibition of sex selection procedures* in Decree 104/2003/NĐ-CP on implementing Population Ordinance	Instruction 44/2005: Regulation on solving complaints (MOH 2005)
Sector under regulation	Public	Public and Private	Public
Regulatory approach	State command and control Market oriented Consumer oriented / driven	State command and control Market oriented Consumer oriented / driven	State command and control Market oriented Consumer oriented / driven
What is being regulated	Quality and quantity	Quantity	Equity

2.3. Data collection methods

2.3.1. Study sites

Data for the study was collected both at national (central) level and in two provinces situated in the North and South of Vietnam that reflected regional variation in general, and in particular variations in SRB trends. The selected province from the North was Bac Giang, which had the highest SRB imbalance at the time of study (119/100) and the province in the South was Dong Thap, which had the lowest SRB imbalance (104.5/100) (see Figure 1).

In each province, two districts were selected, one having comprehensive EMOC services (C-section and blood transfusion services) and the other having none (no C-section or blood transfusion). Data at commune level was collected only for EMOC and the ANC cases. Two communes in each district were selected at random.

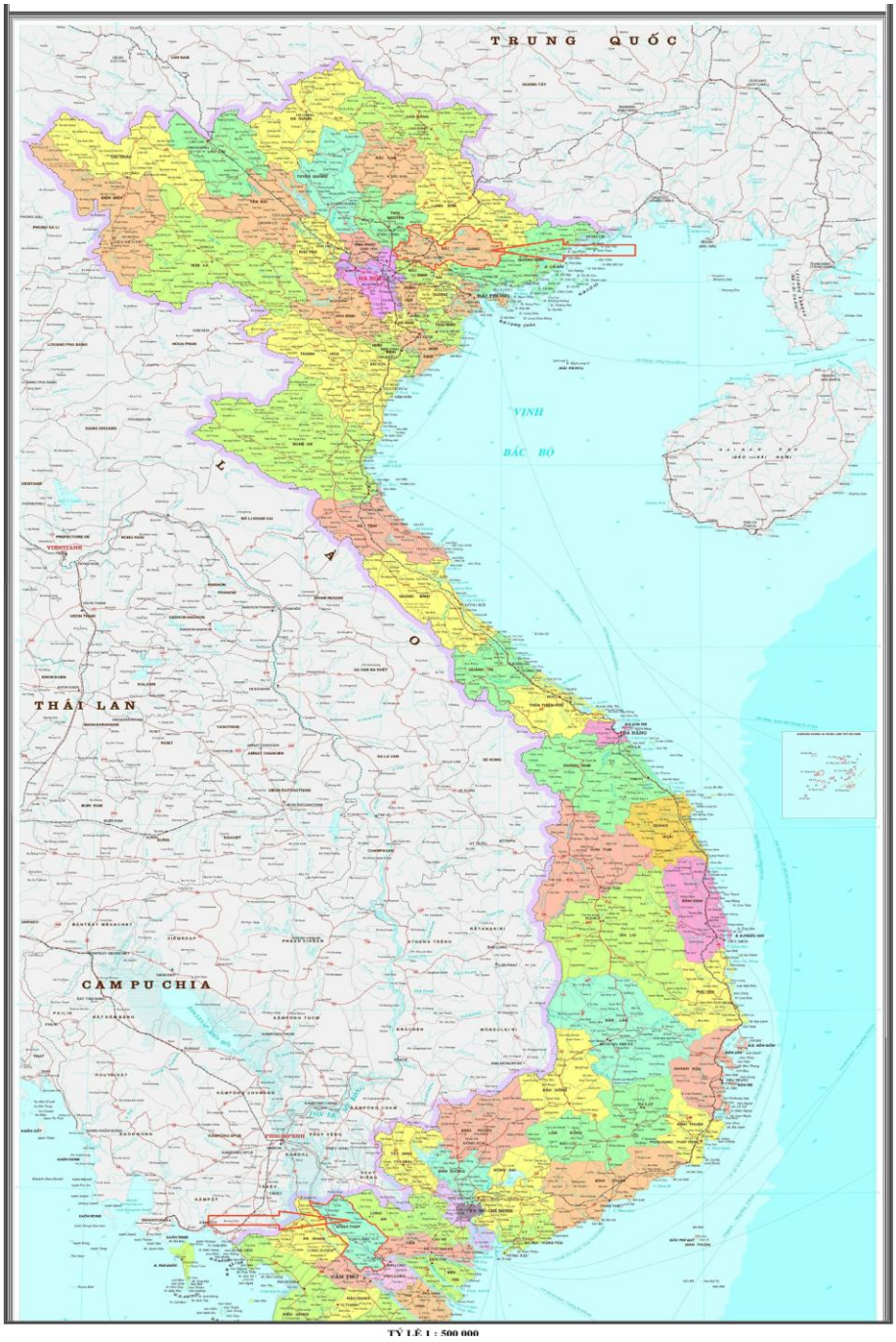

Figure 1: Map of Vietnam (source: Mapinfo Vietnam)

Bac Giang, in the North, is a mountainous province. It is 3,823 square kilometres in area, and the population size is 1,569,556 (as of 31/12/2010), spreading across nine districts and one main city. Economic activities include agro-forestry, fishery, industry and services. The GDP is 600 USD/year and the poverty rate is 10% of households (Source: Bac Giang Provincial Committee 2010).

Dong Thap, in the South, is a province in the Mekong delta region. It is 3,283 square kilometres in area. The population is 1,713,000 (at 31/12/2010) living in nine districts and two towns. The main economic activities include agriculture, industry and trade. The GDP is 774 USD/year and poverty rate is 4.5% of households (Source: Dong Thap Provincial Committee 2010).

Table 4 below documents some mother and child health indicators in Bac Giang and Dong Thap provinces between 2006 and 2010.

Table 4: Mother and child health indicators of Bac Giang and Dong Thap provinces

Indicators	**2006**		**2007**		**2008**		**2009**		**2010**	
	BG	**DT**	**BG**	**DT**	**BG**	**DT**	**BG**	**DT**	**BG**	**DT**
Child mortality <1 year old (‰)	4.8	3.88	4	3.95	3.4	3.2	3.3	4.17	4.94	4.15
Child mortality < 5 year old (‰)	5.9	8.39	4.8	7.7	4.0	7.7	NA	7.38	NA	7.35
Malnutrition of children <5 years old	26.2	23.0	23.9	21.7	22.5	20.3	21	19.4	19.5	18.9

Low birth weight	3.7	6.4	3.53	6.7	3	6.4	3.7	7.66	3.1	6.58
MMR (100000 live births)	7.3	39.58	3.4	27.78	0	19.36	27.2	23.16	NA	23.16
ANC rates	90.4		87.2		97.0		95.8		99.7	
% delivery at health facilities	98.8	99.98	98.9	99.98	99.3	99.98	99.2	100.0	99.5	100.0
Sex ratio at birth	123	115	121	110	119	112	122	107.7	119	104.9

(Source: BG and DT Provincial Department of Health, 2010)

The data in Table 4 shows some differences between the two provinces. The DT region has much higher mortality rates of children under five years old, higher low birth weight, and higher MMR. In contrast, the BG region has much higher mortality rates of children under one year old, higher malnutrition of children under five years old and a higher sex ratio at birth. The data suggests the possibility that BG might have better EMOC services than DT, while son preference is more prevalent.

2.3.2. Data collection methods

Data collection was undertaken from both primary and secondary sources. Types of secondary data included scientific papers, grey literature and other sources, such as government reports and media related to the regulation processes of the three case studies. Methods for retrieving secondary data included web searches using Google as the key search engine. The key words included general reference to maternal health care and to specific case studies such as EMOC, ANC and GR. Electronic databases of legal documents of the health system were also accessed. Reports of the health system were obtained based on personal relationships between the research team and those authorised to provide the data at different levels of administration.

Primary data was collected through key informant semi-structured interviews, expert consultation meetings, a verification workshop and direct observation at field sites. Interviews were conducted with informants at different levels of the health system, including actors responsible for regulation design, administration and implementation, and health service users and the community (see Table 5). Respondents were identified with non random purposive sampling. Altogether, the number of in-depth interviews conducted for the GR, ANC, and EMOC case studies were 45, 63, and 65, respectively. It should be noted that the number of interviews undertaken exceeded that proposed by the methodology because many more actors were involved in the implementation of different regulations than we had assumed. For those actors whose responsibilities overlapped across case studies, the interview guide for each study regulation was not combined but was used separately by different interviewers responsible for each particular case study.

Table 5: Key informants in the HESVIC study

Type	Key informant	EMOC	ANC	GR	Total
Regulation designers	Central level public policy makers, who are involved in formulation, implementation and evaluation of regulation	**4**	**4**	**2**	**10**
Administrators	Provincial level/public officials who are in charge of administration, implementation of regulation	**12**	**14**	**6**	**32**
	District level/public officials who are in charge of implementation of regulation	**17**	**16**	**6**	**39**
Regulated staff	Implementers of regulations (managers of public and private hospitals)	**21**	**14**	**26**	**61**
Users	Pregnant women and their families, who are using maternal services	**17**	**15**	**7**	**39**

Others	Those actors who have roles in regulation (health insurance agency in EMOC)	**6**			**6**
	Total	**65**	**63**	**47**	**175**

2.4. Data management and analysis

Secondary data was reviewed and key information was entered into a library using Endnote software. This information was used as a reference for the country background and context, supporting the analysis of the study.

All interviews were digitally recorded and transcribed. A conceptual framework, which is presented in the next subsection, was used for analysis of data. A node tree was developed for all three case studies with grandparent nodes being the different components of the conceptual framework, and all transcripts were coded based on the node tree. All codes were entered in N-vivo 7. Queries by parent nodes and by province were run during analysis of the data. A mind map for summarising preliminary results was constructed to inform subsequent stages of analysis.

2.5. Ethical issues

The application for ethical approval was sent to the Institutional Review Board at the Hanoi School of Public Health (HSPH). The first stage was applied for piloting the data collection. The second stage was applied for the second and third phases of data collection. All processes requiring application of ethical standards followed instructions of the Institutional Review Board at the HSPH.

- **Informed consent**. An informed consent statement was explained to and agreed by, all respondents. The agreement was in written form.
- **Confidentiality**. All data were stored under identification number or classification of key informant in the electronic files with access restricted to approved members of the research team. All the information was used for scientific purposes only.

- **Anonymity**. The aim was to ensure that outputs arising from the research do not attribute information to any particular source unless prior agreement is given. For health policy research, this is a challenge as the potential pool of respondents (e.g. politicians, senior civil servants) is small. The respondent was only coded in the quotation under type of respondent as agreed among research countries. No specific name or position of individuals was reported.
- **Feedback.** All reports were sent to key respondents for their feedback in the English version. On average, each case report was sent to about five respondents for comments before editing.

2.6. Personnel

Successful completion of this research required the formation, management, training and co-operation of a qualified group of researchers. The country team consisted of 10 members: a principal investigator (PI) and three case study teams (nine persons). Each case study team had one senior researcher who was responsible for the case study from data collection and analysis through report writing and dissemination. There were also two junior members of each case study team who assisted in this process. Internal meetings for each of the three cases were held regularly. Planning sessions were always conducted jointly among the three cases before each phase of data collection, analysis and reporting. Progress updates were provided regularly to the research co-ordinator. The research co-ordinator took final responsibility for report writing and dissemination. Emails were the most regular communication channel among the country team.

Given the topics being researched, the research team also aimed to include both sexes at senior and junior levels. Care was taken to ensure that personnel were suitably qualified in both the research topics and the research methods to be used. A series of capacity development activities were implemented from the start of the project to strengthen the team's research capacity. These activities included in-country briefing sessions, in-country training workshops, mainly on N-Vivo use*,* joint training workshops with all three study countries, study visits, and regular reflection, feedback and discussion during the project.

Throughout the project, the country research team was paired with a European partner, the Nuffield Centre of Health and Development (University of Leeds). The European partner aimed to assist and support the country team as required during data collection, analysis, and report writing. The NCIHD worked with HSPH through the whole process: from instrument development and piloting, data collection, analysis through report writing. Apart from frequent exchanges by email, the NCIHD also undertook several visits (about one to two weeks per visit) to work at the HSPH premises (2011) and the HSPH team also visited the NCIHD premises (2012) to facilitate assistance to the HSPH team throughout the research process. In addition, all the case reports and comparison and conclusion sections were sent to NCIHD for comments before editing. Technical support from NCIHD was valuable, particularly in explaining theoretical concepts and commenting on the report.

Further support was provided by ITM, the lead partner for the research methodology development, and the Country Research Advisory Group, who acted as a source of technical advice and as a sounding board for emerging issues throughout the research, and who provided a mechanism for dissemination both during and at the end of the research period.

CHAPTER 3. CONCEPTUAL FRAMEWORK

The HESVIC research was guided by a conceptual framework presented in Figure 2. In this framework, the regulation process is viewed as a flow of different stages running from health policy (top) towards possible effects on equitable access to quality health care of the regulation, on health care delivery (bottom). There is also reversed flow running from effect to policy – e.g. through the management of control systems and of information planning and liaison. This framework also highlights the dynamics of interaction between actors (both visible and invisible) and maternal health regulation, and how these might be seen in the context of the health system and its wider environment. This wider environment, which impinges on regulation processes, encompasses elements from the socio-cultural, political, historical, and economic contexts.

This framework was applied to the HESVIC study in all three countries, including Vietnam, with some variation for the GR and ANC cases. Since the GR regulation is not specifically designed for maternal health, any specific effects on equitable maternal health care of GR were explored in the context of OBGYN hospitals/wards. The ANC regulation is designed to prevent disclosure of the sex of the foetus to the mothers; therefore both the intended and unintended effects of ANC regulation were explored.

There are numerous studies in Vietnam that suggest a growing interest in factors that affect equitable access to quality health care (5). However, these studies have focused on different individual demographic and socio-economic factors, and different components of the health system such as human resources for health (HRH) and health financing. Occasionally the literature refers to health governance but not with a focus on the quality of maternal health services. There remains thus a visible lack of evidence on how regulation and governance can have an effect upon equitable access to quality maternal health care. We seek to address this gap by taking ‘access to maternal health care’ as a service tracer and, complementing it by analysis of the regulation processes, within the context of the health system, the interaction of different actors and the operation of wider environmental factors. We hope that

this will contribute to bridging the above research gap and help inform regulation and policy decisions aimed at improving access to quality maternal health care in particular, and health care in general.

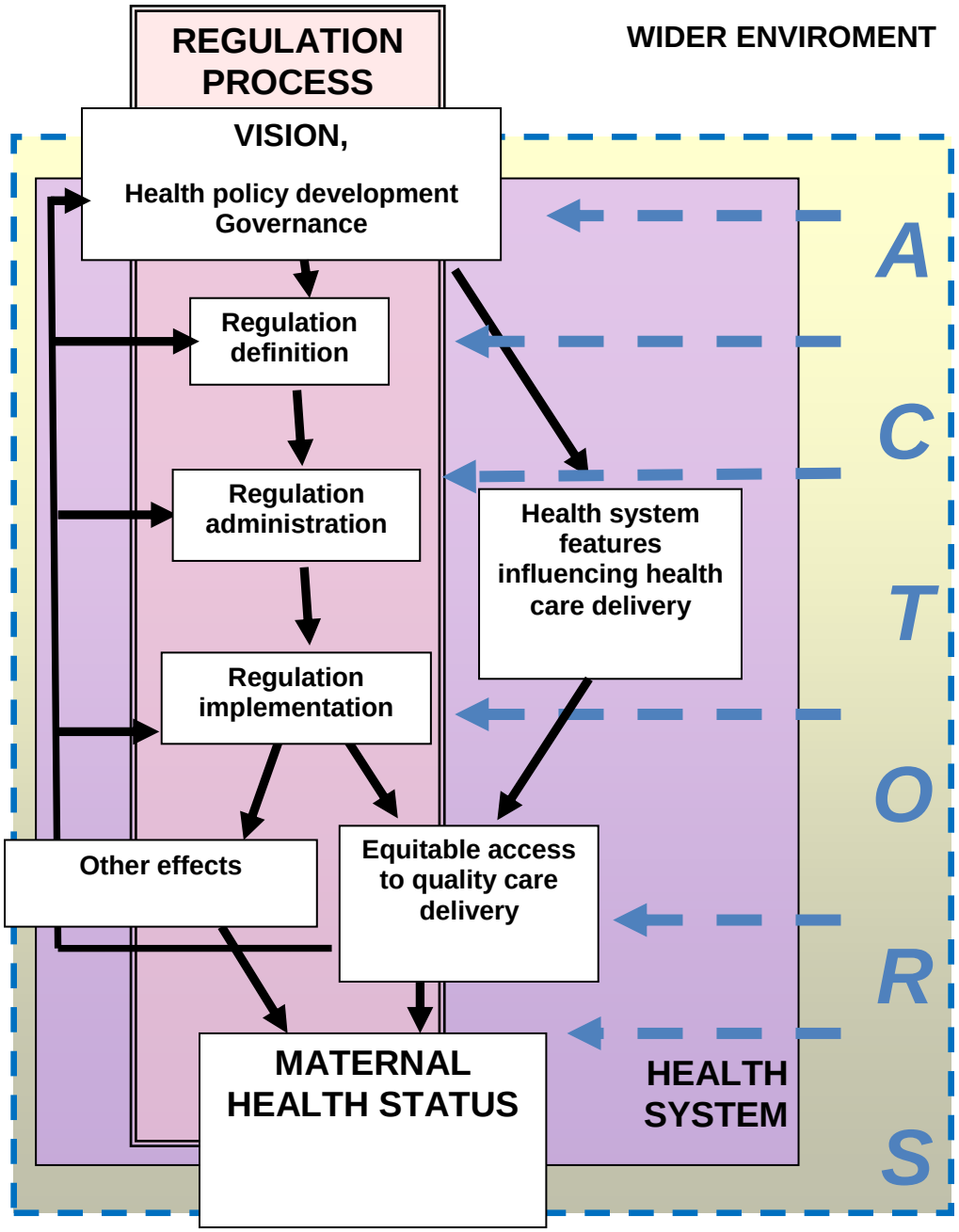

Figure 2: Conceptual framework for understanding regulation within the health system

CHAPTER 4. INTRODUCTION TO THE COUNTRY CONTEXT

This section is aimed at providing readers with brief description of the relevant features of policy, health services, social and cultural contexts as well as the prevalence and the nature of the problem each case study regulation seeks to address.

4.1. Socio-demographic status

Vietnam's population was over 86,927,700 in 2009. In the past, Vietnam had rapid population growth but the average growth rate has reduced significantly to a rather low level at 1.05% for the 1999–2010 period compared to 1.7% for the 1989–1999 period (6). The total fertility rate (births per woman) decreased from 3.3 (1990) to 2.00 by 2010 (6). During the same period, the crude birth rate (CBR) was decreasing from 19.9‰ to 17.1‰ (6), while the proportion of older people was increasing between 1999 and 2010 (7).

Vietnam has achieved much progress in reducing gender gaps and promoting women's empowerment. The Gender Inequality Index (GII) measures the losses in achievement to women due to gender inequality, in terms of reproductive health, empowerment and labour market participation. By 2011, the GII of Vietnam was 0.305, and ranked 48 out of 187 countries (8). However, access to education and training for girls and women from ethnic minority groups in mountainous, remote and isolated areas is more difficult than for boys and men. The proportion of women with the highest education levels is still low in comparison with men.

The national sex ratio imbalance is alarming (111 boys/100 girls) in the country. Yet, gender bias and the mentality of 'male preference' remains prevalent (9). Decreased fertility and son-preference together with the increasing availability of modern sex determination techniques are three key conditions for an imbalance in the sex ratio at birth (10).

4.2. The health system and maternal health services

4.2.1. Health system and maternal and child health network

The health system of Vietnam is organised in four layers: central, provincial, district and commune levels, based on an overarching administrative system under the direction of the MOH. Each commune has one commune health centre (CHC), to cover a population of 5000 to 10,000 (See Figure 3).

At the central level, the MOH is the government agency in charge of state management of health care, health protection and promotion and public health services. In addition, the MOH has 70 subordinate institutions in three main areas: hospitals, preventive medicine and specialist institutes, and medical colleges and universities. The General Office of Population and Family Planning (GOPFP) is in charge of population and family planning issues, including the control and prevention of an imbalanced SRB. The Maternal and Child Health (MCH) department is in charge of maternal and child health services in the country. At the national level, the two national OBGYN hospitals (one in the North and one in the South) are the highest referral levels in maternal health services in Vietnam. They provide all EMOC and ANC services, and are also subject to GR regulations.

At the provincial level, the provincial health department (PHD) works under the leadership of the Provincial People's Committee (PPC), and performs tasks and fulfils obligation as authorised by the Provincial People's Committee for the health sector. The PHD is responsible for managing all health care services including curative services, preventive medicine, health protection and promotion and for managing population issues such as family planning, care of the elderly and an imbalanced sex ratio at birth.

The OBGYN department of the provincial hospital or the OBGYN hospital is the leading technical agency in maternal health in the province. They are in charge of providing technical support to OBGYN services at the lower levels. They work closely with the provincial centre on Reproductive Health Care (RHC) in conducting different maternal health programmes or services such as family planning, communication campaigns on safe motherhood, prevention of reproductive tract infections etc. The Provincial Centre of Population and Family Planning

(PCPFP) liaises with the RHC centre regarding population, delivery and family planning services. In each province, there are also a few private hospitals under PHD administration, managed by the Department of Private Practice and Medicine. In BG province, there is one private hospital, and there are two in DT province.

At district level, health management is not uniform due to the reforms of 2005. Three different models of district health are currently available in Vietnam (See Table 6).

Table 6: District health management model

	District hospital	**District center of preventive medicine**	**District health office**	**Management of CHCs**
Model 1 (40%)	X	X	X	DHO
Model 2 (40%)	X	X	X	DCPM
Model 3 (20%)	District health centre		X	District health centre

District hospitals are the first referral level for curative services in the district. There are OBGYN wards at these hospitals that provide EMOC and ANC services. These are also subject to GR regulation. The District Centre for Population and Family Planning (DCPFP) is in charge of provisional programmes related to population and family planning issues, including any imbalanced SRB. The District Health Office is also in charge of private health clinics in their locality.

At commune level, the heath centre is designated to provide primary health care, carry out activities for early detection of epidemics, provide care and treatment for common diseases and normal deliveries without assisted vaginal delivery, mobilise people to use family planning

and practice preventive hygiene, and health promotion. It is managed by the District Health Office or the District Centre of Preventive Medicine and the commune People's Committee and receives technical support from the district hospitals and District Health Centre or DCPM. Usually, in each CHC, there is one midwife/assistant physician for obstetric and paediatric care who is in charge of maternal services. They are also supposed to provide all the five functions of basic EMOC.

By the end of 2008, 99% of all communes had a CHC; 65.9% of CHCs had doctors; 93.1% had a midwife or assistant doctor specialised in paediatric and obstetric care; and 84.4% of villages had active village health workers (11).

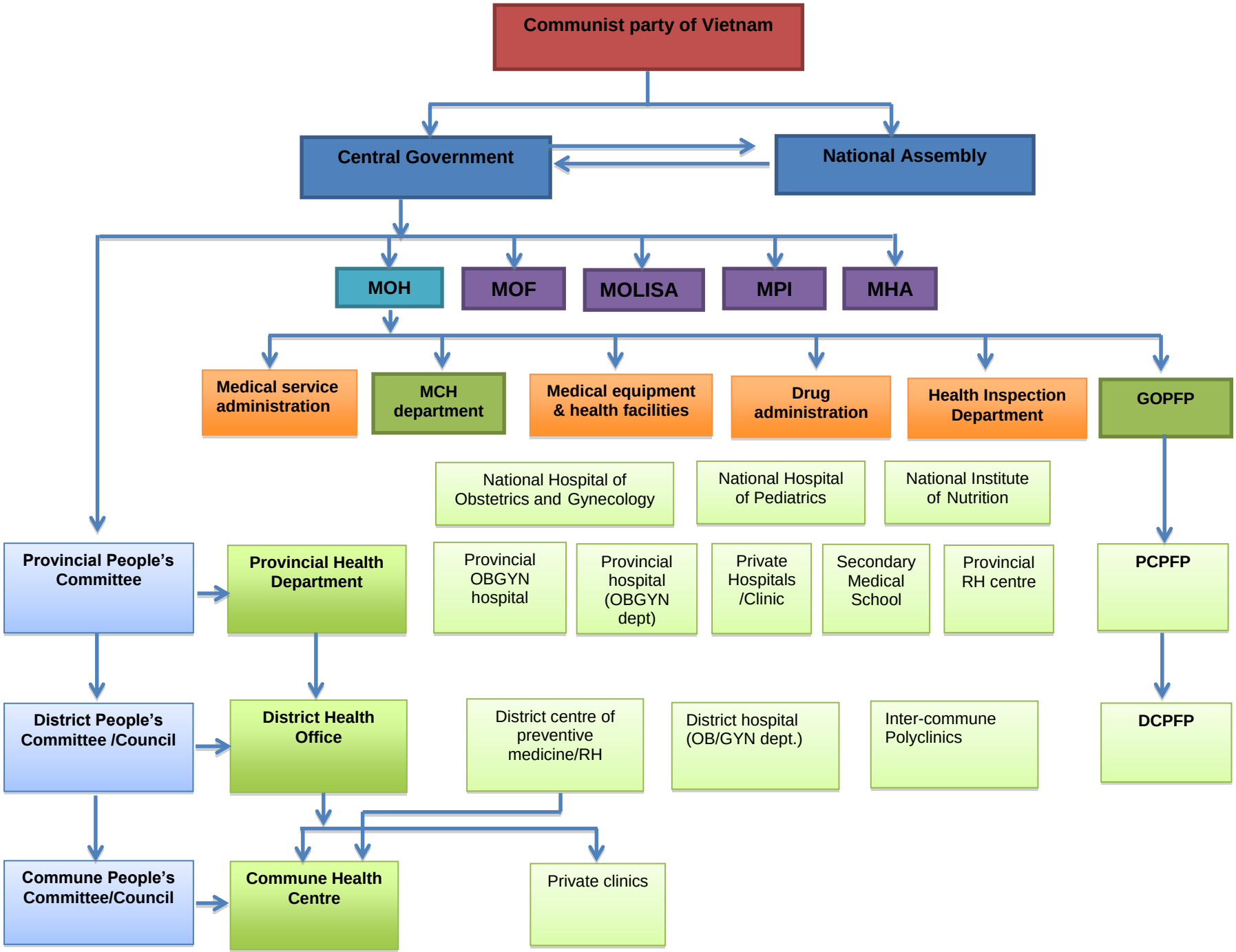

Figure 3. MCH network in Vietnam

4.2.2. Expansion of private health services

The private sector is growing rapidly and plays an increasing role in ambulatory services, covering some 32% of total patient visits in 2008. However, its share of inpatient services continues to be very limited covering only 1.65% of total inpatient treatment in 2008–2009 (12) .

To date, the average number of private health workers per 100,000 inhabitants is 28 and the rate of private hospital beds per 100,000 inhabitants is 0.7. This rate will be increased up to five beds by the year 2020 (13). The number of private health facilities in urban areas is higher than in rural and remote areas (14).

Nearly 83% of all private physicians are government employees, as compared with 45% of private pharmacists and only 2.5% of traditional healers. Most work in public health facilities and practice at their own private clinics outside working hours. This provides opportunities for many private health providers to remain up-to-date on new governmental regulations or technical requirements in the public health sector. Private health organisations provide 70% of all curative health care in urban areas, and 30% in rural areas (15).

The management of private hospitals/clinics/practitioners follows the Ordinance on Private Practice of 1993. However, this deals mainly with administrative procedures such as registering facilities and specifying the qualification of practitioners (16). The Department of Private Practice Medicine in the PHD is responsible for issuing registrations to private health facilities. However, in practice, there are numerous unregistered facilities. In addition, there is a far larger and mobile group of private medical providers including those who are traditional healers and without a fixed clinical location. These groups are very active, especially in rural areas, and often visit patients in their homes.

The licensing of establishments and/or individuals is yet to be fully applied to public and private practitioners in Vietnam (17). Although the new Law on Examination and Treatment mentions ‘licensing’ there is yet to be a testing system for licensing. Therefore, the quality of health care service is not assured in this context, suggesting

a need for better governance of private health sector (18). This reference is from 2001. Nothing newer?

4.2.3. Maternal health care outputs and service delivery

Vietnam has achieved much progress in reducing MMR from 200/100,000 in the 1990s to 69/100,000 in 2009 (19). The main causes of maternal mortality in Vietnam are haemorrhage (31.7%), eclampsia (16.9%), and sepsis (14.3%) (20). However, there are big discrepancies in MMR between the regions: it is three to ten times higher in mountainous areas and among ethnic minorities than in the mainland areas and among those of dominant/majority ethnic groups. In the mountainous areas, a low rate of ANC visits and high levels of home delivery (up to 35.6% in some places) is recorded for the most recent year of available statistics. Key factors influencing high MMR in these areas relate to three kinds of delay: delays due to poor awareness and practice of safe motherhood among local people; delays due to distances from the health facility and bad road conditions; and delays in getting the relevant service in health facilities due to lack of available services (1, 21). The cost of services is also a barrier to using services, especially costs incurred indirectly.

ANC visits, however, are steadily increasing in this region and currently 81.9% of women make three visits per pregnancy. In addition, 95.5% of deliveries take place with assistance from trained health workers. However the home delivery rate is still very high in some regions, such as Northwest (35.6%); Tay Nguyen (15%); and Northeast (12%). 92.5% of women receive post-natal care and the complication rate is 2.8% (2010), with infections and pre-eclampsia the most common complications.

There are several strategies recommended by the WHO to reduce the MMR in developing countries. Among these, access to EMOC, the availability of skilled birth attendants, access to family planning and an effective referral system are cited as the most effective strategies (20). In order to provide comprehensive EMOC, all hospitals from district level upwards should be equipped with an operating theatre, an intensive care unit and laboratory facilities together with capable OBGYN staff, anaesthetics and other service providers (22). The district hospitals should also have a referral system (ambulance, phone) to assist the commune level in cases of

complications, including obstructed labour. Only for very serious or difficult cases is there a need to refer women to the provincial level facility.

Often, however, these services are missing. In 2010, C-section services were available at only 68.2% of district hospitals; blood transfusion was available at 59.8%; and only 55.1% of district hospitals provided both services (23). The considerable variability of EMOC services available at district hospitals is mostly related to urban-rural differences and to socioeconomic status. District hospitals located in better off regions have higher rates of EMOC services than those in the poorer regions (56%>44%). District hospitals in isolated geographic regions also have fewer EMOC services than those in more central locations (38%<62%). The district hospitals in the Red Delta region for example, offered much higher levels of EMOC services than those in the Mekong Delta region (75.5%> 27.8%).

Levels of service in CHCs are influenced by similar factors. In 2010, only 2.6% CHCs were providing all the basic EMOC services and 11.5% of CHCs did not provide any basic EMOC services (23). There is wide variation across regions, with CHCs located in better off areas having more EMOC services than those in difficult regions (24.9%>9.7%). CHCs located in the Red Delta region, for example, also offered more basic EMOC services than those in the Mekong region (26.3%>19.8%). Furthermore, the number of CHCs with sufficient facilities, such as equipment, drugs and other services is very small (0.1%), and this is one reason for the severe underutilisation of these services.

Private health facilities play an important role in providing reproductive health services for users/patients. Patients and their families appear to prefer private services because they are perceived as more convenient and user friendly. However, private health care provision is also more expensive. Most poor people cannot afford these expenses and therefore more commonly use public health services (12, 24). Publicly employed medical staff trained in the public health sector bring the benefits they have obtained from continuous professional development into their private clinics. However, it is clear that providing refresher training to private providers is not included in the overall training plans of local health authorities.

4.2.4. Health sector financial inputs

The total health budget has increased remarkably in 10 years (see Figure 4 below).

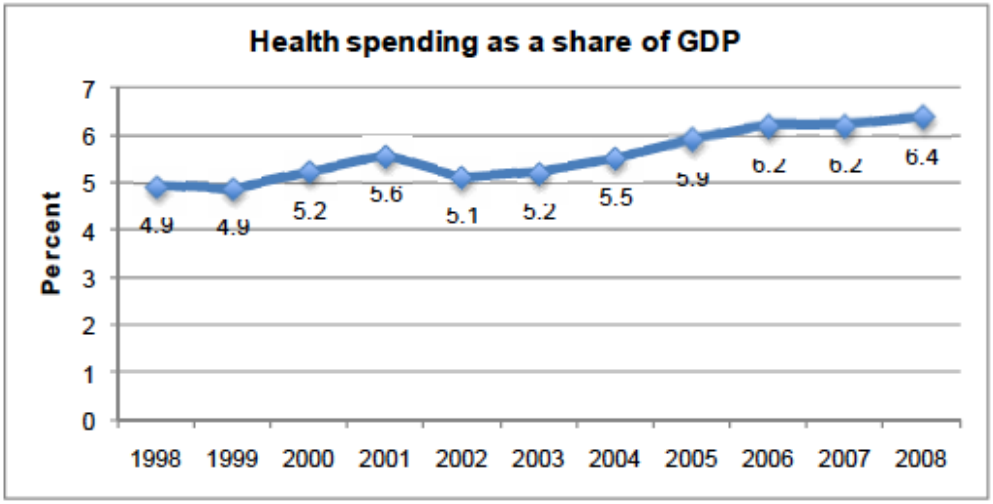

Figure 4: Health expenditure in Vietnam over 10 years 1998-2008 (source: National Health Accounts)

Total health spending compared to GDP has increased almost every year between 1998-2008 and from 2000 has always reached at least five percent of GDP, reaching 6.2% of GDP in 2007 (4). In comparison to other countries of the region, such as Indonesia, Thailand and the Philippines, Vietnam has a relatively higher ratio of spending on health to GDP.

Health expenditure in Vietnam is composed of a variety of sources: government, health insurance, donor assistance, household out-of-pocket expenditures and other private expenditures. Household out-of-pocket expenditure accounts for most expenditure (67%), and totals at almost three times higher than expenditure from the government budget (25).

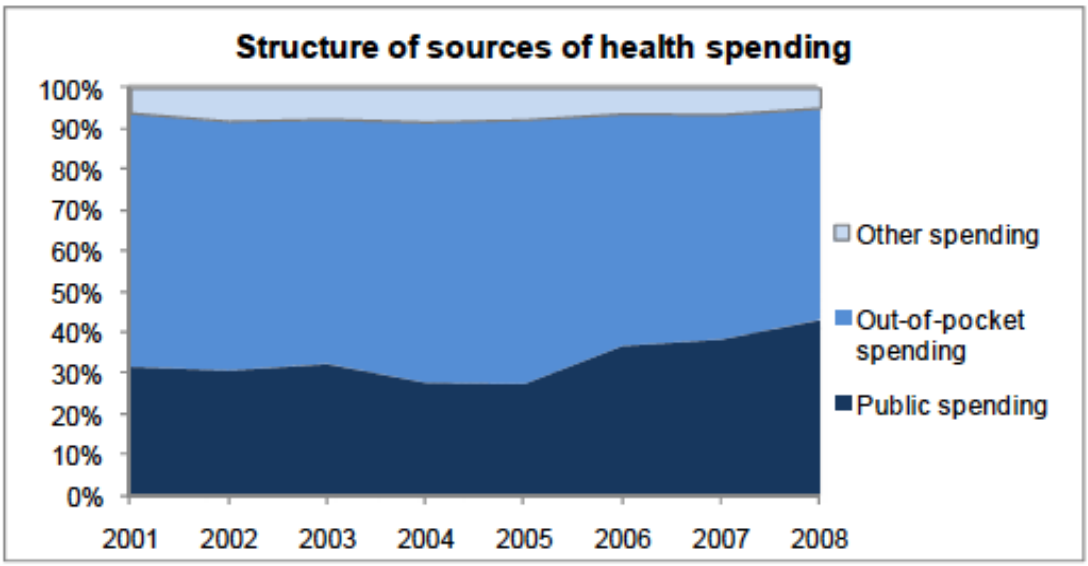

Figure 5: Distribution of health expenditure in Vietnam, 2001-2008

(Source: National Health Accounts)

Over half of the out of pocket payments are made to public providers, one-quarter goes towards drugs whilst the remainder goes to private providers, mostly private clinics (see Figure 6 below) (26).

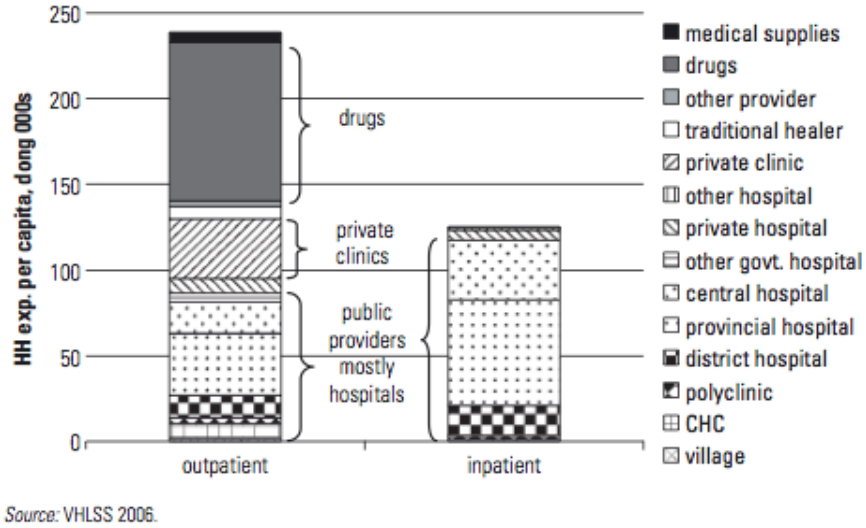

Figure 6: Out of pocket spending in Vietnam, 2006

Reliance on out-of-pocket spending poses obvious problems for the poor and makes catastrophic health payments an important source of economic and social insecurity for all Vietnamese (27). About 10.45% of all households in Vietnam have experienced catastrophic health expenditures (28). The poverty impact of out-of-

pocket payments primarily concerns poor people becoming even poorer rather than the non-poor being made poor. Research shows that it was not expenses associated with inpatient care that increased poverty but rather non-hospital expenditures (travel, food, opportunity costs) (29). This trend is negative from an equity perspective because poor people generally rely more on public services.

The government is advancing health financing policy with orientation towards equity goals, through health insurance coverage for different groups such as children under six years old, the elderly, ethnic minorities and poor people etc. In 2010, health insurance coverage was 60% and the government aimed to achieve universal health coverage by 2014. However these policies only can be effective when standards in health care are improved, including the elimination of unofficial payments (30) and improvement in all the other aspects of accessibility: geographical, intra-institutional, financial, pharmaceutical, psychological, cultural, technical, acceptability, etc. Notice that all these factors (for which specific indicators exist) are relevant barriers to an appropriate distribution of equipment and skilled manpower to effectively raise levels of access to care.

In summary, it can be seen that the real government health spending is still low although the total health expenditure by GDP is relatively high. Most of general government health spending is still on supply side subsidies, with social health insurance accounting for just 17.6% (2008) and mainly covering the better off groups (25, 31, 32).

4.2.5. Governance and the regulation environment in the health sector

Governance in Vietnam is defined as ‘State management’ and is achieved through the principles of co-operation rather than competition and consensus. This is very important in the context of Vietnam. Between the government and the Communist Party of Vietnam (CPV), for example, the principle of ‘close co-operation and co-ordination’ has also been explicitly agreed (33).

The different administrative levels that can issue regulations/policies in Vietnam are presented in Figure 7 below, which provides an overview of the legislative policy process in Vietnam. This process consists of common rules that are mandatory

when developing and implementing regulations.

Legal documents in Vietnam are divided into primary and secondary regulations. Laws/regulations are legal documents passed by the National Assembly (NA) and its standing committee, the highest constitutional body of the country. These documents consist of the Constitution, laws, resolutions and ordinances. Secondary regulations are issued by state organisations (administrative and judicial organisations). These are legal documents such as orders, decisions and decrees by the Prime Minister or Government Office, of a lesser weight than those related to central legislation. The ministries develop circulars, which provide detailed guidelines for the implementation of the NA's and the Government's legal documents, specify technical standards, procedures, and set technological and economic standards for the sectors they are in charge of (34).

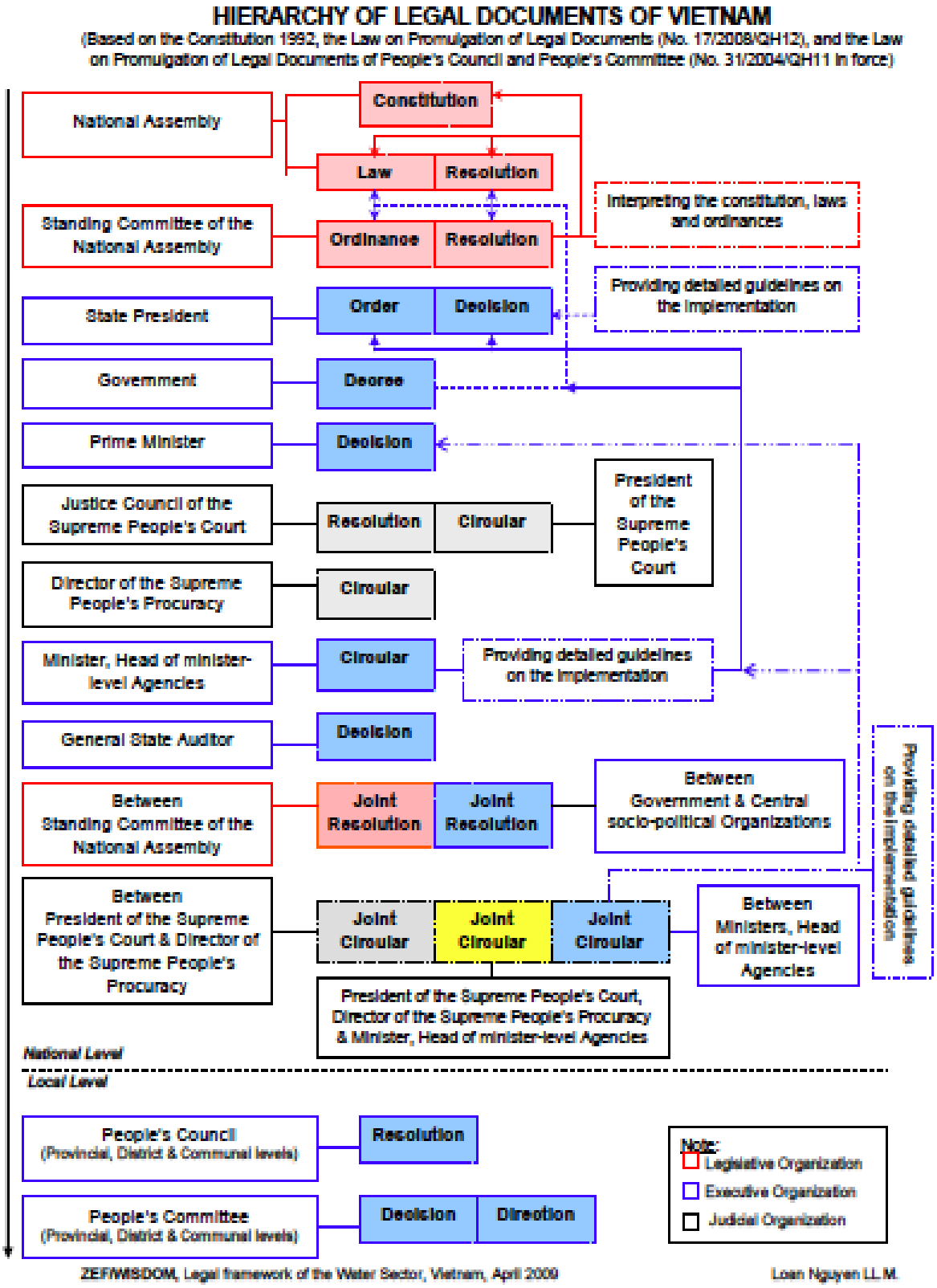

Figure 7: Hierarchy of legal documents in Vietnam

The regulation of the health system is very much influenced by the governance principles and values of the Vietnamese Communist Party and Government of Vietnam. These include prioritising: 1) People's health care and protection, viewed as an important issue and recognised as a responsibility of the state; 2) Supporting social mobilisation in health care and strengthening the health care network at grass roots level; 3) Protecting the poor and vulnerable; and 4) Decentralisation and autonomisation of different functions related to health care.

Within the organisation of the health system, different departments are responsible for regulation of different areas of health services. The MCH department of the MOH is the administrative agency responsible for regulation of maternal health services.
The regulatory framework of the health system in Vietnam operates on multiple aspects and applies to both institutions and individuals in the health sector. The range incorporates: entry, quality, quantity, price, distribution and competitive practice. Different mechanism/strategies are used to ensure the implementation of regulations through command and control; registration/licensing; contracting; incentives; rights and liabilities laws. The key legislation and regulations affecting the health sector are presented in Table 7.

Table 7: Health regulation framework

Regulations (year)	Level	Target	Mechanism/ Strategies	Gaps
Law on examination and treatment (2009)	Entry Quality Quantity	Individual Institution	Licensing and accreditation	No testing system for licensing of providers
Ordinance for private medical and pharmaceutical practice (2003)	Entry Quality Quantity	Private facilities and practitioners	Incentives	Main focus on administrative requirement
Circular 07/2008: Guideline on enrolment for continuing training	Entry Quality Quantity	Individuals	Licensing and accreditation	Lack of mandate

Regulation on hospital performance (1997)	Quality Quantity	Institutions	Command and control	No specifics on quality and quantity of services
Regulation on technical assignment by level (2003); including technical assignment on RHC services (385/2001)	Distribution Quantity		Incentives	No specific mandate for compliance
Health insurance law	Price Quantity	Institutions	Contracting	Limited accountability
Clinical audits, maternal audits	Quality	Institutions	Command and control	No specific mandates
Instruction on solving complaints	Quality	Institution Individuals	Right and liabilities laws	Poor M&E
Different clinical standards on different diseases	Quality	Institution Individuals	Incentives	Lack of mandate
Regulation on fees for services	Prices	Institutions	Command and control	Slow to update
Decree 10/43 on autonomisation	Quantity Competitive practice	Institution	Right and liabilities laws	Equity and quality of services are neglected

In recent years, health governance has focused on the development of policies, mechanisms and instruments for policy implementation, improvements to the structure of the health system as well as monitoring and evaluation to ensure accountability and management of the health information system (4).

Under the Law on *Promulgation of Legal Documents*, health policies, strategies and programmes should go through a consultation process with widespread participation

across communities eliciting comments/feedback during the draft / definition stage of the regulation. Draft laws and decrees should be posted on the websites of the Ministry of Health (MOH) for public consultation before the National Assembly and the Government can approve them. Dialogue and information sharing among agencies in the health sector and beyond, and among actors to promote consensus in policy making, has been strengthened and, through this process, become more effective. Dialogue, discussion and co-operation with international organisations, especially international donors engaged in health policy and health care evaluation, have also been conducted on a regular basis. However, the involvement of community and civil society organisations in policy and strategy making remains limited. There was only consumer protection association available in Vietnam. However, they are not dealing with healthcare services. In part this relates to how citizens' comments and contributions are used, which depends on the particular department leading policy development. To date, for example, use of information gleaned from citizens' comments on websites regarding health policy and strategy remains quite limited. At the same time, the required impact assessment of the draft regulation is often neglected due to lack of resources.

Mechanisms for implementing policies have been improved, as have the guidelines for the management of finances, human resources, the organisation of personnel and health service provision. Whilst guidelines for the diagnosis and treatment of some diseases have been issued, the development and issuance of professional standards remains slow and has failed to meet the demands of the health system in terms of standard treatment guidelines and clinical regulations. The district health reforms have made the management of health services at this level complex and difficult, and regular monitoring and evaluation remains weak (35). In summary, whilst the overall governance of the health system has improved in terms of development, implementation and evaluation, it also continues to face a number of shortcomings. There is a need, for example, to improve capacity for policy making, including the need for systematic collection of an evidence base for the policy making process. Finally, there is a need to strengthen the district health organisations to improve their ability to conduct regular, effective M&E of all relevant regulations.

CHAPTER 5. CASE STUDIES

5.1. Emergency Obstetric Care (EMOC) case study

In 2001, the Ministry of Health (MOH) passed Decision 385/2001 on technical responsibilities at different levels in the reproductive health system in Vietnam, including EMOC functions/services. This case study will try to explore how the governance of Decision 385/2001 has affected equitable access to quality maternal health care in Vietnam.

5.1.1. Processes of Decision 385/2001

5.1.1.1. Policy environment

In order to enable the implementation of the National Reproductive Health Strategy 2001-2010, the MOH introduced several different policies that provided a supportive environment for the implementation of regulations. Those related to EMOC included: (1) Decision 3519/2000/QD-BYT on the guidelines for diagnosis and treatment of five emergency obstetric complications; (2) Standards and guidelines for reproductive health care services in Vietnam; (3) Decision 385/2001 on technical roles and responsibilities at different organisational levels in the reproductive health system; and (4) Decision 23/2005 on technical responsibilities by different organisational levels in the general health system.

Decision 23/2005 provided regulation on the delineation of the technical levels responsible for implementation, and a list of all medical services, including reproductive health services, that are covered by the rule. The list of essential medical services functions as the reference for health facilities that then have to consider whether they would provide these services. If they do, they are required to get approval from the Provincial Health Department (PHD). Based on this formal approval, the health insurance system will pay reimbursements for the services provided. The list is applicable to both public and private health facilities and needs to be updated annually.

Decision 23/2005 (from the Department of Treatment of the MOH) and Decision 385/2001 (from the Maternal and Child Health (MCH) Department of the MOH)

identified a list of reproductive health services including EMOC services to be provided at different facility levels. Therefore, the content of reproductive health care (RHC) services in Decision 385/2001 is consistent with Decision 23/2005.

The process of Decision 385/2001 on EMOC (hereafter, Decision 385 or 'the regulation') consists of four steps: formulation, administration, implementation, and monitoring and evaluation (M&E). In this study, amendments to the regulation are considered as indispensable steps in the formulation of the regulation. At present (2011), the regulation has been amended for the second time since 2008 and this amendment is undergoing final approval by the Ministry of Health (MOH) (36). As the content of Decision 385 is included in Decision 23, the amendment of Decision 385 has to follow an amendment to Decision 23/2005 that has not yet been approved. Figure 8 provides a map of related regulations issued at governmental and ministerial levels. While the government issues national strategies, the national standards/guidelines and decisions are issued at the ministerial level.

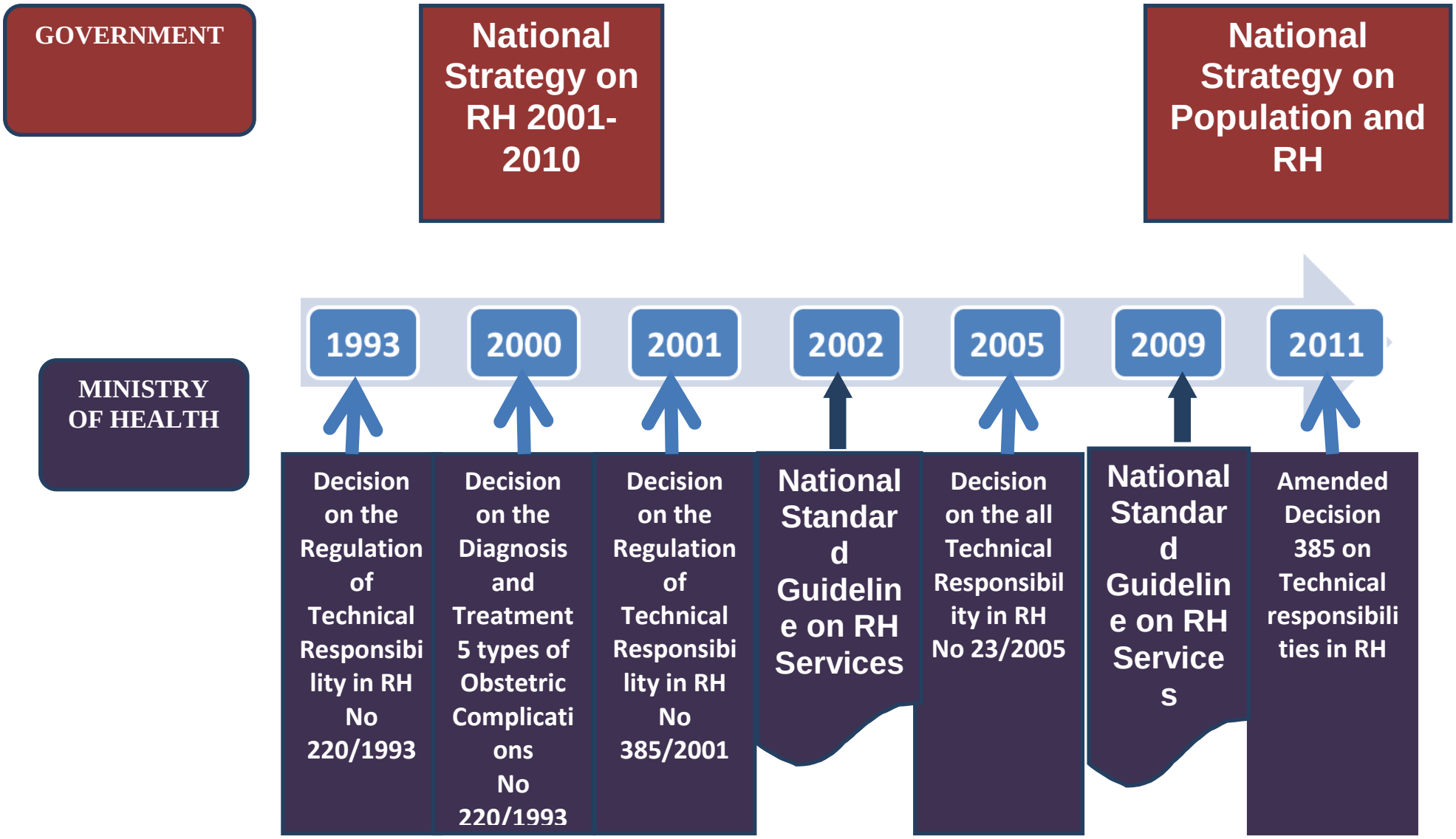

Figure 8: Timeline of regulation related to EMOC

Formulation

Decision 385 was issued in 2001 with the MCH division of the MOH playing a co-ordinating role. The following steps were taken in the process of formulation:

- Setting up a drafting committee with different subgroups responsible for different parts of the regulation;
- Development based on Decision 23/1993 taking evidence into account;
- Updating content in line with international and national standards, and as appropriate to context;
- Revision of some parts to fit with health system changes (such as including the private sector).
- Approval by MOH on 13 February 2001.

It is noted that, regulations on reproductive health in Vietnam often set targets based on the performance from previous years. For example, at the national level, the trained birth attendance rate in Vietnam in 2009 was 94.8 percent. The national target set for the year follows (in 2010) was reasonably higher than that, with 96 percent.

Content

The main objective of Decision 385/2001 is to support technical improvements at reproductive health (RH) facilities at different levels. The regulation replaces the former Decision No. 220 BYT/QT (issued in 1993) on the promulgation of technical responsibilities in Maternal and Child Health/Family Planning (MCH/FP) in the health system. This new decision has been changed to fit with the new context as a result of the reform of the MCH network, the growth of the private sector in the health system, and the need to meet MDG goals. Decision 385 consists of two parts:

- Part 1 specifies the target of the regulation and includes all types of health facilities involved in providing RH services, including public and non-public ones. As specified in the regulation, non-public health facilities include private, co-operative (partially public), externally funded and other legal health facilities.
- Part 2 refers to specific RH services that should be provided within public health facilities at each level, from central to commune level. For application in non-

public health facilities, the Department of Private Practice Medicine Management at the PHD should decide on RH services in accordance with the Ordinance on Private Medical Practice and existing related documents. Non-public health facilities are required to follow all current standards and guidelines issued by the MOH.

It should be noted that EMOC services were not specified separately in the regulation, but this clearly states that basic obstetric care (except assisted vaginal delivery) should be applied at commune level and comprehensive obstetric care (including C-section and blood transfusion) should be applied at district and higher levels. There are 6 basic EMOC functions at CHCs recommended by the World Health Organisation. However, in Vietnam, at commune level, basic obstetric care means five functions of EMOC (parenteral antibiotics; parenteral oxytocics; parenteral anticonvulsants; manual removal of the placenta; manual removal of retained products). Vaginal assisted delivery, the sixth basic function, is not allowed at CHCs in Vietnam due to a concern for the inability to treat complications in a timely manner at commune health facilities. At district level or higher, eight functions of EMOC (the six basic functions as in CHCs, plus C-section and blood transfusion) should be performed. Decision 385 has only specified 'technical' responsibilities, not the control of medicines or price caps relating to defined activities. The Department of Professional Medical Management has responsibility for setting prices for different types of technical assignments (TAs), based on the health insurance law. Setting prices for techniques had to be undertaken in collaboration with the Office of Health Insurance, and other actors (i.e. finance department). This group is also responsible for an annual update of the TAs and their corresponding fees that would then be submitted to the Provincial People's Committee and People's Council for approval prior to its implementation. Several pricing regulations were developed in Vietnam that affect the price of health service cost, law of health insurance, health price frame, regulation on hospital financial autonomy, to name a few.

The regulation specifies that 'non-public health facilities provide reproductive health services in accordance with the Ordinance on Private Medical Practice dated 30 September 1993 and other related guidance documents'. The regulation has been widely considered to provide 'desirable standards' of RHC services for health

facilities. However, there is no clause within the regulation that states the consequences of non-compliance.

Amendment of the regulation

Decision 385 has been amended since 2008. Comments from actors from national to grassroots levels through workshops and electronic communication were collected. Donors such as the UNFPA were also invited to provide comments. The draft of the amended regulation has updated the technical procedures specified as EMOC functions and the responsibilities of different health facilities in the aftermath of changes to the health system, especially at the district and commune levels. Approval of the amendments awaits and will follow approval of amendments to Decision 23/2005.

5.1.1.2. Administration

This section provides information about administrative activities from central to commune levels in relation to the regulation. Administrative activities in this report deal with how information on the regulation and its guidance documents were disseminated within and across teams in the health services system. Our findings suggest that the administration of the regulation varied between different levels of the health system.

At central level, the MCH department informed the MOH agencies and departments and provincial organisations of the content of the regulation and provided guidance on its implementation. The following activities were (are) delivered: (I suggest to use the present tense throughout the next paras)

- Sending hard copies of the regulation by post and announcing it in workshops and regular staff meetings.
- Dissemination of the regulation to the PHD, the provincial centre for RHC, provincial hospitals, and district hospitals.

At the provincial level, the Department of Professional Medical Management at the PHD was to take the lead in the administration of the document. However, Decision

23, the guidance for implementation, was sent by post and no training was conducted. Specifically, the following activities were undertaken:

- Send out the regulation to all departments and agencies within the province via post, local area network (LAN) or internet (as in the case of Dong Thap province).
- Send out hard copies of the regulation to relevant district health agencies.
- Organise training workshops for directors of provincial and district hospitals on the content of the regulation.
- Administering Decision 385/2001 to lower levels of the organisation by the PHD or provincial centre for RHC.

At the district level, the Planning and Administrative Office (*Phong ke hoach tong hop*) of the district hospital took the main responsibility for administration. The District Health Office (DHO) and District Centre of Preventive Medicine (DCPM) played the management and co-ordinating role for the administration. Administration activities at district level included:

- The director of the district hospital received the regulation, either by post or meeting at the provincial level.
- The district hospital management board (including the director) discussed the implementation plan at the hospital.
- The district hospital management board disseminated the regulation via regular staff meetings and meetings with head of the OBGYN department, whilst hard copies of the regulation were also sent to different hospital departments, either directly at meetings, or via LAN and emails.
- The district hospital then administered the regulation and provided further guidance for its implementation to the commune level.

At commune level, the commune health centres (CHCs) are in charge of all administration activities, including:

- The head of the CHC received information about the regulation from the district, either by post or during staff meetings at the district level.
- The head of the CHC then informed CHC staff, especially those in charge of OBGYN.

This case study suggests several constraints in the administration of the regulation. For example, many actors involved in the regulation process were not even aware of the regulation. This is partly because the regulation was issued ten years ago, in 2001. Since 2001 many new directors/heads of OBGYN departments have been appointed. They are not aware of Decision 385 because there is no update on the regulation. In our study, many of them confused Decision 385 with Decision 23, both of which were issued by the Ministry of Health. Decision 23 specified all technical medical assignments that could be performed at different levels, including those related to EMOC. As one administrator in Dong Thap province put it:

> *I am in this position for only three years so I do not know much about this decision*. (EMOC_Administrator12_ DT)

This is partly because there are no regular mechanisms for updating this regulation for new staff. In fact, training for implementation of the regulation was undertaken only once, in 2001, for Decision 385.

5.1.1.3. Implementation

The World Health Organisation (WHO) recommends several strategies to reduce the MMR in developing countries. Access to EMOC, skilled birth attendance (SBA) and effective referral systems are among the most critical of these strategies. According to the WHO, if the district hospital and upwards provides comprehensive EMOC and the CHC provides basic EMOC, it is likely that the MMR will be reduced.

The implementation stage of the regulation includes registration and annual update and approval of EMOC service provision. The implementation process is presented in Figure 9. Several factors that influence the implementation of EMOC services, especially at the district level, are discussed later in this report. Since the private sector was not actively involved in the implementation of the regulation, this discussion mainly focuses on the public sector.

Registration of technical assignments

One of the main activities in the regulation implementation process is the registration of technical assignments (TA). For the public sector, the registration of TA services takes the following steps (see Figure 9):

- Assessment: A review of the current situation with regard to equipment, human resources and capabilities of staff is conducted to serve as the basis for an accredited list of technical services that might be provided at the health facility. Then the list of TAs to be registered at each health facility is submitted for verification by higher levels.
- Verification: the higher levels will then verify the proposed list of TAs. The higher level will make decision on whether to register or update each item on the list.
- Approval: The verified list of TAs is sent to the PHD for approval. The process for review and approval is about one week in Bac Giang and about two weeks in Dong Thap province.
- Registration of services in the private sector is different in that all technical services should be registered from the beginning of the establishment of the private hospital/clinic. This process is specified in the Law on Private Health Practice.

Annual update of the TA list

- An annual update is made from the district to the provincial level. Sometimes this update is required twice a year.
- The updated list is then sent to the PHD in the same manner as for registration of TAs.

Approval of higher level TAs

If the district health facility wants to register techniques that are allowed to be performed at higher level, approval from the higher TA level often takes the following steps:

- At the district level, the obstetric department has to submit the updated list to the higher TA level and then to the director of the district hospital.

- The hospital will then send the request for approval of the updated list to the PHD.
- The PHD sets up a verification team to confirm whether the district hospital is in fact capable of implementing the updated list or upper level TA, based on the review of the health facility.
- Approval will be made based on the verification report. The price for the service will then be communicated.

> *For this higher TA level, I had proposed to the PHD, and they set up a verification team to see if we can do this assignment. If these assignments are approved, they will also inform about the price attached to each assignment.* (EMOC_Implementer06_ BG)

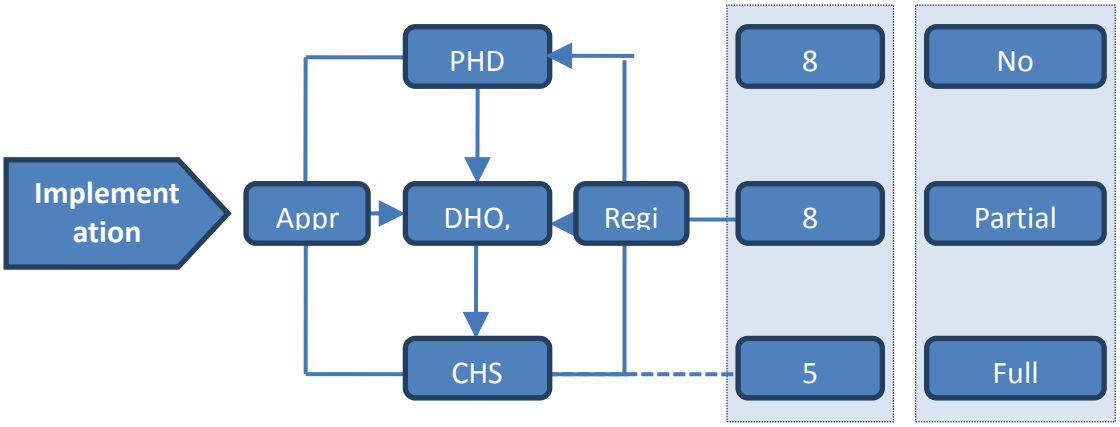

Figure 9: Implementation process of EMOC functions

Provision of EMOC services

At the central and provincial level, comprehensive EMOC services are delivered at public hospitals. In addition, private hospitals (e.g. Domedic hospital in Dong Thap province) also provides comprehensive EMOC. The clients have to pay higher fees to access private health facilities, because the health insurance pays only 50% of fees for clients accessing private hospital, while in public hospitals it pays 70%). Comprehensive EMOC is available at all provincial hospitals, due to the availability of resources.

The provincial hospitals are in charge of providing technical support to the district level by supplying blood and obstetric specialists to help with emergency cases on site. Furthermore, technical support may be undertaken through regular meetings with district hospital managers.

At district level, the data from the MCH Department of MOH in 2010 showed that, there was increasing coverage of EMOC services between 2007 and 2010, from 63% to 68.2% for C-section services and from 47% to 59.8% for blood transfusion services. However, these figures are still low. There are several contextual factors affecting the provision of EMOC services at the district level (see Section 5.1.4). The shortage of human resources and inadequate facilities are among the main reasons for a lack of comprehensive EMOC at district hospitals. Other reasons include a fear of complications among health workers (37).

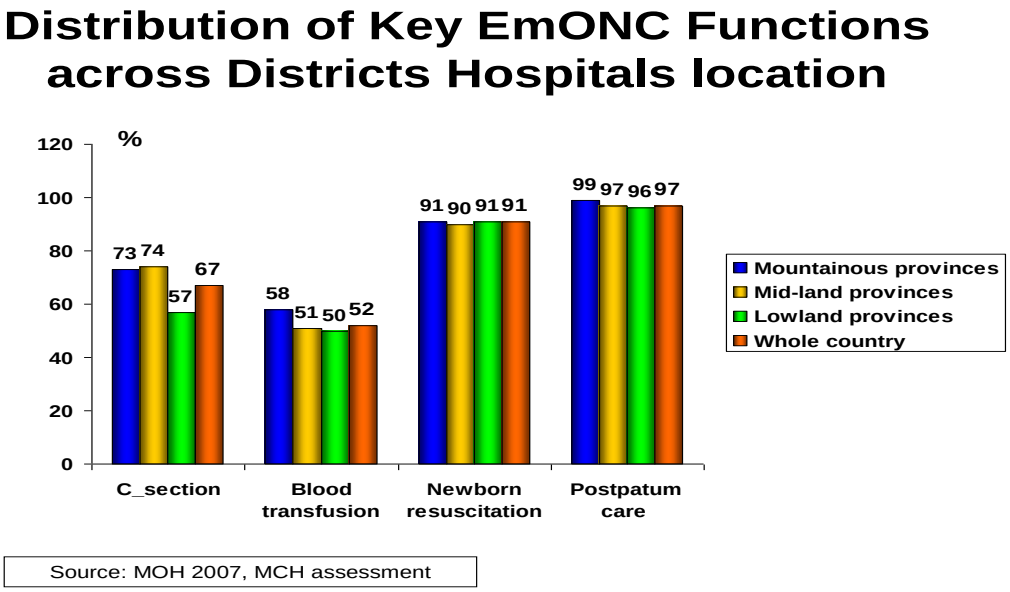

Figure 10: Distribution of key EMOC functions by district hospital locations
(Source: MOH, 2007)

An assessment in 2007 of 63 provinces in Vietnam showed higher coverage of EMOC services (C-section and blood transfusion) at district hospitals in the mountainous and midland provinces than in lowland provinces (73-74% vs. 57%) (See Figure 10) (38). However, the MMR in mountainous provinces remains relatively high, both due to home birthing practices and distance to/ accessibility of district hospitals.

The higher TA level services can sometimes also be performed at the district level with support from higher levels. For example, a second C-section with earlier scarring is not a district level function. However, this can now be performed with technical assistance from higher level hospitals. As one respondent suggested:

> *Here at the district level we can do operations such as for ectopic pregnancy. For a second C-section with scar, this is an upper level technique, and can only be done at the provincial obstetric hospital, not at the district hospital anymore. But if there is sudden case, we see if we can do here if the provincial doctor can come down to help*. (EMOC_Implementer05_ BG)

At the commune level, the CHC is supposed to provide basic EMOC services following national standards and guidelines on RHC services. However, basic EMOC was not performed at all communes. At commune level, according to recent data from 2010, only 23.6% of CHCs could perform all basic EMOC functions; 83.6% of CHCs could perform a normal delivery; 49.5% could perform manual removal of placenta; 46.7% could administer parenteral anticonvulsants for pre-eclampsia and eclampsia; 64.7% can perform removal of retained products; and 70.4% can administer parenteral oxytocic drugs (Table 8). Mekong Delta region has the highest rate of basic EMOC functions at CHC level (30.9%), while in other places the rate of basic EMOC provision is lower: 26.3% in the Red River Delta region, 24.6% in North Central region, 22% in North East zone and lower than 20% in other regions.

Table 8: Percentages of CHCs performing EMOC services

EMOC services	Percentage of CHCs
Normal delivery	83.6
Parenteral anticonvulsants for pre-eclampsia	46.7
Manual removal of placenta	49.5
Removal of retained products	64.7
Parenteral oxytocic drugs	70.4

All basic EMOC services	23.6

5.1.1.4 Monitoring and evaluation

There are different activities in the monitoring and evaluation process. A top-down style has been observed in the supervision of the implementation of TAs. The national level supervises the provincial level, which in turn supervises the district and subsequently the commune level. If the lower level provides a higher-level TA than approved, the supervising level will report to its higher level for sanction. However, this scenario is very rare.

Monitoring and supervision in the form of supervising visits to lower levels also reflect this top-down style. As scheduled, the district hospital and the district health office are supposed to jointly conduct monthly monitoring and supervision visits to CHCs. A supervising team is set up with members from related organisations (including the hospital, RHC and preventive health centre). For the private sector, the Department of Private Practice Medicine has to organise supervising visits separately. In practice, however, these visits to both the public and the private sectors were not as frequent as scheduled due to the lack of human resources.

One kind of technical support for CHCs is through sending doctors when needed. In case of an emergency, CHCs will provide first aid care while waiting for support from doctors and/or blood from the higher level. Sometimes an ambulance from the district is provided to help CHCs.

Participants spoke at length about the inefficient monitoring of all technical assignment services at CHCs, including basic EMOC. Monitoring via monthly supervising visits seems to be the most effective way, because it can provide a continuous form of medical education. Staff from the higher level can directly observe and supervise the services provided on site, and then provide advice or training if needed. Unfortunately, however, most supervision visits consist of checking reports and logbooks rather than sending technical staff to the lower levels for technical support.

A different form of supervision also takes place within each level, but continues to reflect the top-down approach with irregular and not supportive manners. For example, at the district hospital, the head of OBGYN department is able to supervise other doctors in the department. At the hospital, technical support and supervision can also be conducted on-site or via regular staff meetings.

For EMOC services, field visits and logbook checking could identify whether TAs are under or over-performing. But we found that in all the documents and in particular the logbooks available, no evidence of under or over-performance had been recorded.

5.1.1.5 Rewards and sanctions

As discussed earlier, Decision 385 is considered as 'standard guidelines' for providing EMOC services. Therefore, no sanctions or rewards are clearly specified in the Decision, except that insurance re-imbursement will be improved (is this a minor rewards?). For the same reason, the implementation of these services varies at each level. In reality, health facilities will not receive official sanctions for non-compliance with the EMOC regulation. No incentives are reportedly available for EMOC. There are thus no official sanctions for under performance of EMOC services at all levels.

Although the Department of Professional Medical Management is the key actor in the implementation of the regulation, their attitude toward the implementation is 'you do it if you can' (*lam duoc thi lam, ko lam duoc thi thoi)*. Merit points (*diem thi dua*) from the DHO might be awarded in general cases reflecting the existence of a 'reward system' but not particularly related to the implementation of the regulation. It was reported that a hospital's merit points would be deducted at the end of the year, if a TA was not implemented. These merit points are generally used as one way to assess the performance of the hospital. Merits, in most cases, will entail a small symbolic monetary prize. No formal sanctions were applied if the health facility has not conducted a TA as they are supposed to do.

> *Generally speaking, these standards were set for health facilities to implement. If they do not implement them, they will not be fined. However, the*

health facility is still assessed by the PHD and will have fine of reducing the merit points. (EMOC_Administrator02_BG)

However, sanctions for over performance (*vuot tuyen*) are possible. As reported in this study, the health facility will be criticised or punished if they are found to deliver services that are not approved by the PHD, especially services in higher-level TAs, such as doing a second C-section with scar. The PHD will set up a committee (often consisting of representatives of the Department of Professional Medical Management, the provincial hospital, and an inspector) to consider the level of sanction. In practice, however, no punishment or sanction was reported in either of the provinces under study. Feedback loops are weak, leading to the poor implementation of the regulation because there is lack of an effective M&E mechanism.

5.1.2 Regulation approaches

The process of implementation of Decision 385 has taken two main approaches: a state-led-command approach, and an enabling approach. These approaches interact in ways that affect the implementation of the regulation.

5.1.2.1. State command approach

This regulation was developed and implemented in a typical state led 'command' approach. This approach is reflected in the top-down manner of the whole regulation process. As discussed above, the top-down approach was most clearly observed in the monitoring and supervision process.

A full state command approach can often assure the implementation of any regulation in Vietnam. However, the implementation of EMOC services as specified in the Decision 385 was varied. This is partly because the Decision is mainly a technical guideline and importantly, it is not compulsory for all health services, thus leading to discretion in implementation. It should be noted that, under the state command approach, compulsory status is necessary in order to make the regulation work. For a regulation relating to providing health services like Decision 385, it is

difficult to create a ‘compulsory’ regulation because providing services has certain pre-requisites, such as financial and human resources, which were affected by several factors.

5.1.2.2. Enabling approach

The EMOC regulation provided ‘desirable technical standards’, with the aim of enabling hospitals to increase availability and accessibility to EMOC services at district level. This process, it was hoped, would increase access to EMOC services for citizens in the different regions of the country, thus indirectly working towards more equity in health services.

5.1.3. Actors

5.1.3.1. Description of actors

Actors involved in the processes of Decision 385 derive from different groups in each stage of the process. Notably, some actors were involved in more than one stage. Descriptions of the main actors involved at each stage are presented in Table 9 and discussed below. The table highlights the diversity of tasks by different actors and the objectives that they are supposed to achieve.

Table 9: Actors and roles in the EMOC regulation process

Actors	Tasks	Objectives
Central level		
MOH (MCH department)	- Formulation, administration, and M&E of EMOC in whole country; - Responsible for governance of the whole RH system.	Ensuring patients achieve equitable access to quality care
Provincial Health Department (director)/ Dept of Professional Medical Management	- Administration and M&E of EMOC cases in local health system; - Making final approval of EMOC upgrading services for hospital; - Responsible for governance of local health system.	Ensuring equity for patients
UNFPA	- Co-operating with MOH in formulating	Ensuring patients achieve

	the regulation.	equitable access to quality care
Provincial level		
Provincial RH centre	- M&E of EMOC activities, making report annually; - Supporting local health EMOC activities.	Ensuring quality improvement of local health services
District Health Office/ District Health Centre	- Co-operating with district hospital in administration, and M&E of EMOC cases at CHC levels; - Managing CHC network including basic EMOC.	Ensuring quality improvement of local health services
Public provincial hospital (directors)	- Ensuring EMOC services at health facilities in provinces; - Administration and M&E of EMOC activities; - Supporting district hospitals in case of complications.	Maintaining good hospital service Attracting patients and incomes
District level		
Public district hospital (directors)	- Administration and M&E of EMOC activities, motivating health providers (attracting, training); - Supporting CHCs in case of complications; - Ensuring EMOC services at health facilities in district level; - Referring patients to provincial level if needed.	Maintaining good hospital service Attracting patients and incomes
Private hospital (directors)	- Administration and M&E of EMOC activities, motivating health providers (attracting public health providers, open services at weekend) - Competing and co-operating with public sector on EMOC services	Maintaining good hospital reputation to compete with public sector; More focus on attracting patients and generating incomes;

		Satisfying clients' demands and making profit.
Service providers at hospital	- Ensuring EMOC services at health facilities; - Implementing EMOC services according to assignment and competencies; - Quality improvement of local health services.	Ensuring comprehensive EMOC and equity for patients.
Commune level		
Service providers at CHC	- Ensuring EMOC services at health facilities; - Implementing EMOC services according to assignment and competencies; - Referring women in case of complications.	Ensuring patients achieve equitable access to quality care.
Service users	- Receiving good services, ensuring healthy mother and child	Equitable access to quality care.

The following section provides an overview of the key actors involved in the processes of Decision 385 as well as other actors who are more indirectly involved.

MCH department of the MOH

The MCH department is active in the development of related policies that reflect the context, such as changes in the health system at district level, and especially the growth of the private health sector. However, the content of Decision 385 has not been updated in the aftermath of health system reform (2005). The MCH department tried to amend Decision 385 but this has not yet been approved.

Administration of Medical Services (AMS) – MOH

The AMS and the MOH are responsible for Decision 23/2005. The advantage of Decision 23/2005 is that it covers all aspects of the medical system, including MCH

and EMOC. The regulation is widely used by all practitioners, hospitals and CHCs, since it serves as the basis for all health insurance payments. The content of Decision 23 on EMOC is consistent with that of Decision 385.

UNFPA

The UNFPA's RH unit has also played an important role in providing financial and technical support for the policy and regulation process. UNFPA has shown a strong commitment to support the MOH in Vietnam for policy development on RHC services.

Department of Professional Medical Management within the PHD

The Department of Professional Medical Management is the important unit within the PHD, as it takes the main responsibility for both preventive and curative activities at different levels of the public health sector within the province. The unit was involved in the dissemination of the regulation to the lower levels, sending the regulation via post/mail or providing training workshops. It also plays a role in creating an action plan for registering the TAs, reviewing the situation and then submitting the list to the director of the PHD for approval. Besides, this unit has to work closely with health insurance offices to approve the price of health services at different levels within a province, before approval by the provincial People's Committee. Supervision and the provision of health information reports are also among the main tasks of this department. This actor also plays a role in developing training and in the broader development of the health system within each province.

Department of Private Practice Medicine within the PHD

The Department of Private Practice Medicine is responsible for the management of all preventive and curative activities in private health facilities within a province. This department plays a minor role in implementing Decision 385. In Bac Giang province, the Department of Private Practice Medicine and Department of Professional Medical Management are separate, while in Dong Thap province, the two units are unified under the Department of Professional Medical Management.

Public provincial hospitals

The public provincial hospitals are responsible for providing medical services and disseminating the regulation within hospitals of the province. Besides this, provincial hospitals also are in charge of providing technical support and supervision visits to lower level facilities. In Bac Giang, there is one provincial obstetric hospital and four other provincial level hospitals. The provincial hospitals in both Bac Giang and Dong Thap provide comprehensive EMOC (C-section and blood bank for transfusion). Provincial hospitals are responsible for providing blood to district hospitals for C-sections and other emergency cases if blood units are not available at district hospitals.

The Department of Examination and Treatment (MOH) and the Department of Private Health Practices Management at Provincial Health Department are responsible for assessing the legality and the size of private facilities based on the technical list that the private health facilities registered when established. In Vietnam, there are mainly two types of the private health facilities, including private health clinics and hospitals. Private hospitals are often equivalent to provincial level hospitals although the scope of services provided in private hospitals could be much smaller than that of public provincial hospitals.

Public district hospitals

District hospitals play key roles in implementing comprehensive EMOC. These are the first referral level for CHCs in case of obstetric emergency. In Bac Giang province, nine out of ten district hospitals have registered for comprehensive EMOC; the remaining hospital is located in an urban setting nearby the provincial hospital. In Dong Thap, four out of eight district hospitals have registered for comprehensive EMOC, including the district hospital located at the city. Reasons for partially implemented EMOC are a lack of human resources as well as absence of an operating theatre. Some districts hospitals do not have an operating theatre due to lack of resources (lack of funds to build the operating theatre, and lack of success in raising funds for this; as well as lack of surgeons to do OBGYN operations). Another reason is the vicinity of the provincial hospital. Patients often go to higher level hospitals nearby for services – this is the case for Lang Giang district hospital in Bac

Giang, for example. Not all district hospitals have a blood bank; some only have reserve blood units that can keep two to four units of blood for emergency cases. If needed, district hospitals can call for support from the blood bank at provincial hospitals.

The regulation was developed as presenting 'desirable standards', but without subsequent mechanisms to make health facilities follow them. This gives flexibility to the local level to choose whether to achieve the desired standard functions or not. Due to this flexibility, district hospitals can perform TAs differently depending on the availability of human resources, infrastructure and equipment. In other words, there is no clear mechanism of accountability for the director of a district hospital if the hospital performs fewer functions than specified in Decision 385. At district hospitals, the only mandatory feature is asking for approval from higher level (PHD and provincial hospital) in cases where they perform techniques higher than the functions specified in Decision 385.

The director of the hospital plays a key role in motivating and managing its activities. This wide variation in the implementation of the regulation at local level depends very much on the local health managers' motivation to achieve the technical standards on EMOC. If all directors of district hospitals were motivated to mobilize funding to improve infrastructure and strengthen the capacity of human resources at a hospital through technical support and in-service training, comprehensive EMOC services could be provided at all district hospitals. For example, Tam Nong district hospital in Dong Thap province has been able to provide good EMOC services through training and efficient management. There are several factors hindering district hospital directors from allocating funding for building operation theatres. For example, they need the funding to invest in other more prioritised issues; they are not aware of the urgent necessity to have operation theatre in the district hospital (because there is provincial hospital nearby); or the lack of surgeons makes building an operating theatre seem superfluous.

Implementers of services (obstetric staff and midwives) at hospitals and CHCs

The task of health providers at district hospitals is to provide full technical support for the eight functions of comprehensive EMOC. However, a lack of qualified health

providers is reported to be the main cause for the unavailability of comprehensive services at district hospitals. Qualified doctors, for example, are often not motivated to work in the districts due to the low incomes and allowance, lack of training opportunities, and poor living and working conditions in comparison with those working at provincial/national levels and other urban areas.

The CHCs play a key role in implementing basic EMOC services. There are approximately 11,000 CHCs nationwide. On average, there are 8.9 staff working in each CHC, of which there should be one general practitioner, 0.4 assistant doctors on obstetrics and paediatrics and 1.5 midwives (39). However, our review of secondary data from 2000-2010 in Bac Giang and Dong Thap suggested that delivery cases assisted by the CHCs in the two provinces of this study have decreased from 100-150 cases/year in early 2000 to 10-30 deliveries/years in 2010. This trend is partly related to low competencies in EMOC services due to lack of practice, especially among young or newly recruited OBGYN doctors. The local community and the medical staff themselves do not trust the delivery skills of local medical staff and therefore often seek to be transferred or go directly to a higher level of care. Health staff at CHCs therefore tend to provide antenatal and postnatal care. Furthermore, low health insurance payments do not motivate health providers who could provide EMOC services to work in CHCs.

> *A case of delivery at CHCs can be paid only 150,000 VND (7 USD*). (EMOC_Administrator13_DT)

Missing actors

Private hospital

In this study, private hospitals seem not to have been involved in the development or implementation of Decision 385. Rather, they operate according to the Ordinance on Private Medical Practice (1993) and the Law of Medical Treatment (which applies to both public and private sectors).

From interviews it is clear that private hospitals were not actively involved in the regulation process. They were not invited to participate in the development or amendment process. This is partly explained by the fact that very few private

hospitals provide basic or comprehensive EMOC services (there is no private hospital in Bac Giang province and only one in Dong Thap providing EMOC services). Both policy makers and UNFPA agreed with the recommendation that private hospitals should be significantly involved in the regulation amendment process in the future.

It is interesting to note that the C-section rate in the private hospital is quite high. Data from both interviews and secondary data at the private hospital in Dong Thap province revealed that the C-section rate may reach approximately 50% of total delivery cases. The amount paid by health insurance for C-sections is much higher than for normal deliveries. This incentive for private providers, among other things, may have worked to increase the rate of C-sections. It is necessary to improve supervision and monitoring of private hospitals to control C-section rates.

Service users

Regarding the regulation process, the demand of service users (women) was still ignored, especially in the designing process. This is partly because policy makers think this regulation is a technical regulation designed for health professionals. Decision 385 is designed to assure equitable access to quality EMOC services. Under this regulation, the availability of basic EMOC services at CHC level and comprehensive EMOC services at district level is the main target.

A number of district hospitals in the two provinces of the study cannot perform fully comprehensive EMOC. Combined with the common perception that the quality of services is better at the provincial level than the district level, this situation may result in the over-burdening of provincial hospitals.

In recent years, the government decided all regulations including health regulation should be posted in the website for public comments before issuing. The clients/users are able to know the prices of drugs and services when accessing health services (i.e. via notice board, website of the health facilities).

5.1.3.2. Actor power

Decision 385 aims to provide wide coverage of basic and comprehensive EMOC services, mainly at commune and district levels. For our analysis, the power of actors were categorised in four types based on the power of actors (in terms of making decision the regulation process) and the potential of actors (in terms of implementation of the regulation and provision of services).

Table 10: Levels of power in EMOC service provision and potential of actors

Power/Potential	Low potential	High potential
High power	-	- MCH department/ MOH - UNFPA - Provincial Health Department (director, professional health department) - Public hospitals (director)
Low power	- Patients/pregnant women	- Private hospital - Head, District Health Office - District Health Centre - Provincial RH Centre - CHCs - Service providers

Table 10 presents this analysis of actors according to their power and potential in implementing EMOC, and suggests that actors who have high power and high potential were nearly all directly involved in the regulation processes. The MCH department of the MOH and the UNFPA are in potential positions that can make/approve the list of EMOC services. Their working position and their knowledge and rights give them both power and potential. UNFPA has resources and knowledge for supporting the MCH department in updating regulation. Besides, the director of the PHD, the head of the Department of Professional Medical Management and the director of a public hospital have high levels of power and potential, due to their professional position, responsibilities, rights and their knowledge. They have key roles to play in increasing the awareness of hospitals and providers about the need to provide EMOC in accordance with their technical

functions. Moreover, they also have the power to approve the list of TA providers at the hospitals/CHCs.

Those actors with low power and high potential are the DHO, the District Health Centre on Preventive Medicine, the provincial RHC, CHCs, director of private sector and service providers. These do not have decision making power over the list of EMOC services provided at local health facilities, although they know very clearly what is involved in providing these services.

The views of pregnant women, their families and the community are not generally considered by policy makers in EMOC regulation e.g. because they are not or not much collectively organized. Whilst women have a strong interest in and demand for EMOC services, they are not in the position to make decisions and are affected by others' decisions. Furthermore, they have limited knowledge on technical regulations such as regulation 385. They therefore have both low power and low potential.

The actor network

'Actor power' refers to the extent to which actors are able to affect the decisions of others, and are able to control the implementation of the regulation. Power derives from the nature of an actor's organisation or their position in relation to other actors.
There are key actors involved at each level of the regulation process. Figure 11 represents the actors involved in 'power relationships' during the process. In this figure, the size of circles indicates power in the EMOC process; the arrow indicates the relationship between actors, and the thickness and direction of the line indicates the strength and direction of influence of one group over another.

Figure 11 below shows that the network of actors involved in the process is broad and complex. This will be further discussed in the section on actors' involvement below.

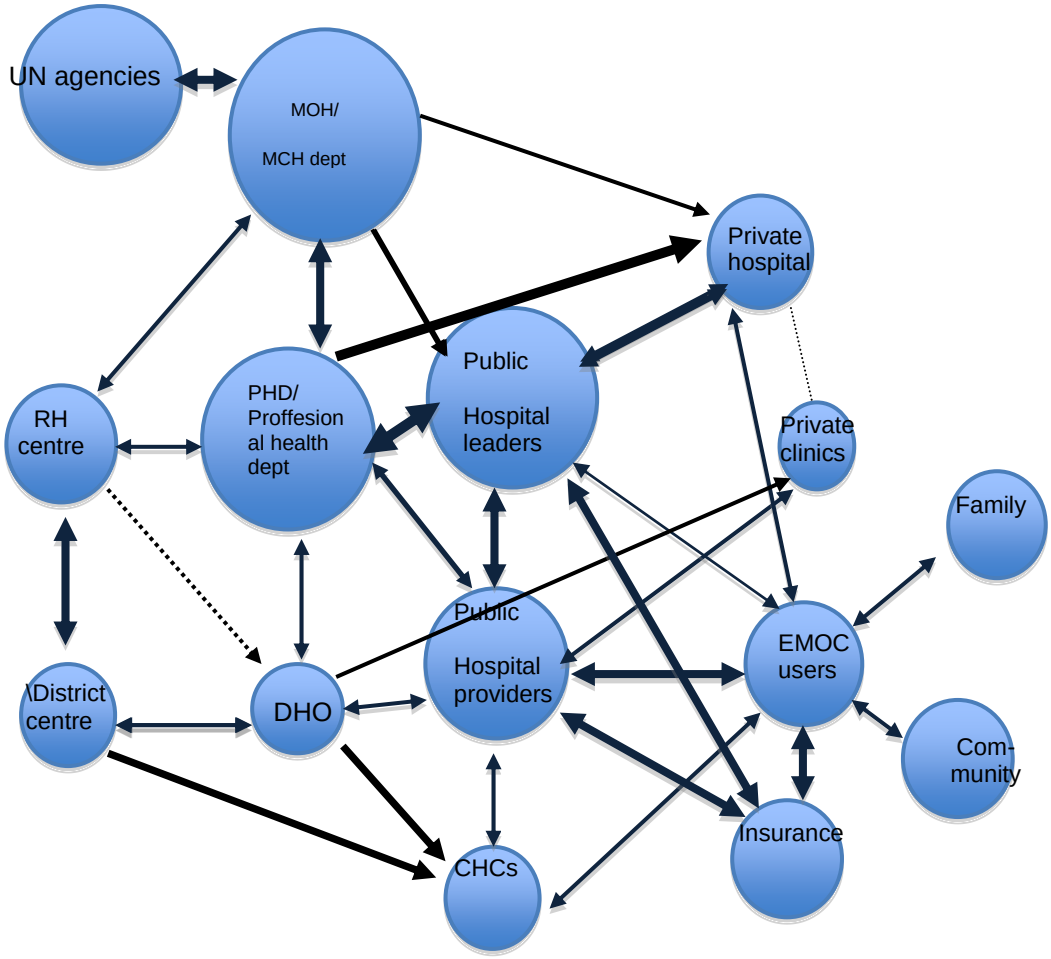

Figure 11: Actors involvement and relationships in the regulation process

The figure illustrates the relationships among all related actors with service users (pregnant women) being the centre. The relationship is determined by levels of direct or indirect influence, and is dependent on the power and interaction between actors in the regulation processes. The relationship is also influenced by the context (culture, the health system, and socio-economic factors).

In general, there is a good collaboration among different levels of actors. At the central level, there was good collaboration between the MOH and UNFPA to formulate the regulation. At the provincial level, collaboration is mostly based on general task assignments of the health system within a province. With regard to Decision 385, the provincial health department and public hospital directors (provincial and district level) play key roles in co-ordinating technical activities and in

the distribution of resources.

There is also clear direction from and effective co-ordination undertaken by the PHD to the provincial hospitals. Collaboration at the district level, however, was not as good as that at higher levels, which may have contributed to the uneven implementation of comprehensive EMOC services at district level. For example, poor co-ordination has been shown in the monitoring and evaluation process at the district level, horizontal collaboration among these institutions appears poorer after splitting the district health centre into three independent institutions – district hospital, district preventive health centre and District Health Office. This relates to the reforms of the health system at district level which will be discussed later in the report.

Although there is increasing involvement of the private sector, it still plays a minor role in EMOC. PHDs, on the other hand, play a key role in consulting local authorities about EMOC issues and implementing EMOC related activities (such as gauging prices of services, and making resources available). All other related sectors (insurance, planning and investment, finance) collaborate with the health departments in implementing and controlling activities as well as conducting administration and implementation activities within their own sector.

5.1.4. Contextual factors affecting the regulation

5.1.4.1. Insufficient resources for providing EMOC services at different levels

In Vietnam by 2010, only 68.2% of district hospitals could perform C-sections and 59.8% of district hospitals could perform blood transfusion (23). District hospitals which have operating theatres can provide these services.

> *There are two models of district hospital: with and without operating theatre. All district hospitals with an operating theatre have blood transfusion and vice versa.* (EMOC_Administrator11_ DT).

Shortage of human resources for health in OBGYN; operating theatres; blood banks, and other infrastructure facilities are the most frequently cited reasons for EMOC services not being provided.

In the study, two selected district hospitals could not provide all basic EMOC services (Lai Vung and Lang Giang). These two district hospitals are about 15-25 km away from the provincial hospitals, where comprehensive EMOC is provided. Normally, a district hospital is graded three in the public health system and is eligible to build an operating theatre. However, the decision to build an operating theatre depends on financial and human resources.

Blood banks are often not available at district level. In some districts, only reserve blood is available. If there is no reserve blood at the district level, in emergency cases, they have to buy from the provincial hospital. It was reported that in emergency cases where blood is needed but not available (i.e. reserve blood does not match the blood group of the patient), family members are the source of blood for the patient.

Often, a lack of blood supply leads to a delay in managing emergency cases, thus the absence of a blood bank influences the availability of services, the quality of care, and equitable access to EMOC.

> *Sometimes we have to use blood transfusions in emergency treatment. For obstetric care, we use these in cases of ectopic pregnancy when there is a uterus rupture. If we don't have enough blood, we have to go to the province to buy it, asking a lab person to go.* (EMOC_Implementer05_ BG)

> *For emergency cases, such as severe haemorrhage due to a uterus rupture in ectopic pregnancy, you have to ask family members for blood. If the uterus has no contractions while doing a C-section and severe haemorrhage happens, we have to get blood from family members.* (EMOC_Implementer12_ BG).

A shortage of OBGYN surgeons, anaesthetists and midwives at district level is also common. According to the new assessment of the MCH system by the MOH in 2010, at district hospital, almost all doctors working at district level are general doctors (accounting for 60% total doctors in each hospital) while only about 27% of OBGYN doctors are working at district level. In the mountainous areas (Central Highland and Northwest), the rate of OBGYN doctors at district level is less than 20%. Similarly, an average of only five midwives work in each district hospital (23). This number is far lower than required.

In our study, the lack of anaesthetists as well as OBGYN surgeons were the key issues affecting the implementation of full EMOC services. In Vietnam, only OBGYN doctors are eligible to perform C-sections and anaesthetists must be doctors. Newly graduated doctors with official degrees often do not want to work at the district level. Those obstetric specialists who are working at district level, often do not want to stay in the job. In fact, at some districts under study, C-sections could not be performed even though an operating theatre was available, due to the lack of doctors and especially, for example, if the obstetric surgeon is not available because of job transfer or other reasons. This was the case in Lang Giang district hospital:

> *Now, to tell you the truth, we are really lacking in personnel, so we cannot do C-sections. Some new doctors have gone for a higher level training or move to provincial hospital, so we have not been able to do C-sections since early this year. (*EMOC_Implementer06_ BG*)*

The lack of human resources in general and specialists in particular at district level is mainly because the health system does not attract health professionals at district and commune level. TAs might not be implemented for this reason. Both difficulty in recruiting young doctors to work at district and CHC levels, and poor assignment of personnel were identified as constraints by key informants:

> *Young doctors don't want to work at our hospital, which has low salaries and few training opportunities. They almost all work in the city. (*EMOC_Implementer27_ DT*)*

*I am an OBGYN doctor, I did my first specialised degree in OBGYN, but I have been assigned as head of planning for nearly 15 years. Now I am going to retired, and the leader has assigned me as the head of the OBGYN department, but I can't do C-section operations anymore. (*EMOC_Implementer39_BG*)*

To support the lower levels to achieve TAs, the MOH implemented Decision 1816/QĐ-BYT dated 26-5-2008 to rotate the doctors from higher levels to support the lower level in upgrading their knowledge and skills in different specialties. Technical transfer for C-section, for example, was done at district level.

Some technique such as C-section on a patient with an old C-section scar will be transferred from provincial to district hospital. (*EMOC_Implementer05_ BG*)

However, the effectiveness of the programme is questionable (MOH, 2009) because doctors at senior levels generally don't want to go to the lower level. Therefore, instead of staying at the district level to provide support for three months, the duration of training/transfer of technical services is much shorter than it is supposed to be. In this study, only a one day visit was reported. On this basis it seems that assistance at the district and the commune level, from the provincial level was probably ineffective as it was performed in a symbolic manner.

The worst thing is that they do not have a job description with regard to their possible role in demonstration, observation, technical supervision, evaluation, etc. Usually they come down for one day, because they are busy with other things (*EMOC_Implementer27_ DT*)

At the commune level, the lack of drugs and inadequate infrastructure are key obstacles to the implementation of EMOC services. For example, magnesium sulphate for emergency care of pre-eclampsia and eclampsia might not be available: this was the case in some CHCs in Bac Giang, although most CHCs in Dong Thap did have supplies.

> *The recent treatment therapy for emergency obstetric care includes the use of magnesium sulphate. In the national guidelines, it is compulsory to use this. But magnesium sulphate is not in the essential drug list. So the therapy is like that, but you don't have the medications, so how can you treat them, you see? (*EMOC_Administrator11_ DT)

This reveals that in Vietnam, the complexity of regulation the complexity of regulations (i.e. EMOC services were affected by different regulations by the MOH) within health system and health insurance contributed to difficulties in providing EMOC services.

The lack of other drugs such as morphine is also a problem for the implementation of EMOC at commune level. The following statement regarding the availability of morphine at commune level showed the poor co-ordination between health insurance and the medications indicated in the essential drug list for EMOC cases.

> *The implementation of this regulation (385) is not compulsory, so it is not implemented much. The first problem is morphine. This is not supposed to be used at commune level, but is still indicated as a treatment therapy for EMOC. But the doctor there cannot use that drug. So we use any medications available to provide basic care for patients. (*EMOC_Administrator11_ DT)

At the district hospitals, a shortage of hospital beds, and a lack of facilities to support the performance of doctors and recovery of patients were observed. For example, patients in one specialist hospital ward could be forced to stay in a bed in another ward. Moreover, inadequate and low quality equipment (string/ operation thread), low payments by health insurance for C-sections (15 USD per C-section) were also identified as issues that affect the provision of EMOC. One interviewee, for example, claimed that the low quality of thread could create complications after surgery. In this study, a lack of funds even for photocopying to disseminate the regulation at the district level was reported as influencing the administration process of the regulation. Furthermore, doctors at the district level are afraid of complications from C-sections, which can result in them referring patients to an upper level. One further reason

mentioned for not providing EMOC services was when hospitals were being re-constructed.

5.1.4.2. District level reforms

The reforms of the health sector have been in effect since 2005. However, there is still a great deal of inconsistency in their implementation throughout the country. In reality, there are currently two systems: one that follows the old organisational structure and another that uses the new structure.

The consequences of district level reform, such as poor co-ordination among district agencies, were frequently reported in interviews:

> *The functions and responsibilities of these [newly structured] organisations are different. No one listens to each other. The DHO should have comprehensively managed the health system at the local level, it would be easier that way. But in this system, the District Health Centre and district hospital are both under the DHO, so these three bodies are not following each other. (*EMOC_Administrator11_ DT*)*

This new organisational structure hinders effective co-ordination and supervision of the CHCs. As suggested by several participants in the study, this is due to the fact that those who provide technical supervision (often the District Health Centres and district hospitals) are not 'the real fathers' who pay CHC staff salaries, while DHO pays CHCs staff salaries manages administration work in general. Supervision and supporting visits (*chi dao tuyen*) are therefore often not effective because the District Health Centre and district hospitals - who jointly provide supervision for CHCs, do not have much credibility in advising how to manage these techniques at commune level:

> *The most difficult issue in providing supervision support for the CHC is they are still thinking the DHO is their real father, and they only listen to the real father. We manage them in terms of technical support, but we are like foster parents, so they won't listen as much. That's the most difficult thing. Because*

the DHO provides salaries for the commune, it has happened that some of my staff went down to help, but no one met with them. (EMOC_Implementer37_BG)

The research also showed that, the new management system leads to a lack of resources; as a result, TAs might not be performed as effectively and comprehensively as intended. In the same way, supervision visits, which are regularly scheduled, are often not conducted nor recorded in the logbook of the CHC.

I think the district doesn't carry their functions well, because of the separation of organisations. Because there are three organisations, there is a shortage of human resources. (EMOC_Implementer38_BG)

5.1.4.3. Hospital autonomisation and marketisation in health care

Hospitals aim to sustain autonomy under the government policy on autonomy (i.e. Decree 43) by trying to provide services that attract more patients. The competition between public and private sectors was seen in our study in Dong Thap province, where the private hospital offered services both on working days and at weekends in order to provide more services and attract a greater number of patients.

Our services are available both on working days and at weekends. At the weekend, we receive more clients than the public hospital. (EMOC_DT_Private hospital_Administration)

In particular, if a patient has money, he/she can access better services at private hospitals – or even, due to autonomisation and marketisation, in the public sector – by ordering 'on demand services', specifically including a furnished room for patients after delivery. It was reported that an increasing number of pregnant women are now using services of this kind because they are not very expensive.

Almost all hospitals are now using an autonomous approach. Clients who have money can order services 'on demand'; they can choose their doctor and they

do not have to share beds with other patients. (EMOC_BG-BVtinh_implementer)

A market-oriented economy, complemented by hospital autonomy, has produced a situation in which EMOC users pay for services and therefore make choices. In the context of improved living conditions and a smaller family size, safety in delivery has become a very important issue. As a result, pregnant women and their families often choose a higher level of service. EMOC services are covered by health insurance at all levels, which helps users to cover the cost, as there are fewer direct payments. The fact that patients are opting for higher levels for delivery has resulted in numerous difficulties for the health system, as well as for the health insurance system. For example, the health insurance system at the district level might still have to pay towards insurance expenses for patients who use the scheme to pay for services at the provincial level. This then leaves district level facilities with fewer insurance funded services for their population, even though they do not provide EMOC services as they are supposed to do. It should be noted that these costs covered by the health insurance are only used for the basic services including essential drugs. Patients will have to pay for better services, for example, higher quality drugs that are not in the health insurance list, or higher quality patient's bed/room. Some private health facilities also use the health insurance scheme, however, these patients have to pay higher cost for private services.

In related ways, the marketisation in health care has increased the C-section rate, as previously discussed. Doctors might also prefer to do C-sections because this takes less time, usually has fewer complications, and is therefore perceived as preferable to a normal delivery. Furthermore, as EMOC is for emergency cases, users have health insurance for this, which can be used at all levels of services including public and private providers. If patients have to pay for the service, they will naturally go for the one that they believe will be able to provide a better service. Usually, the health insurance pays for emergency services, and the share paid by the user amounts to the same price at different levels of health facility. However, since in EMOC, safety is the most important, users and their families often decide to be treated at higher level. This phenomenon will be discussed further in the Section 5.1.4.6. Private health facilities often target the services that are perceived to produce greater 'benefit',

such as C-sections. The rate of C-sections in Bac Giang and Dong Thap provinces is increasing, and in 2010 was 13.1% and 15.57% respectively.

> *Some TAs at district levels are under implemented because of the influence of Decision 43 on hospital autonomy. They won't do services that do not generate income. So they will follow that path and not implement everything they are supposed to. They skip some techniques and target services with more benefit. (*EMOC_Administrator14_DT*)*

5.1.4.4. Health insurance

From the medical provider point of view, health insurance payments are generally insufficient to include both a treatment and its associated administrative costs. The low price paid for EMOC services within the health system will lead to reduced allowances for health staff providing the services. Fees supported by health insurance are often not enough for an emergency service. Interviews from this study suggest that doctors, as a result of this situation, will refer the delivery to the higher provincial level. Furthermore, since the health insurance system provides a quota for drugs available at each level, the choice of drugs used is also restricted at lower levels, which, according to patients, reduces the quality of service.

5.1.4.5. Complexity of regulations

As mentioned earlier, there are a number of legal documents relating to TAs, including Decision 23; national standards and guidelines on RHC services; and the Ordinance on Private Medical Practice. Although these regulations and guidelines are related to EMOC, their content is different. This has created the complexity of the regulatory framework around EMOC, leading to difficulties for health care providers and health facilities. Private health facilities, for example, follow the Ordinance on Private Medical Practice, instead of other regulations, while the public facilities follow the Decision 23 on TAs.

5.1.4.6. Health seeking behaviour: the selection of higher-level providers

A selection of service providers as well as levels of service provided has been reported in the study. Interviewees spoke at length about their belief that quality and safety at higher levels of service is better than that at lower levels, which drives the tendency, as discussed, to go to higher-level, especially provincial level, services, where there are bigger hospitals, and better quality doctors. Some clients also expressed that they preferred private hospitals. These perceptions have contributed to low utilisation of district and commune health services.

> *Usually private doctors have a lot of patients, and they have experience because they work in big hospital, so pregnant women prefer them, such as doctors in Sa Dec, people like them better.* (EMOC_Administrator12_ DT)

> *I think delivery at provincial level or a specialised hospital is better, safer. Some people I know went to the commune level, they had complications and had to go to the district level. They transferred them again to the provincial level because she needed an operation. So it took a lot of time and is not safe. Better to go straight to the provincial hospital. (Patient, 28 year-old, Dong Thap)*

The smaller family size of one to two children together with improved living conditions means that a patient is often willing to pay for assured ‘better’ services, with all necessary equipment available. For more complicated cases, they often decide to go up to provincial level where a functioning operating theatre is always available, together with a pool of well-qualified doctors (anaesthetists and obstetric surgeons). In the case of EMOC, these services can be paid for at all levels by health insurance, and hospital fees are the same at each level. Users who access higher levels only pay more for the cost of transportation, and other indirect costs. Safety, therefore, is better assured at the higher level.

> *All communes have CHCs, why are people not going there to deliver but going straight to the other hospitals? Because up there they have an operation theatre and the service is of higher quality. The rate of having three children is low; they have only one or two precious children. So they want to go where they are safe.* (EMOC_Administrator12_ DT)

Cultural belief on the time of delivery: selection of C-section

Another factor related to the use of the C-section is a cultural one: Vietnamese people believe in fortune and fate, and therefore many prefer to choose an 'auspicious time' for a child to be born. C- section is then often the family's choice.

> *Now people have higher living conditions, and better understanding. They have only one or up to two children, so when they give birth, they tend to select the place to deliver; it's a market mechanism – choosing the place, choosing doctors. Some families can afford to go to the higher level for operations to choose the time to give birth. (*EMOC_Administrator06_ BG*)*

This health seeking behaviour affects the implementation of the regulation. This situation overburdens the higher-level hospitals, as the following opinion illustrates:

> *There is one real situation that I want to report to you: that is that the technical capability at district level is low. Nowadays, the people's needs are increasingly high. Meanwhile, human resources, facilities, and drugs in the public sector are still limited. So that's the difference between supply and demand, and the needs of people are not met by the health sector. Therefore, patients will look for reliable place, with better technical capabilities, which meets the needs of the health sector. It is understandable that they go upper levels. (*EMOC_Implementer02_ BG *)*

Some interviewees, especially pregnant women and their families, believe that C-section is safer for babies than normal delivery. This is a further reason for the choice of C-section among many families in Vietnam.

These factors together create a vicious cycle: at commune level, one reason why basic EMOC is not fully implemented is because not many deliveries take place there. In the study, it was reported that only ten percent of all deliveries take place at CHC level. Unlike at district level, at CHC level, upper level techniques have often not been implemented.

5.1.5. Effects of the regulation on equitable access to EMOC services

This section presents the intended effects of Decision 385 on providing EMOC services, which mainly focuses on the implementation of EMOC services and equitable access to quality of EMOC services. The content of Decision 385 on EMOC is similar to that of the Decision 23 on technical assignments of all medical services. In this study, therefore, the effects were not only reflected by Decision 385, but also by Decision 23, as well as a number of other regulations related to technical assignments on EMOC services (i.e. national standards and guidelines on RHC services). The EMOC regulation is here therefore interchangeably referred to both as Decision 385/2001 and Decision 23/2005.

Increase in coverage of EMOC services

It is important to note that the intended effect of the regulation is to increase the coverage of EMOC services at all levels, especially district and commune levels. In practice, however, ten years since the regulation was issued, the implementation of EMOC services is still modest with only slight increases in coverage. Nationally, 68.2% of district hospitals can perform C-section services and 59.8% of district hospital can perform blood transfusions in 2010 compared to the corresponding figures of 63% and 47% in 2007 (23, 37).

In Bac Giang and Dong Thap province, the coverage of comprehensive EMOC services has increased in the last years. Fieldwork did not allow us to retrieve the exact amount of increase in C-section availability in district hospitals in the last ten years. However, there is some evidence of efforts being made towards the provision of comprehensive EMOC, particularly C-section, in the public sector. For example, some district hospitals utilised government bonds *(trai phieu chinh phu)* – a form of public funding – to build operating theatres.

The availability of an operating theatre is a pre-condition for the provision of comprehensive EMOC, including C-section and blood transfusion. Some district hospitals – for example, one in Dong Thap province – have plans to construct operating theatres; others, such as Lai Vung district hospital, have theatres currently under construction. In Bac Giang, nine of ten district hospitals are able to provide

comprehensive EMOC. On the other hand, in Dong Thap, only four of eight district hospitals have so far been able to provide comprehensive EMOC services. There are two more operating theatres under construction, which are expected to operate in 2012.

Second, training for staff, especially for OBGYN doctors, has increased over the past years. Under the influence of Decision 1816, also known as National Project 1816, doctors from the upper levels have been working at the lower district and commune levels. For example, in Bac Giang, in 2010, 17 staff from central level worked in the provincial hospitals, 26 techniques have been transferred to lower level, and 20 training workshops have been organised at provincial level. At the district level, 18 staff were sent to district hospitals to support with medical techniques including OBGYN techniques, and six training workshops have been organised for health staff. At the commune level, 22 staff from the district level have been sent to 22 CHCs. They offer techniques and support for all medical services, including OBGYN techniques.

The effect of the Decision 385 on the increase in coverage, however, is difficult to assess. First, as mentioned above, the EMOC-related content of Decision 385 is similar to that of Decision 23. Second, the increase in C-section services and number of operation theatres is affected by different contextual factors, such as economic and health system factors, not only the regulatory context in which Decision 385 is included.

Decision 385 has no clear and direct effect on equity. However, the increase in the coverage of services has lead to an increase in availability of services. Most users (pregnant women) are more easily accessing EMOC services where available. For those who cannot afford to access the higher services that they want, they still are able to access services in their locality. The problem for these women is that they still have to go to the higher level of services when the local facility cannot do the procedures at the commune level. Equity, in this case, is not assured for these women.

*For those who live around here, we can serve them if they come here. If we can do [the service], they won't have to go anywhere far. Unless we can't do the higher technical procedure, then they have to go [to upper services]. (*EMOC_Implementer05_ BG*)*

Although the district hospitals are not able to provide comprehensive EMOC, the PHD has a plan to ensure the delivery of EMOC services to local citizens by assigning nearby provincial level hospitals to provide services. This is evidence of efforts being made by the PHD to ensure equitable access to maternal health care in the province.

However, the provision of EMOC services is not always stable at district level. Even where an operating theatre and blood transfusion are available, the lack of human resource sometimes makes comprehensive EMOC impossible.

*At the moment, to tell you the truth, we lack [specialist] personnel so we cannot do that [C-section]. We had all the services in previous years. (*EMOC_Implementer06_ BG *)*

There is a significant difference in the implementation of EMOC services in the public and private sectors. Although Decision 385 covers both sectors, the public sector takes the dominant role in providing EMOC.

Implementation of basic EMOC at commune level, however, seems to be decreasing. Only about 10% of all deliveries were undertaken at this level in 2010. In Vietnam, CHCs are expected to provide essential obstetric care, except techniques for assisted vaginal delivery. However 5% of CHCs are without any OBGYN providers (40). In recent years, delivery cases assisted by the CHCs in BG and DT provinces decreased from 100-150 cases /year in early 2000 to 10-30 cases /year in 2010 (review of secondary data from 2000-2010 in BG and DT province). This creates inequity in access to quality of care and may explain the trend of women choosing the district hospital or a higher level facility to deliver a baby. The low level of deliveries at CHC level may result in two consequences: an overload of patients at

the higher level and lowered capacity of health workers at CHC level due to lack of practice. The second consequence can then enhance the rate at which patients choose higher health facility for delivery, hence exacerbating the overload at higher levels.

> *The CHC here is quite near a district hospital, so people go directly to the district or provincial hospital.* (EMOC_Implementer01_ BG)

The study showed that the expansion of EMOC services occurred after decision 385 took effect. However it is difficult to state categorically that this expansion is due to Decision 385. It is clear, however, that if the Decision had been mandatory, especially at commune and district levels, then we would have been assured of an increase in coverage nationwide. The lack of mandate partly explains the modest impact of the Decision in terms of coverage.

Quality of services

This regulation has had some effect in improving the quality of services at all levels. First, as doctors know what services they should provide at their levels, they have more focus on those skills and might try to learn to conduct all the techniques specified in the regulation so that they can perform all these techniques when needed. However, in this study, several clinical staff reported that the quality of services provided could be improved. As assignments are updated every year, doctors at all levels have more opportunities to learn about the techniques within their specified functions. Decision 385 allowed for deliveries at a higher level TA. This provides the opportunities for health providers to upgrade their skills. As one OBGYN specialist said:

> *In fact the technical assignments will help us to know more about what we need to do. So if this year, we cannot do the techniques as suggested in the technical assignments, we will try to get more skills and knowledge on the other techniques that we didn't do yet, so next year we can register. (*EMOC_Implementer27_ DT*)*

Inequitable access

Although the intention of the regulation was to increase equitable access to good quality services, in practice the regulation mainly affected equitable access only within the public sector.

The role of the private sector in providing maternal health services is vague. According to secondary data in the two study provinces, 95-99% of delivery services were provided by the public sector. In Bac Giang, no cases took place in the private sector, since there are no private hospitals or clinics there. In Dong Thap, there is only one private hospital with 20 beds in the OBGYN department, but there are several private midwifery clinics, often providing basic EMOC. In Dong Thap, the rate of delivery in the private sector is about 1-5% and our interviews suggest the trend of delivery in the private sector has been decreasing over the recent years, contrary to national trends.

As indicated in the in-depth interviews, within the public sector, in recent years there has been an increasing trend towards delivery at district and provincial levels. Deliveries at CHCs have decreased rapidly over the past five years. As discussed, the main reason for choosing higher levels of service for delivery is people's belief in the availability of better quality at this level, and the increasing prioritisation of safety by patients. Another reason reported included the fact that delivery is covered by health insurance at any levels of care and for all emergency cases. Apart from these structural factors, the increasing need on the part of patients to consider the safest delivery is an important factor in the choice among women of a higher level of service. This kind of health seeking behaviour – using mainly the higher levels of service – has led to the underutilisation of CHCs. For those women who decide to use the CHC service for delivery, it is probable that they have a good prognosis for normal delivery, and/or they cannot afford to access health services at higher levels.

Whilst a district hospital is considered an emergency referral service for transferring women with complications from the CHC, if the district cannot perform comprehensive EMOC the woman will have to be transferred again to the provincial level. In this case her life may be threatened and the patient's family will have to

spend more time and money accessing the right place. This creates an inequity in access to quality of care among health facilities, especially regarding availability of comprehensive EMOC at the district level.

> *If no C-section and blood transfusion are available in the district hospital, this may make it difficult for patients. If the commune health workers know that the district hospital cannot perform C-section, then we transfer directly to provincial hospital. In fact there are a lot of cases which, for this reason, go directly to the provincial hospital themselves. They can access the provincial hospital in only 30-40 minute by car.* (EMOC_Implementer27_ DT).

Unintended effects

Many of the issues already described suggest unintended effects such as improper use of basic and comprehensive EMOC services; lower utilisation of CHCs for basic EMOC and overburdened provincial hospitals. Clients and family members have to pay out of pocket for transportation and other indirect costs. Besides these, poor monitoring and evaluation at private hospitals may be leading to unintended consequences of high rates of C-section, reported as up to 50% of delivery cases. This may carry greater health risks and can result in obstetric complications including maternal death.

5.1.6. Discussion

This case study was on the provision of EMOC services as specified in Decision 385 by the Ministry of Health since 2001. There are two key findings in the study:

- The implementation of the MOH regulation on EMOC in Decision 385 has been modest.
- The intended effects of the regulation on providing EMOC services are also modest with regard to accessibility of good quality of health services. There is a clear adverse effect of overburden on upper level provincial hospitals, due to patients increasingly choosing to deliver in these facilities.

This discussion therefore focuses on the above findings by addressing two questions: 1) What are the factors influencing the modest implementation of EMOC services at different levels? 2) Why were the intended effects of the regulation not achieved and what are factors for that have influenced this?

Factors involved in the modest implementation of EMOC services are related to the following key components: the contextual factors especially lack of resources, the process of the regulation, the actors involved.

5.1.6.1. Process

There are different factors influencing the implementation of EMOC services at district and commune levels. First, the regulation process, including all four steps of formulation, administration, implementation and M&E, was not well undertaken. The regulation aimed at providing guidelines for health facilities but without being mandatory. The annual update on technical assignments has reflected this lack of compulsion to apply the regulation.

> *The design of the regulation is open. It allows health facilities to revise and update their own technical assignments every year, so that they can make their own plan for providing EMOC services. (Leader of MCH Department)*

The administration process was also not conducted effectively. As discussed earlier, several interviewees at different levels were unaware of the regulation. Many were confused between this regulation and Decision 23, which was issued by the Ministry of Health on all technical medical assignments, including those related to EMOC. Feedback loops were weak, leading to poor implementation.

5.1.6.2. Actors involved

At the level of formulation, the MCH Department of the MOH has a key role to amend the EMOC regulation. But the MOH appears to have developed different regulations (policies, guidelines) within the EMOC framework, creating confusion for users of Decision 385. The MCH should be a focal point for the formulation process of EMOC related regulations. This research suggests that it is necessary to have only one core regulation on EMOC rather than different types of regulations, as is

currently the case. This should be done in order to reduce the confusion for health staff who have to implement services.

The directors of district hospitals should have also played a key role in the implementation of EMOC at the district level. The study showed that the support and backing of the director at district level is of critical significance, as EMOC is not mandatory to implement, so district hospitals can choose whether to provide comprehensive EMOC. It is therefore important to inform the district hospital leaders about the content of and the importance of providing the EMOC functions at this level.

Another actor that needs to be considered to ensure effective implementation of the EMOC legislation are the users. The voice of pregnant women, and their health seeking behaviour relating to the selection of EMOC services, should have been taken much more into account. There should have been a check on whether their needs can be met by existing EMOC services, and that there would be no underutilisation of EMOC services at CHCs. Similarly, there should have been measures to check and prevent patients from over-stretching the services of provincial hospitals (OBGYN departments in particular). To effectively realise the regulation, there should have been more support provided to health facilities, especially at district level, to provide quality EMOC services.

5.1.6.3. Contextual factors

There are three contextual factors relating to the provision of EMOC services. These include the organisation of the health system; cultural and behavioural factors; and socio-economic factors.

For the EMOC regulation, health system factors play a key role in the implementation of regulation. The health system also has an important impact on the provision of EMOC services. As specified in the regulation, EMOC services should be provided in the context of favourable conditions. The lack of facilities (operating theatre and blood bank/reserve blood), human resources (OBGYN doctor, anaesthetists), and drugs are the key structural factors hindering the availability of

EMOC services. In a context of limited resources like Vietnam, the district health system faces difficulties in providing services that women are in need of. In other words, if sufficient resources were provided, EMOC services will be covered at district and upper level. The issue of resource allocation at district level is influenced by complicated factors such as the priority of reproductive health care in local health context, the commitment of the leaders...

Third, the health seeking behaviour of service users, including pregnant women and their families is the basis of utilisation of EMOC services. The need to have safe delivery and the belief that higher levels can provide better and a safer services among users has led to overload at the provincial and central hospital levels. Participants in the study also revealed that doctors at CHCs and at district hospitals would often refer patients to deliver at higher level facilities such as the provincial level. This is partly because the health insurance system covers all emergency cases.

5.1.6.4. Governance

This discussion uses the principles of 'good governance' as a theoretical framework to analyse the two findings. This theoretical framework has four elements, including standards, information, incentives and accountability. These elements can be reflected in the process, and in relation to actors, and the context of the regulation 385.

In the EMOC case, there are clear **standards** (benchmarks) which have been set out for different levels corresponding to the functions of EMOC. These standards are often considered as the *legal targets* for health facilities in providing EMOC services. *Legal targets* mean that while there is no mandate for implementation of all services, the standards do specify that health facilities are not allowed to perform services specified for higher levels. This is at the root of the limited implementation and inconsistency in existing EMOC service provision at all levels. The leaders of health facilities, especially at the level of the district hospital, can choose to either to perform or not to perform full EMOC services.

This study highlights the need for some level of mandate in the formulation of regulations. If no mandate is applied, then there is high possibility of non-compliance to the regulation. The state-command approach that has been taken in the health system will consolidate the implementation of any regulation with mandatory standards.

On the one hand, the providers make an effort to provide EMOC services as suggested in the regulations (both in Decision 385 and Decision 23); their practices were constrained by different structural factors. Key factors include the state command model, which stresses the importance of a top-down, bureaucratic approach/mechanism. This approach is reflected in the whole policy process through formulation, administration, implementation and M&E. For regulation with a state command approach, there should be some level of mandate, not just targets or guidelines, to make implementation effective. For example, in the guidelines for the implementation of Decision 385 on EMOC services, the kinds of district hospitals (i.e. hospitals in what condition and situation) that *have to* provide comprehensive EMOC services should be clarified, rather than specifying that all district hospital *should* provide comprehensive EMOC. On the other hand, the market oriented approach also plays an important role in the decision of users in choosing the services. Within the social context of small family size and improvements in living conditions, the users (families and pregnant women) prefer better services, that are available at the higher levels (specialised and/or provincial hospitals). This results in their accessing upper level services for delivery and in the case of EMOC.

This situation illustrates the difference in the two explanatory models that result in the flexibility in providing EMOC services. Two situations occur on the ground: first, the wide variation in the implementation of EMOC and second, where patients go to the upper level of services. These two issues have created the plurality and complexity of providing EMOC services at different levels.

A regulation that is not mandatory creates flexibility in implementation. In the absence of a mandatory approach, **incentives** and sanctions were also not clearly specified in the content of the regulation. In the EMOC case, incentives were rather in the form of increasing competition between providers. On the other hand,

sanctions or punitive measures in the form of reducing competition marks (merit points) could have been more effective in encouraging application of the regulation. In reality, no sanctions were reported in the study. Sanctions only occurred when the health facility was reported to have performed high-level techniques that were not allowed at that level.

In this study, staff at district and commune level commonly spoke about their **low motivation** in providing EMOC services in particular. This low motivation was affected by different factors, such as low recoupment of health insurance fees for services; excessive workload; and limited chances for further training, to name a few. The lack of a mandate in formulating and implementing the regulation, along with an unclear mechanism on incentives and sanctions, has resulted in the **poor accountability** on the part of service providers. Poor accountability will result in modest implementation, and more importantly, quality of services might not be assured.

Information is another important element of good governance. However, there are issues related to the transparency and clarity of the regulation. Several providers in the study do not know the content of the regulation, not to mention the name of Decision 385. They mainly follow Decision 23, also issued by the MOH. There is no reminder within the system, for those who have been recruited more recently, on how one might apply the regulation in the ten years since it was established.

The content of Decision 385 is out of date, and no longer in line with health system reform. During fieldwork, it was found that medical providers were often unaware of Decision 385 and resorted instead to Decision 23. Thus implementation of Decision 385 in terms of EMOC functions is ineffective. The monitoring and evaluation process is conducted, but not as regularly as intended, mainly due to the lack of human resources.

The *street level bureaucrats* model (42) could be used to explain the modest implementation of EMOC services. In the context where a loose process occurs and favourable conditions for effective implementation are not available, the role of leaders of health facilities are important. These people are the ones who can make

decisions on whether or not to provide EMOC services and to what extent the services can be provided, so their interpretation of the regulation, as well as their assessment of the health facility's situation, is important. This partly explains why services were implemented in some facilities but not in others (34).

5.1.7. Conclusions

The regulation covers a wide range of RH services, including safe motherhood and EMOC areas. Although EMOC was not specified separately in the regulation, it is clear that basic obstetric care (except assisted vaginal delivery) was applied at commune level and comprehensive EMOC (C-section and blood transfusion) was applied at district and at the provincial level. The regulation was developed as part of 'desirable standards' for technical responsibilities for reproductive health care in health facilities of Vietnam. According to the local context (of the health facility, human resources and financial resources), each facility was advised to try to reach the standards of technical procedures, according to the level specified in Decision 385. However, no specifications were set out for non-compliance with the regulation.

Decision 385 was selected to study in order to explore why comprehensive EMOC or basic EMOC was available at certain health facilities and levels but not at others. The objective of the regulation was to promulgate the technical assignments for different RH facilities within the health system (in both public and private sectors).
The regulation passed the stages of formulation, administration, implementation and evaluation with a second amendment. Different actors were involved in different regulation processes, with different levels of power and potential.

The study showed that the implementation of the regulation is modest and that it had very limited effects in increasing equitable access to good quality EMOC services. However, it has contributed to a modest increase in the coverage of EMOC services at the district level. The regulation has also contributed to increasing the quality of services. In the market-oriented economy, with the hospital autonomy policy, women have more choice in terms of accessing services. Service providers will need to improve their technical skills to meet with the increasing demand of women for quality services. Moreover, as mentioned earlier, the insurance scheme that allows

all women to access higher level in case of emergency has contributed to overburden of the higher level.

There is also an unintended effect related to the increasing and widespread utilisation of higher level services (*vuot tuyen*), an overburdening of upper level hospitals (*qua tai benh vien*), and an underutilisation of services at grassroots level (*duoi tai*). It is not clear whether this can be related directly to the regulation or to a range of other circumstances.

The modest effects of the regulation can be explained using pluralistic approaches, including the theory of good governance and the street-level bureaucrat model. The difference in the needs of clients, the health seeking behaviour of clients, the context of clients (smaller family size and higher living conditions) and the commitment of providers all contributed to the modest effect of regulation.

5.1.8. Recommendations

Recommendations for better governance of EMOC case will be addressed in this section, including the improvement of four key elements of good governance: standards, incentives, accountability and information at different levels.

Standards

Standards guidelines on EMOC, with the addition of a mandate for the implementation process, should be included in the amended regulation. This will help to increase its application and increase the *accountability* of providers. There needs to be clear guidance on what services should be provided and under which specific conditions.

To do this, the involvement of key actors, especially users and district hospital directors, should be taken into account. In this way, the standards will take a patient-centred approach.

Incentives

The mechanism for incentives and sanctions to providers of EMOC services should be strengthened. It is necessary to provide clear and appropriate incentives and

sanctions in the amended regulation. These could take different forms.

More policies are needed to support health staff at district and commune levels. Incentives should both be in the form of financial support (for example, increasing salary and allowances) and technical support for all staff. Integrating continuing medical education for health staff at all levels should be promoted. In addition, providing a good technical environment (with a functioning operation theatre, enough drugs, enough OBGYN doctors and anaesthetists) is important in assuring not just the availability of services, but also to encourage doctors to stay at district hospitals.

It is necessary to strengthen the existing M&E and reporting systems. These systems will ensure information sharing within the health system. This will help to increase the technical skills of providers, as well as supporting the incentives system, as the level of performance – the basis for rewards and sanctions - will be revealed via supervising visits and recorded in the reporting system.

Accountability

Obviously, accountability will be improved if there is transparency in the incentives and penalties system. Therefore, in order to improve accountability, clear mechanisms for rewards and to some extent, sanctions should be developed (for example, via licensing, and/or a continuing medical education (CME) point system). For example, the regulation should specify the conditions for a district hospital to have operation theatre or OBGY specialist to provide C section.

Information

Sharing information on the regulation should be undertaken on a regular basis for all actors, especially for the directors of district hospitals and for clients. Patients should be informed during their antenatal visits which services are available at the different health facilities. They should also be counselled on what to do in a situation of obstetric emergency. Sharing information with the private sector is also important. Furthermore, improvement of the M&E reporting system and the overall reporting system is also needed.

It is important to note that, in the EMOC case, resources are the key factor that

would complement the four above governance principles. The assurance of necessary resources (human and financial resources) is a clear pre condition for the governance criteria to be well implemented. Therefore it is important to take into account the availability of resources in designing regulations. Making resources available at district level so that they can provide full EMOC should be in the government plan in the near future.

5.2. Antenatal care (ANC) case study

5.2.1. Introduction to the ANC regulation

5.2.1.1. The policy environment

In Vietnam, an imbalance in the male-to-female sex ratio at birth (SRB) became an issue of public concern in the early 21st century. The SRB is calculated by the number of male births over a hundred female births. The most common and acceptable SRB observed in countries in the world is in the range of 104-106. The SRB in Vietnam was first documented in the 1999 population census and has since been reported through annual population change surveys. While in 2000 the SRB was still at normal levels, estimated at 106.2 male births per 100 female births, it increased to 112.1 in 2008, and was 110.6 according to the 2009 census. In some provinces however, the Child Sex Ratio (0-5 years) was as high as 128, as illustrated in Figure 12, indicating that there may be different socio-cultural and economic factors at work in different regions. The SRB can be inferred from the Child Sex Ratio because the under-5 mortality rate in Vietnam is very low, at 23.3/1000 live births (World Bank, 2010).

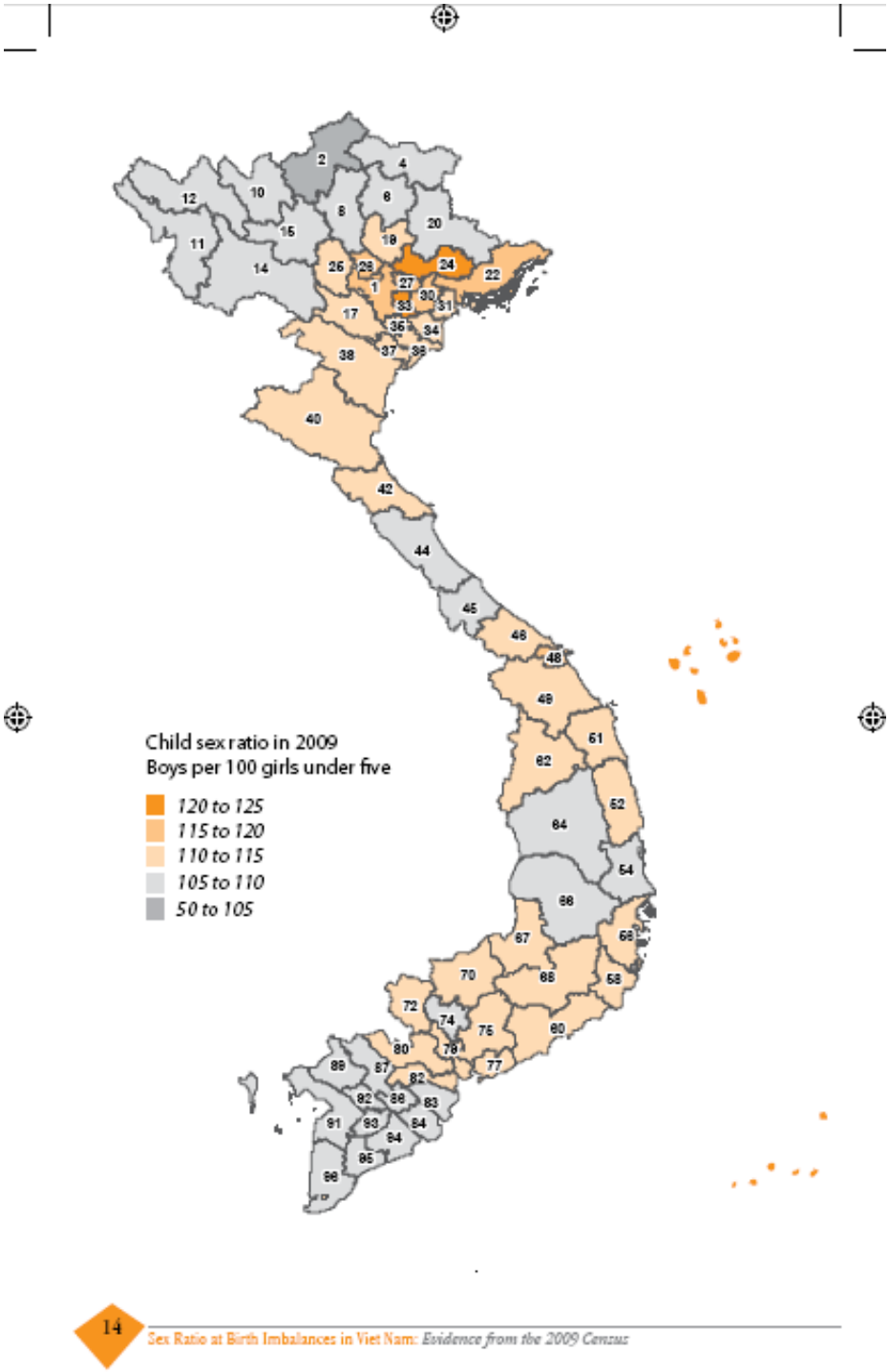

Figure 12: Child sex ratio in Vietnam in 2009

(Source: Population Census 2009, Monograph on SRB)

An SRB varying widely from the biologically natural range of 104-106 male births per 100 female births reflects an intentional intervention in the otherwise biologically stable equilibrium of the number of boys and girls born in a society. In this case, it demonstrates a strong preference for sons that leads families to select the sex of

their children. Demographic projections demonstrate that if the sex ratio imbalance continues to increase after 2010, it will cause a significant rise in the proportion of men in the population. If the sex ratio does not return rapidly to its normal level, the excess number of men compared to women will cause a severe disruption in the marriage system, as is already being observed in some areas of China and India. Other social consequences of an imbalanced sex ratio include increased pressure for women to marry at a younger age, a rising demand for sex work and an expansion of trafficking networks. Examples of gender based violence and human trafficking have already been observed in Vietnam and point to some of the risks faced by vulnerable girls and women if such violence were to increase due to the rising proportion of men in society (43).

During the early years of the documentation of the SRB, it was higher than expected but not at an alarming level, which might lead to an extremely skewed population structure (see Figure 13). However, at that time, Vietnam learnt several lessons about SRB trends, the consequences of its imbalance, and interventions to address these from other Asian countries such as China, India, and South Korea, which had faced SRB imbalance prior to this. Moreover, in Vietnam at that time, there existed a number of factors that were important conditions for SRB imbalance, namely reduced fertility, son preference and increasing availability of sex diagnosis technologies (44), (45), (46), (47), (48).

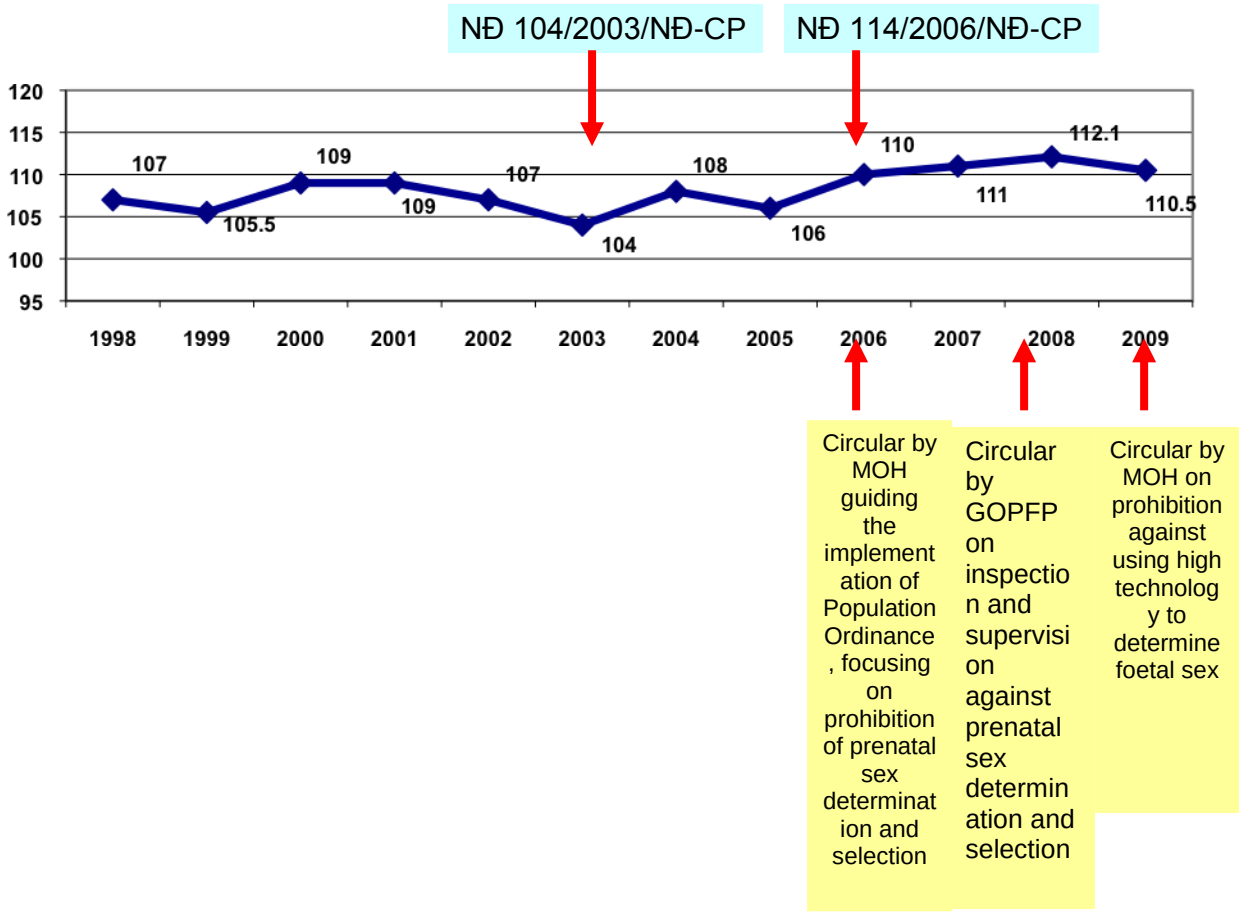

Figure 13: National trend of SRB over time in Vietnam

To address the problem, in 2003, the National Assembly of Vietnam issued the Population Ordinance and following this, the government issued Decree104/2003/ND-CP (referred to here as Decree 104) as guidance for its implementation. The content of the regulation is stated in Article 10, Chapter 2. According to this article, prenatal sex determination in any form and with any methods is prohibited, and abortion on the grounds of sex selection is also prohibited.

To date, Decree 104 is the only regulation document that specifically deals with assurance of SRB balance focusing on ANC services. More recently, the government has placed more efforts into stabilising the SRB to 115 by 2020 by including specific objectives in its National Strategy on Population and Reproductive Health 2011-2020 (49), a government document supporting the implementation of population and reproductive health related legal documents such as the Population

Ordinance and Decree 104. Several measures have already been taken towards this objective. One of the proposed activities in the UN assistance framework to Vietnam during 2011-2016 is to review the effectiveness of the regulations issued in the areas related to SRB (50).

To strengthen Decree 104, an additional regulation on administrative sanctions for the violation of population and child regulations (Decree 114/ND-CP) was issued, as well as guidance documents (see timeline below). In Decree 114 there is one article specifying the sanctions for each violation. Forms of sanctions include fines, suspending the operation of service providing facilities, and disposal of materials (books, magazines, etc.).

Decree 104 is the legislative basis for the following two circulars by the Ministry of Health (MOH) and another circular by the former General Committee for Population, Family and Children (part of which was then merged into the MOH in 2007). The aim of these circulars is to provide concrete guidance for the implementation of Decree 104 within the health and the population sectors. The circulars include the following:

1. Circular number 3698/BYT-SKSS with reference to implementation of the Population Ordinance regarding prohibition of prenatal sex selection, dated 17 May 2006
2. Circular number 5476/BYT-TCDS with reference to monitoring and inspection for prevention of an imbalanced sex ratio and prohibition of prenatal sex selection, dated 7 August 2008
3. Circular number 3121/BYT-BMTE by the MOH on prohibition against using high technology in determining foetal sex, dated 21 May 2009

Figure 14 illustrates the timeline of these various regulations against prenatal sex determination and sex selection in Vietnam. The pink and purple boxes represent regulations issued by the Government, with the dark purple box being the regulation that is studied in this research. Yellow boxes represent guidance documents issued by organisations at ministerial level.

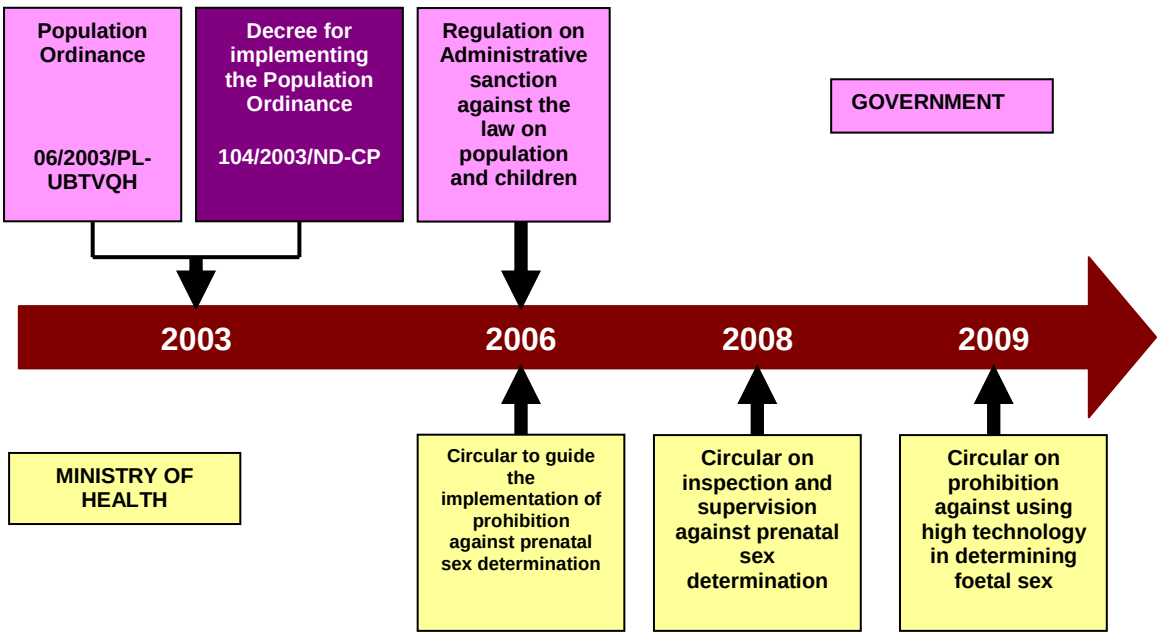

Figure 14. ANC regulation timeline

5.2.1.2. Content

Decree 104/2003/ND-CP (dated 16 September 2003) is the legal document that guides the implementation of the Population Ordinance (approved by National Assembly 9 January 2003). Its objective is to guide the implementation of the Population Ordinance in order to stabilise the population size, structure and quality, including balancing the SRB.

The Decree targets implementing agencies such as government agencies, political and social organisations, professional organisations, economic organisations, military, citizens, and international organisations operated in Vietnam. The targets of the regulation cover both public and private sectors.

The Decree includes 39 articles, grouped in six chapters, namely: 1) General issues, 2) Population size and structure; 3) Population quality; 4) Responsibilities of government agencies and organisations; 5) Incentives and sanctions (applied to both individual health professionals and health facilities and publishers and traders of relating publications); and 6) Application issues.

The content of prohibition of prenatal sex determination is stated in Article 10, chapter 2. According to this article, prenatal sex determination in any form and with any methods is prohibited. Specifically, the following are prohibited:

- Propaganda and communication products that include information related to formation, modification or diagnosis of foetal sex (in the form of talks, written documents, copies of books, magazines, pictures, video and voice records; storage and dissemination of documents, equipment and other items related to baby sex selection).
- Diagnosis and selection of foetal sex with the following methods: identification of symptoms/signs, pulse feeling, tests of blood, genes, cells, ultrasound, etc.
- Abortion for sex selective reasons by any abortion method including the use of drugs.

The Decree was therefore intended to prevent sex selection at birth by prohibiting the methods by which this is achieved. However it should be acknowledged that both the Decree and its guidance documents do not specify what constitutes a concrete violation. This is one of the many factors that have affected the translation of the regulation document into practice. This gap has now been recognised by the General Office of Population and Family Planning (GOPFP), which is considering revising the content of Decree 104 in the near future.

The Decree has one chapter highlighting the responsibilities of government agencies and organisations and includes four articles. In this chapter, responsibilities of different ministerial level institutions, People's Committees and People's Councils at all levels including civil society organisations, are specified.

Although the Decree has one chapter on rewards and sanctions, the information is general. No concrete fines or rewards are specified for violations or compliance. The Decree just says that users of the regulation can refer to other relevant laws and regulations for these behaviours, which are not specified.

5.2.2. Processes

The processes of Decree 104 have followed the general process of a government decree. This includes three stages: formulation, administration and implementation. Monitoring and evaluation are undertaken throughout the three stages. The following subsections describe these processes for Decree 104.

5.2.2.1. Formulation

In 2003, the GOPFP was assigned by the government to be a leader in formulating the SBR decree, in co-operation with related actors such as the MOH, MOET, MOF, MOPI, MOLISA, Women's Union and other mass organisations. At that time, GOPFP was an independent organisation outside the MOH but had a status equivalent to the MOH. In 2007, GOPFP became a department under the MOH.

The main activities of the formulation process were as below:

- Setting up a drafting committee;
- Holding consultation meetings with relevant sectors and ministries;
- Review and revision by the draft committee;
- Submission to the Ministry of Justice for legal appropriateness and for verification;
- Submission to Prime Minister for final approval;
- Approval on 16 Sep 2003 with effect 15 days later;
- Publication of the draft on the websites of the Government and the Ministry of Justice for comments from the public.

The regulation followed the normal procedure for the development of a government regulation in Vietnam, with the involvement of all relevant sectors. People involved in the formulation process, in principle must be vice ministers or heads of relevant departments of the ministries. In reality, they often delegate the responsibility to their technical staff. It should be noted that in the development process of this regulation there was no involvement of international organisations, specialists (researchers), service providers (public and private) or the community. Although in the development process, information about the regulation was published on the websites of the Government and the Ministry of Justice, this was just as an announcement rather

than to obtain comments. Furthermore, this information dissemination channel is only appropriate for a few groups who have high education levels and have access to the Internet. Not all groups can access this channel. This lack of effective consultation is a limitation of the development process for Decree 104.

Exclusion of users is not only reflected in the process of formulation, but also in the content of the regulation itself, in the sense that it focuses only on the supply side of prenatal sex determination and sex selection, i.e. providers' behaviours. It has not adequately addressed the 'demand side' of the regulation, i.e. users' need for sex determination and sex selection in the cultural context of son-preference and the pressure of decreased fertility. It does not specify interventions to change user attitudes in particular, and the whole society in general regarding gender issues, nor does it specify methods to promote girls and women's roles in society.

5.2.2.2. Administration

Although the Decree was formulated and took effect in 2003, the administration process, defined as the development and dissemination of guidance documents, only began three years later, in 2006. The Ministry of Health (GOPFP and MCH departments) developed different guidance documents at different times (see timeline). Information about these ANC regulations was delivered at different levels: central, provincial and district level.

At central level, the GOPFP and MCH departments of the MOH were jointly involved in administering the decree. The GOPFP is the government administrative body in charge of population issues. The MCH department is in charge of providing guidance on maternal and child health issues. The activities delivered by the central level include the following:

- The MOH sent hard copies of the regulations to all Provincial Health Departments (PHDs), central OBGYN hospitals and medical and pharmaceutical universities;
- The GOPFP sent hard copies of the regulations to the Provincial Centre of Population and Family Planning (POPFP);

- The GOPFP disseminated the regulations in related training and workshops to POPFPs;
- In the period 2009-2010, the GOPFP developed an annual plan and allocated resources to 11 provinces with the highest imbalance in SRB; in 2011, this project will be expanded to 43 provinces;
- Training workshops were conducted with 30 provinces with the highest SRB imbalance to discuss solutions and interventions.

At the provincial and district level, the PHD, District Health Office (DHO), and District Centre of Population (DCP) play the main roles in administration of the regulation. The main activities included the following:

- The PHD sent hard copies of the regulation to the DHOs, District Centre of Preventive Medicine (DCPM), DCP and all provincial and district hospitals via post and to other related actors (education, women, youth, farmer, etc) via relevant meetings.
- The PHD uploaded the document in LAN net in Dong Thap. In Bac Giang guidance documents are disseminated by post only.
- The Provincial Centre of Population and Family Planning (PCPFP) sent hard copies to the DCP and related actors at provincial level.
- The DHO sent hard copies to CHCs and private health facilities.
- The DCP sent the regulation to related actors at district level by post or informed them in relevant meetings.

Technical staff in health facilities received information about the Decree through hospital staff meetings or received hard copies sent to the Obstetrics Department. Dissemination is also often integrated in RH or population trainings/workshops for technical staff.

Interviews noted that constraints occurred during the administration process such as delays in dissemination of the regulation and lack of regular reminders. For example, in Dong Thap, information dissemination activities are still, to date, limited. No clear guidance on what the solution might be to an SRB imbalance or on what

interventions could be made, was ever sent to staff. Administrators reminded people of the Decree orally at meetings, but did not produce any guidance for action.

The provincial inspectorate system in both provinces, although playing a key role in controlling the implementation of the Decree, has not been involved in the administration process. Reasons for this include that they are not aware of the Decree. There was not any specific training on the Decree for them.

> *We do not know who interpreted it, there has not been any specific training in it for us. Sometimes, in the annual meeting of Government's Inspection, they mentioned inspection activities in general. The Provincial Health Department here has never organised a specific meeting for dissemination of regulation 104's contents. (ANC_Administrator05_BG)*

5.2.2.3. Implementation of the regulation

Different activities were led by the GOPFP to implement the ANC regulation, jointly with the MOH and other relevant actors including from education and cultural sectors, the Women's Union and the media.

At the provincial and district level, the following activities took place:

- Reporting the imbalance of the SRB to the local authority every quarter (Bac Giang).
- The PCPFP developed annual plans for reducing the imbalance of the SRB and guided the lower level to implement the plan (Bac Giang).
- The PCPFP guided actors to implement a pilot project to control the imbalance of the SRB in six districts with the highest imbalance. Main activities focused on communications on the risks of an imbalanced SRB, promoting a 'no-more than-two-child-family' club that encourages members to limit the number of their children to two only, and mobilising leaders and other actors in this process. Population related indicators were included as indicators for local authorities to assess whether a family, a village etc. is entitled to 'cultural family', 'cultural village' status (Bac Giang).

- Signed contracts were developed with other actors to conduct communication activities. These activities were delivered through indirect channels, such as the mass media, posters, banners, films, and directly through meetings, clubs and workshops. They included different target groups such as the Women's Union and the Labour Union.
- Compliance with the regulation was verified during supervision visits at different levels. However, only five or six non-compliant health facilities and bookshops were detected throughout the country since the regulation took effect. In these cases, doctors had left written evidence of violation. In DT province, no cases were detected.

At the communal level, even in Bac Giang province which has been funded by the GOPFP to implement an SRB balancing project (see below), there are no specific activities to control sex selection at birth. Most activities at the CHC concern family planning. Although the ANC regulation was available in 2003, some CHCs only received information about it in 2009 from the DHO.

> *In general, there has been almost no activity to guide the implementation of the regulation? A: Yes. Q: No communication activities? A: No. Population communication covers only family planning and the two child policy. (ANC_Implementer19_BG)*

In contrast to quite active implementation of Decree 104 at the district level in Bac Giang, there has been quite passive implementation in Dong Thap. Other than sending information to different actors about the regulation, no specific solution or interventions were reported. This was due, in our view, to the perception that the imbalance SRB is not a problem in Dong Thap and therefore there is no need to intervene. The involvement of other sectors (e.g. mass organisations, legislation, education and training) is quite limited since the issue was considered a priority of the population sector, and these sectors also suffered from an excessive workload. No clear collaboration mechanism was developed or utilised.

> *Honestly, we just inform only our staffs of the regulation. We have not conducted any intervention outside our institution. The situation would be*

different if SRB were a problem here. We would invest more in it. In Dong Thap, the SRB is still acceptable. Therefore, the only administration activity we conducted was providing knowledge or raising awareness. We have not had a professional system for the SRB issue because this is not a priority problem here. We have not adequately invested in dealing with this issue. (ANC_Administrator16_DT)

Other sectors just participated in that small area. Their participation is just superficial. It does not show their interest and enthusiasm in this issue and their participation also is not effective. (ANC_Administrator09_DT).

Resources allocated for implementation of Decree 104

In the content of Decree 104, there is one chapter stipulating the responsibility of different actors. Formulation of resource mobilisation and allocation mechanisms for this Decree is to be undertaken by the Ministry of Finance. On the other hand, People's Committees and People's Councils at all levels are responsible for implementing these mechanisms and policies.

However, in reality, there has been no separate nationwide budget source for the processes of implementation of the regulation. All activities related to these processes are considered as part of the routine tasks of the administration and staff. Hence there are no special funds apart from the budget already allocated to routine population activities at all levels.

Importantly, it should be noted that in 2009, the GOPFP developed and implemented a project including activities to reduce the SRB imbalance. The project has been implemented in only 30 of 64 provinces. Bac Giang is a project province while Dong Thap is not.

As assigned by the MOH, the GOPFP developed a project to cope with the SRB imbalance. However, this project has been piloted in 30 provinces only. (ANC_Administrator02_Central)

The PCPFP in Bac Giang province is the focal point and co-ordinator of the national project on ensuring a balanced SRB in the province. It provides technical consultation to the Provincial People's Committee on population issues. However, the budget for this project is only 10,000 USD/year/province. This budget is to be provided to project provinces for the next two years only, which threatens the sustainability of its activities, and its size does means that regular administration activities such as meetings and training are limited. Communication facilities are also very limited, which is a significant constraint on the population system's effective implementation.

> *We do not have enough budget to do it in all districts. If the problem was prevalent in the province, we would not have enough budget to cover all districts. The budget from the higher level is allocated to us as a lump sum for all activities. We do not know how much should be spent on specific activities. We cannot provide training to every service provider. There are thousands of providers in the province. If everyone was provided with training, it would cost a huge amount of money (ANC_Administrator16_DT).*

In non-project provinces, no extra resources were specifically allocated to SRB balancing activities, which are considered part of their regular tasks. This is a big constraint to implementation of the regulation in all non-project provinces.

> *In Dong Thap, we do not have budget allocated for this issue. This is partly because the General Department of Health piloted the project in 10 provinces only, making our budget very limited. Therefore, it is very hard for us to administer and implement the regulation due to lack of budget. If we want to mobilise local financial sources, we must have a rationale for it. ANC_Administrator17_DT)*

Whilst a varied picture emerges of regulation implementation in provinces with and without a specific project, the level of resources available reflects the fact that an additional budget is a very important factor influencing whether the regulation is translated into practice or not in each of the regions covered.

5.2.2.4. Control of regulation implementation

The control of regulation implementation is conducted through supervision and inspection activities. In principle, these activities are led by population inspectors and health inspectors (see Section 5.2.4). Supervision and inspection visits are often multi-disciplinary and multi-sectoral, which means that each visit covers different issues (drug, food safety, clinical services, population issues, etc) and is conducted by a team composed of different actors.

In principle, supervision and inspection activities for Decree 104 are aimed at:

1. Assessing the situation of prenatal sex determination, including the communication and dissemination of sex selection measures in books, on websites and in other publications, as well as the provision of prenatal sex determination and sex selection at health facilities, and identifying the causes of this situation. This could be done by checking records and documents at health facilities, asking health providers and/or clients about provision of services, or randomly visiting bookshops and screening websites.
2. Timely detection and handling of behaviours that violate the regulation.
3. Strengthening communication and education about the regulation, the law against prenatal sex determination and sex selection for organisations and individuals, in order to raise awareness and prevent violation.

In principle and in practice, a supervision/inspection procedure includes several steps, illustrated in Figure 15.

The annual supervision/inspection plan on the ANC regulation is approved by the GOPFP. At the provincial level, the PCPFP played the leading role in conducting supervision /inspection activities in collaboration with other actors. However, the plan was not implemented duly, with frequencies of visits being much less than planned. In DT, the key informant did not confirm that the GOPFP’s plan on supervision had been carried out.

I just know that a guidance document was sent from the higher level but I have not seen any supervision visit to health facilities on this issue paid by them. We just provide them with information and call for their compliance. There is also no direction for us to conduct supervision activities. (ANC_Administrator17_DT)

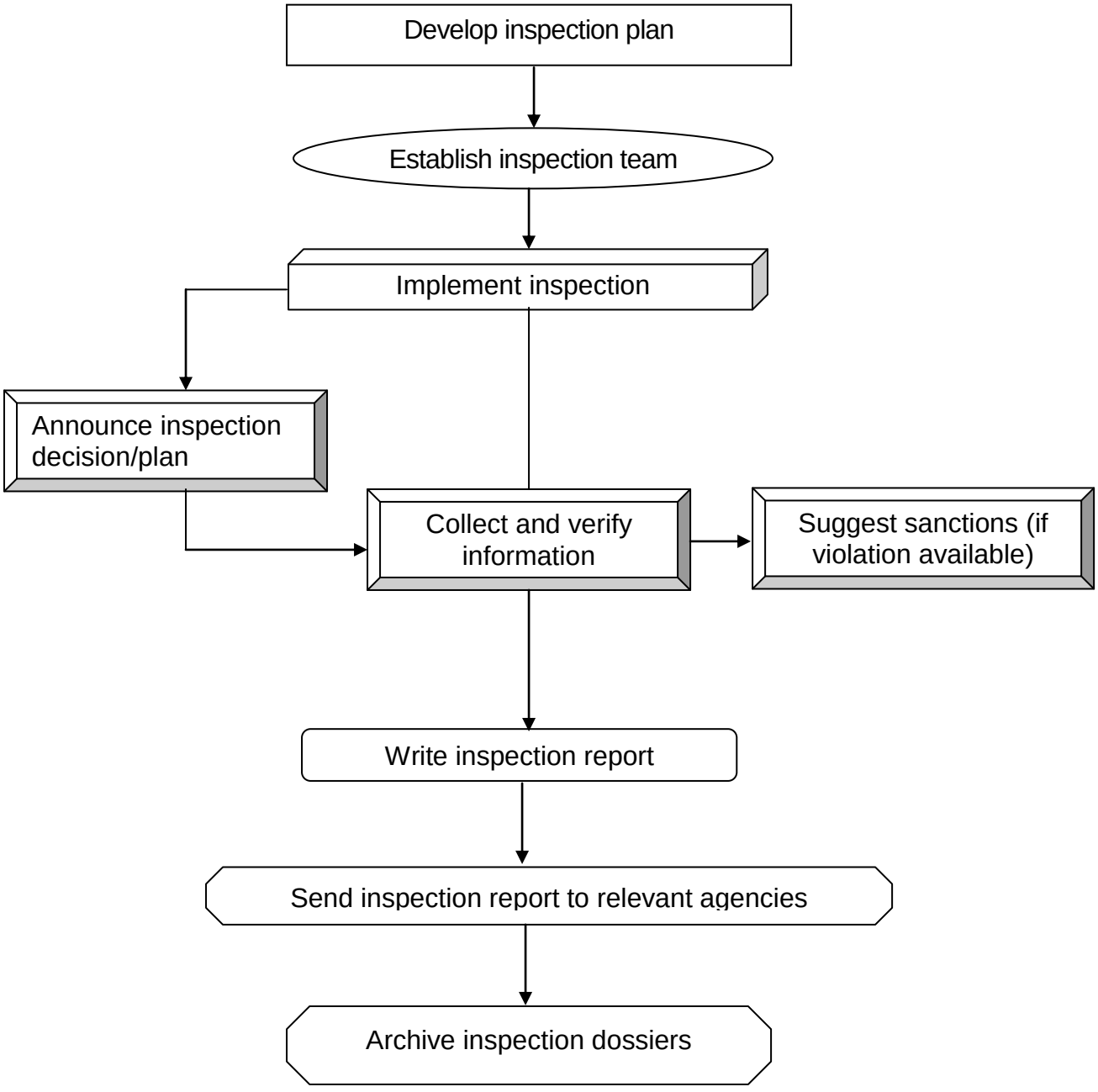

Figure 15: ANC supervision/inspection procedure

Different supervision visits were conducted in different places depending upon assigned tasks of the relevant actors and on the availability of human resources:

- Health inspectors paid visits to OBGYN hospitals.
- Inter-disciplinary supervision visits were made to private health facilities. Besides health and population staff, people from other sectors such as the police, the food safety sector, local authorities, business managers, etc also participated in the visits.
- In Bac Giang, the PCPFP and related sectors paid visits to book shops and publishing houses twice a year to check whether any products on sex selection procedures were being sold.
- No regular supervision visits were reported in Dong Thap due to lack of time and human resources, and a high workload.

Activities conducted during each supervision visit included checking records for required information as well as for evidence of violation of the regulation; checking the availability and functionality of equipment and drug inventory; and reviewing reports. Supervision covered many issues related to medical and pharmaceutical practices and did not focus only on sex determination and selection.

At health facilities, besides supervision/inspection, internal supervision is also expected on the part of the head of the health facility. However, in reality we discovered that this is generally not conducted. Hospitals rely on providers' self-awareness and do not try to implement any control measures.

> *We cannot supervise that, but we did tell our staff not to provide sex determination services. We cannot know for sure whether the doctors tell relatives the foetus's gender or not. (ANC_Implementer23_DT)*

Constraints

Supervision and monitoring of the implementation of the regulation has several constraints. First, there is no close linkage between the population sector and other sectors in supervision. Second, the supervision is not conducted regularly because of a lack of human resources, especially at the communal level. In addition, health inspectors were not very competent with dealing with population issues, especially in the handling of violation cases. Health inspectors are those from the inspectorate department at MOH and in the PHD. There is no position of health inspector at

district and commune levels. They are responsible for inspecting medical and pharmaceutical practices including population activities. It was thus impossible for inspectors to obtain evidence of non-compliance by health providers. We discovered that health providers often used 'body language' or verbal codes to indicate the sex of a foetus. These behaviours are not covered as violations in Decree 104 or other related guidance documents.

Also, inspectors cannot pay spontaneous visits to health facilities according to the inspection law. These have to be planned in advance and the health facilities will be aware of the visit, making it hard to detect any violation. Inspectors are also not allowed to use techniques such as role-play, or secret recording, which might facilitate detection in this case. In addition, although the population department at all levels is directly involved in inspection, they are not authorised to make decisions on sanctions themselves. These must be approved by health inspectors at the MOH or PHD.

> *We are not authorised to conduct inspection without informing the facility in advance. You see, the inspection law has that limitation so it hard for us to control the implementation of the regulation. Another limitation is that we cannot fine them at the scene. We just can document the violation in minutes of the inspection and send it to the DoH's leaders for them to consider the penalties. It's unlike in other countries where inspector can fine the violators at the scene. Here it takes much time for a sanction decision. (ANC_Administrator02_Central)*

A further issue is that the population department cannot make independent decisions on inspection.

> *We cannot decide ourselves on inspection. We have to get approval from many bodies. The situation is the same here at central level. The General Department of Population cannot issue inspection decisions. It is the leaders of the Ministry of Health who issue inspection decisions. At provincial level, the Provincial Department of Population cannot issue inspection decisions. They have to make a plan, submit the plan to the Provincial Health Department for approval. Then health inspectors of the Department of*

Inspectorate within the Provincial Health Department will pay inspection visits. But their staff is very limited in terms of quantity. If they are able to arrange the visits then they'll visit the health facilities. If they cannot arrange, they will not pay any visit. (ANC_Administrator02_Central)

Supervision/inspection on prenatal sex determination is rare and cannot cover all health facilities. Often, only supervision and inspection on curative and pharmaceutical practices are conducted on a regular basis. The content of inter-disciplinary supervision to private health facilities also follows the Ordinance of Private Practice Medicine (scope of practice, registration), and is not specifically related to the issue of SRB imbalance.

We conduct supervision visits based on the annual plan. Often, overall supervision covering every aspect of medical and pharmaceutical practices are conducted regularly. Supervision or inspection for a small specific aspect is not conducted on a regular basis. (ANC_Administrator09_DT).

No, supervision is not done as regularly as once a year. The Provincial Health Department's supervision team can just cover 50% of the health facilities. Health managers at district level, if assigned by the Provincial Health Department, can cover 100% of private health facilities in the district. It's like that, we have to assign the District Health Office to the task and then the District Health Office assigns the task to Commune Health Centres. In that way we can cover 100% of private health facilities. The number of our staff is too few, we cannot cover 100% by ourselves. (ANC_Administrator02_BG)

Rewards, penalties/sanctions

Rewards and sanctions are important elements in controlling the implementation of the regulation. As already mentioned, Decree 114 was promulgated to support the enforcement of Decree 104. It specifies administrative sanctions for violations of legal documents on population issues. However, prenatal sex determination and sex selection can also be considered as violations of health regulations in general, and to address it, other health regulations can also be utilised. Examples of these regulations include the Ordinance of Private Practice Medicine, the Ordinance on

Government Officials, and the Ordinance on Administrative Violation in Practicing Curative Services.
In reality, however despite the availability of Decree114, informants including both providers and controllers had very poor awareness of it.

> *We do not know about Regulation 114. (ANC_Implementer11_BG)*
> *We do not know about specific sanctions. We just know that administrative sanctions are applied in general. (ANC_Administrator17_DT)*

Controllers in both provinces reported using other health regulations than Decree 114, for prenatal sex determination and sex selection, such as the Ordinance of Private Medical and Pharmaceutical Practice, which specifies legal medical and pharmaceutical practices in the private sector as well as sanctions for violation, and the Administration of Sanctions for Violation Related to Curative Practices.

It should be noted that although these regulations are supposed to support each other, penalty levels for the same violating behaviour are different in each individual regulation.

Furthermore, the regulation on administrative sanctions for the violation of population regulations (114/ND-CP) needs to be amended, because, as interviewees pointed out, it contains some inappropriate features. For example, the definition of 'violating behaviours' in the regulation should be more clear and specific; the police should be involved in inspection and M&E activities, etc. These issues are concerns of the GOPFP, which planned an amendment of regulation 114, but a final decision about it has not yet been reached.

> *As assigned by the Ministry of Health, in 2009 the General Department of Population adjusted and amended regulation 114, which stipulates administrative sanctions for violation of the Population Ordinance. The main adjustment was on those penalties for sex determination and sex selection. Specifically, we defined violating behaviours more clearly, increased the fines, added some actors participating in detecting and handling violation such as public security, and allowed the use of detective techniques. We submitted*

the amended regulation on December 12, 2009 but to date is has not been approved (ANC_Administrator02_Central).

5.2.3. Regulation approach

Decree 104 has used several regulation approaches to obtain a balanced SRB in Vietnam. The first approach that can be observed is the state command approach, in which the regulation is led, initiated and monitored by the government and its agencies. It can be seen that those institutions involved in the processes of the regulation, from its formulation to its implementation include the Prime Minister, the population and health systems and other sectors (Ministry of Culture, Information and Tourism, Ministry of Justice, Ministry of Education and Training etc.). Among these different actors, the population system and in general the health sector have the dominant role in every stage of the regulation process. Although civil society organisations are mentioned as actors, in practice their role is very limited, and the SRB is not considered as a priority for their agenda. The decree is typically top-down. This is evidenced by the fact that the development of the decree was only based on the desire of the leadership. There was no feedback or comments from the community or from providers in any of the processes of developing the regulation. There was also no pilot testing for validity and feasibility before the regulation officially took effect.

The regulation is based on a 'prohibitive' approach where the focus is on prohibiting the behaviours of providers whose services enable, determine and select foetal sex. Meanwhile, for service users, the regulation simply encourages them to stop using the services, although this has been done only through communication in the press and other media.

Also, the operation of market mechanisms can be observed in the regulation's processes. The effect of the regulation depends very much on the relation between provider, especially private providers, and clients. Private providers' compliance behaviours are strongly driven by clients' demand for sex determination services. The pressure to make profit and to attract clients is a motivation for private providers to violate the regulation. In the public health facilities the providers better comply with the regulation compared to private practice as the link between the profit and the

service they provide is less direct compared to private providers. This will be analysed in more detail in Section 5

5.2.4. Actors

5.2.4.1. Description of actors

Actors involved in the processes of ANC regulation derive from different groups. However, those within the health sector and health inspectors play key roles in developing, administrating, implementing, and monitoring and evaluation processes. Many institutional actors, for example, were involved in more than one stage of the regulation process. Table 11 summarises the tasks and objectives of the actors involved in the processes of Decree 104. The table highlights the diversity of tasks of the actors, and the objectives that they are supposed to achieve.

Table 11: Summary of ANC actors' tasks and objectives

Actors	Tasks	Objectives
CENTRAL		
GOPFP/ MOH	- Formulation, administration, and M&E - Designing and implementing target programmes and projects related to population and family planning - Budget allocation for implementation in the health system - GOPFP inspectorate staff supervise and inspect compliance with regulation	Quality improvement of health services, improvement of population quality
MCH dept/ MOH	Administration	Quality improvement of local health services
Other ministries (MOCST, MOJ, SCNA, MOET, MPI, MOLISA)	Formulation, administration, implementation and M&E (interdisciplinary supervision and vertical supervision within their sector)	Compliance with ANC regulation and quality improvement of health service
PROVINCIAL LEVEL		

PCPFP/PHD	- Administration, implementation and M&E in the province - Providing technical consultation to the Provincial People's Committee on population issues	Quality improvement of local health services
Health Inspectorate/ PHD	Supervision/inspection in health facilities, including private health facilities	- Compliance with ANC regulation - Quality improvement of local health services
Dept. of Private Practice Medicine	Supervision/inspection in private health facilities	- Compliance with ANC regulation - Quality improvement of local health services
Provincial hospitals (directors)	- Implementation and M&E of regulation - Apply sanctions for violation and rewards for good performance according to the hospital's regulation	- Compliance with ANC regulation - Quality improvement of local health services
DISTRICT LEVEL		
District Health Office	Administration and M&E in the district and commune health facilities, including private health facilities	- Compliance with ANC regulation - Quality improvement of local health services
District Centre of Population	Administration, implementation and M&E in the district and commune health facilities, including private health facilities	- Compliance with ANC regulation - Quality improvement of local population and health services
District hospitals (directors)	- Implementation and M&E of regulation - Application of sanctions for violation and rewards for good performance according to the hospital's regulation	- Compliance with ANC regulation - Quality improvement of local health

		services
District Centre of Preventive Medicine	Administration of regulation	- Compliance with ANC regulation - Quality improvement of local health services
COMMUNE LEVEL		
Commune Health Centres (public providers)	- Refuse users' requests for prenatal sex determination and sex selection - Report violations at private health facilities to District Health Office - Implementation of regulation - Supervision of private health facilities	- Compliance with ANC regulation - Quality improvement of local health services
OTHER ACTORS		
Private providers	Implementation of regulation	- Satisfy clients' demands and make profit
Pregnant women and families	Implementation of regulation	- Keeping family size small while still strongly influenced by son preference
CSO (Women's Union)	Conducting communication activities to improve women's awareness of the regulation	Improved awareness of the community about the regulation
Local authority at all levels	Co-ordinating the local Committee for Population issues	Ensuring local balanced and quality population

The following provides an overview of the key actors involved in the processes of Decree 104, while also looking at other actors more indirectly involved.

Population network: GOPFP, PCPFP and DCPFP

The GOPFP is currently a division under the Ministry of Health. At the time the regulation was being developed, it was a ministerial level organisation, managing population, family and child related issues. However, in 2007, the organisation was split up into three agencies and merged into different ministries. The population division was merged into the MOH. Nowadays, the population sector is organised in three layers: GOPFP at the MOH, a Provincial Centre of Population and Family Planning (PCPFP) at the PHD, and a District Centre of Population and Family Planning (DCPFP), which is directly under administration of the PHD. However, until now, the structure at local levels in some provinces has not been stable. Staff turn over is frequent. In some communes in Bac Giang, there is still no clear job description for population staff based at the CHCs.

With regard to the ANC regulation, during the formulation process, the GOPFP was assigned by the government to take the lead in the drafting committee and co-ordinate the drafting process. They were in charge of drafting the regulation and circulating the drafts to relevant sectors for comments and revision.

The GOPFP also took charge of planning, budget allocation, raising funds for and guiding the implementation of the regulation within the health system. Guidance could be in the form of sending circulars by post from higher levels to lower levels (see Section 5.2.2.2), communicating the content of the regulation through meetings with population staff or through professional trainings. Although an assigned task of the GOPFP, administration of the regulation took place only three years after the Decree took effect due to the organisational restructuring process.

> *In 2006 the Decree was issued. In 2007, the GOPFP was merged to the MOH. The time after issuance is often the time when a regulation is implemented very actively, but for this regulation resources and interest were focused on organisational stabilisation at that time. After the organisation had been stabilised, in 2009, they went back to focus on implementing the regulation. This was also the time when the problem of SRB imbalance was emerging. (ANC_Administrator02_Central)*

The population sector is also assigned to the implementation of specific programmes and projects related to population and family planning issues. These programmes cover advocacy for integrating family planning and reproductive health services for regions with high fertility rates; improvements to the population information system; improvements in local population structures and quality; RH awareness raising for adolescents, as well as other programmes. Only by 2009 (six years after the regulation took effect), did the GOPFP start activities aimed at balancing the SRB.

> *As I already said, in 2006 after the issuance of the regulation, the National Committee for Population, Family and Children was interested only in child related issues. SRB was not a priority at that time. Right after the splitting of the Committee, no one took responsibility for this issue. Only after the organisation had been stabilised did people start working on administration and implementation of the regulation. It was delayed for three years. (ANC_Administrator02_Central)*

They also conducted supervision visits to health facilities in collaboration with other members of the Provincial Steering Committee for population issues (culture, public security, planning and investment, etc), to check compliance with the population ordinance. In Bac Giang, where the SRB is very high at 119/100 in 2010, although the SRB project is being run, supervision visits to health facilities are nevertheless rare. In Dong Thap, due to the fact that the SRB is currently not perceived by staff to be a problem at 104.9/100 in 2010, combined with a lack of staff, monitoring and supervision activities remain superficial.

However, the PCPFP cannot directly assign tasks to population staff in the CHC. In every province, this has to be done through the DHO, because there is usually only one member of staff in charge of population issues at a CHC. In the past, the population staff belonged to the commune People's Committee, so the PCPFC could directly provide technical advice to the People's Committee at different levels, to implement the regulation. Since Decision 34 by the Chair of the provincial People's Committee on implementing Circular 05 by the MOH was introduced, population staff members belong to CHCs, and are therefore not authorised to directly guide the

implementation of regulations in communes. They only can do this through the DHO, which is responsible for CHCs in the district.

Due to the organisational restructuring in 2007, a lack of staff is also reported. In both provinces, the number of staff available is lower than the number stipulated by the MOH (15 / 20 in Dong Thap, 7/10 in Bac Giang). Most staff members are new and few have a medical or population background. This is very important as lack of experience also means lack of knowledge about the health system, health regulations and services. Moreover, supervisors without a medical background are not always confident when supervising doctors.

> *No medical doctors applied for a post here. There was one assistant doctor working here but for only a few months. She moved due to the too low income. According to the MOH's regulation, each Provincial Health Department must have at least 20 staff, but we currently have only 15. (ANC_Administrator16_DT)*

It is very difficult to recruit more staff from other localities or to mobilise them from other health organisations in the districts to the DCPFP, due to the low income offered.

> *As planned, we should have 10 staff but in reality we have only 7. (ANC_Implementer18_DT)*

Often, therefore, personnel at this level are not well qualified and do not have sufficient experience in dealing with the problem of SRB imbalance, especially in controlling violations of the regulations.

> *Human resources are the same. There's nothing to say about motivation, it is still the same as in other government organisations. People here are inexperienced, as I already said. (ANC_Administrator02_Central)*

Incentives for population staff are low, so that few people want to work in this sector. There is no allowance, for example, for transportation costs for population staff, who have to use their own vehicles for supervision visits, sometimes to very remote areas.

> *This sector does not provide any extra allowance to staff. Those who are competent and want to work for the government often do not chose the population sector (ANC_Administrator16_DT).*

From the DCPFP and downward, some staff were trained in administration and implementation of the regulation by the GOPFP, but this training is not regular and does not include all staff.

> *Of course we invited people for training. In the past, when the Committee of Population, Family and Children still existed [three years before the interview], we invited inspectors of the committee to participate in training on this issue. There was no training organised by the higher level for our staff, there were only circulars sent to us. (ANC_Administrator09_DT).*

Population inspectors

Only at the national level is there a position of a population inspector who works under the direction of the MOH. At the provincial level, the health inspectorate division also covers population-related activities.

Population inspectors from the national level pay supervision visits to local health facilities, both public and private in order to check the implementation of the Population Ordinance. They do this with the support of local health inspectors and staff from the PCPFP.

However, population inspectors are not always trained in inspection techniques. In addition, there are many resulting constraints such as a general lack of competence, as well as not being allowed to use techniques such as unplanned visits or secret

recordings. These act as obstacles which prevent them from obtaining any evidence of non-compliance with the ANC regulation.

Health inspectors

The health inspectors are tasked to do the inspection and administer sanctions for non-compliance with regulations. A director of the PHD must approve the sanctions before fines are paid.

> *We are not authorised to conduct inspections without informing the facility in advance. You see, the inspection law has that limitation so it hard for us to control the implementation of the regulation. Another limitation is that we cannot fine them at the scene. We just can document the violation in an inspection minute and send it to the DoH's leaders for them to consider the penalties. It's not like in other countries where inspectors can fine the violators at the scene. Here it takes a long time for a sanction decision. (ANC_Administrator02_Central)*

The health inspectors are also often involved in inter-disciplinary visits to health facilities to ensure compliance with health regulations. They do this in collaboration with other sectors such as public security, forestry inspection, husbandry management, market management. The purposes of these visits are not related to ANC regulation only

> *We do not conduct a separate supervision visit on this issue. We integrate it into general supervision visits to private health practices. The problem here is that no one documents the foetus's gender, so we cannot obtain any evidence of violation. (ANC_Administrator10_DT)*

The number of health inspectors is limited, and they have to assume multiple tasks, inspecting different issues including curative services, food safety, pharmaceutical practices and population issues. Therefore they cannot focus on controlling prenatal sex determination. On the other hand, it is difficult to recruit more staffs.

The number of inspection staff at the Provincial Health Department is very few while there are many hot issues that need to be inspected, especial private medical and pharmaceutical practices, and food hygiene and safety practices. A few inspection staff at the Provincial Health Department is not enough to cover this issue. This is a limitation in our work. (ANC_Administrator02_Central)

While their workload is huge, incentives are very limited. Their salary is very low, which results in poor motivation for work. Inspectors receive an occupational allowance, which is also low. After five years working as an inspector, the salary increases by 5% and by 1% in subsequent years. Allowances are provided to them, but only in the form of uniform (two sets per year), shoes (two pairs a year) and a raincoat (one per year). The monthly salary is about USD 200, which is small compared to those working in the private sector.

Furthermore, health inspectors at the PHD have not been trained in population issues:

Health inspectors have not been trained in this issue. They are familiar with inspecting medical and pharmaceutical practices. However, they have not been trained in inspecting sex determination practices. (ANC_Administrator02_Central)

Public health providers

Providers at public provincial and district hospitals are aware of and support the implementation of the regulation. They received information of the regulation via the media, professional trainings and from hospitals' leaders. However, awareness is much lower among those working in CHCs, who are responsible for communication activities:

Some communes are interested, some are very ignorant. I think it is a matter of awareness and responsibility. In some communes, all sectors including the

People's Committee are involved. But in some other communes, people do not care much. (ANC_Implementer18_BG)

Public health providers are more likely to comply with Decree 104 when they work in public settings than when they work in their private clinic. They appear to follow the regulation rather strictly, as confirmed not only by public providers, but also by health managers, users, and even private providers. Inspection reports from the GOPFP also mention this (51). When patients request sex identification, most of the time public providers refuse, and the ultrasound machine is mainly used to detect foetal defects. Public providers also provide advice to those who are considering late stage abortion, which can result in serious health consequences for the woman (see Section 5.2.5.3).

No one can force public providers to disclose foetal sex. But private providers, who are actually also working in public hospitals, are willing to do it. That's the reality. (ANC_Implementer8_BG)
Q: Can you tell me where people can go to know their unborn child's gender?
A: They can go to most of the private clinics providing ultrasound.
(ANC_user12_DT)

The number of patients in public facilities is high, therefore they have no pressure to increase the number of patients. They also have no clear financial incentives for non-compliance.

It's easy [to abide by the regulation]. There's nothing difficult here. The community always respects doctors. Whether we tell or not does not matter. They do not force us to do so. Or if they ask us, we can say we can't see the foetal gender from the ultrasound result. That's it. Nothing difficult. (ANC_Implementer36_DT)

I think the situation in public hospitals is that, as in my province, public providers do not reveal foetal sex. In most cases, mothers find out from private providers. These private providers never leave written evidence, they just tell the mother her baby's sex orally. (ANC_Administrator3_ BG)

In addition, for public sector actors, if non-compliance was detected, sanctions would be applied and they would be affected both financially and otherwise. For example, they would not get awards for good work performance at the end of the year. However, the same doctors could still violate the regulation by disclosing foetal sex if and when the patient reaches their private clinic.

Private providers

Most public providers also practice in their private health clinics/facilities outside working hours. In Dong Thap, 80% of public providers are involved in dual tasks, and 20% are pure private providers – these are often retired doctors, working at a private general clinics. They work really intensively. Dual-practice doctors work at their own clinic both during lunch break and for the whole evening after official hours. Their services include gynaecology check-ups and treatment, ANC examinations including ultrasound and also abortion (including late stage abortions). Some clinics are very well equipped with colour ultrasound machines and high cost services (20 USD per ultrasound visit), which is very high in relation to local income levels, whereas the average cost of ultrasound in both public and private facilities is 200,000 VND or 10 USD). Private facilities have not been closely monitored and supervised by state organisations responsible for monitoring them, especially in Dong Thap.

Those private providers who are also public providers received information on Decree 104 through professional training events, the mass media and also from the public facilities in which they work.

> *I know of the regulation through training. Moreover, I can get the information from public media and on the Internet. The information is prevalent. (ANC_Implementer07_BG)*

In contrast, those who are involved only in private provision have fewer opportunities to access formal documents from state organisations, but are likely be aware of the regulation through the media. With 80% dual employment, lack of information is unlikely to be a significant issue.

Data from both interviews and GOPFP inspection reports (52) reveals that compliance with Decree 104 by private providers is poor. Profit is a key incentive for private providers, and therefore they are likely to satisfy patients' demands to know the sex of the foetus. If they do not provide sex diagnosis when requested, patients will not return to their clinic, which will eventually be threatened with closure. Sex identification during ultrasound will also often be revealed to patients due to a pre-existing close relationship between the provider and the patient.

> *I think in private clinics, if the doctor satisfies their clients' needs, the number of clients coming to the clinics will increase. If people hear that a certain doctor does not reveal foetal sex, they will not come to him/her. (ANC_Implementer11_BG)*

Health service users

Data shows that users are not aware of the regulation. In general, users have not been involved in any part or process of the regulation. However, they are key actors who can strongly influence the effectiveness of the regulation, especially when taking the culture of son-preference into account. It can be seen that the demand to know the sex of the foetus is a major incentive encouraging health providers, especially private ones, to violate the regulation (see Section 5.2.5).

Other actors

Besides the population system, health inspectors, service providers and users have the most influence in the process of the regulation. Other actors take part in certain stages of the process but with lower levels of participation. The following paragraphs briefly describe the levels of involvement and characteristics of these actors.

Other ministries

Ministries including the MOJ, MOCST, MPI, MOF, MOLISA, and NA's Committee of Social Issues are members of the drafting committee. They were in charge of establishing the technical details of the regulation related to their particular sector.

The MOCST is also involved in controlling publications related to prenatal sex determination and sex selection, in collaboration with the MOH.

Department of Private Health Practice Management – PHD

The official tasks of the DOPHP is to supervise and manage private health practices in the provinces. For the regulation on ANC, they are responsible for its supervision and implementation at private health facilities. Since it appears that in Dong Thap, SRB issues are not a priority and only a few of the activities have been undertaken, with low frequency.

Complaints were also raised regarding the lack of staff in this organisation, and lack of population training.

District Health Office

The official tasks of the DHO include advising the local authority on managing health programmes in the districts, as well as managing CHCs and private health facilities in activities such as issuing licenses and registration, conducting supervision and inspection visits, and applying sanctions to private health facilities in cases of violation of the regulation.

Once the DHO received the guidance of Decree 104 from the PHD, they were responsible for circulating this to all health facilities (including private facilities) at lower levels and informing them of the contents of the guidance documents through monthly meetings with communal health stations. They are responsible for ensuring that CHCs and private health facilities are both aware of and comply with the regulation.

In reality, Decree 104 is not considered a priority. In Dong Thap, no supervision activity regarding compliance with Decree 104 has been conducted the DHO to date. Since the SRB is not a problem here, the regulation is ignored. In Bac Giang, although some integrated supervision visits were reported, conducted together with the Provincial Department of Private Health Practice Management or with CHCs, these did not find any evidence of violation.

Commune Health Centres

Some commune health centres provide ultrasound services, but staff are not qualified and the equipment is not modern so it is not used for sex determination.

At this level, there are no specific activities on control of sex selection at birth. They focus on family planning activities only, and at some communes the regulation/ guidance document was only received in 2009 from the DHO. CHCs do not concern themselves much about the issues, they just conduct general population communication (family planning) and report statistics about local population to the higher level.

Women's Union

This is the only mass organisation reported to be involved in implementing the regulation. They also have a vertical system corresponding to the administrative system. Regarding Decree 104, the main implementing activity for the Women's Union, has been to organise workshops on population issues.

Local Authority

In each province at each level there is a Steering Committee for Population Issues whose chair is the vice head of the local People's Committee. Members of this committee include representatives from all sectors. The health sector consults the People's Committee about population matters. Based on this consultation, the People's Committee provides guidance for each sector that will then undertake administration and implementation activities in their vertical system and collaborate with other sector in relevant activities.

Missing actors

As recommended by the vice head of the GOPFP, actors who should have been involved in the implementation of the regulation (but are not mentioned in the regulation document as well as it is a guidance document), include the public security system, to inspect and punish those who violate the regulation; the education sector to have policies in favour of females; and the Ministry of Labour,

Invalid and Social Affairs, to provide policies of jobs in favour of females or families having all female children.

5.2.4.2. Actors' power

Table 12: Actor power in the process of Decree 104

Power/Potential	Low potential	High potential
High power		- Health providers - Health and population inspectors - Population system - Provincial Health Department & District Health Office - Local Authority
Low power	- Provincial Centres for Health Communication & Education - RH departments at all levels - Commune Health Centre - Women's Union	- Pregnant women - Pregnant women's family - Community

The analysis of actor by their power and potential is shown in Table 12. It can be seen that those actors with high power and high potential are all directly involved in the regulation processes. Health providers are those who satisfy the demand for foetal sex identification. Health and population inspectors, the population system, the PHD and DHO have high power and high potential, because of their working position, responsibilities, rights and knowledge. They have key roles in increasing the awareness of providers and community about the issue, and the implementation of the regulation. Moreover, the local authority has the power to co-ordinate activities of all sectors, as well as to decide on resource allocation, sanctions and rewards for all sectors in the locality. This is essential to the success of the regulation.

Those actors with low power and low potential are responsible for communication

activities, and passively implemented their tasks according to others' decisions. Even at the central level, although the MCH Department and MOH were involved in administering the regulations, their role was very blurred in the implementation of the ANC regulation.

Policy makers did not consider pregnant women, their families and the community in the formulation and implementation processes of ANC regulation. Nevertheless, their demands for information on foetal sex is very influential because they often pay for this service, and therefore they have high potential if this behaviour is changed.

5.2.4.3. Actors' network

The network of actors involved in the regulation processes is illustrated in Figure 16. The relationships are based on a nexus between service users (pregnant women and families) and other actors. The relationship could be direct and very influential or could be indirect and limited in influence. The relationship depends on the power and potential between actors in regulation processes. The relationship is also influenced by the context of cultural, health system and socio-economic factors.

The thickness of the arrow symbolises the level of interaction between actors. Collaboration between actors is mostly based on general task assignments of the health and population systems, rather than any specific ANC regulation. With regard to the ANC regulation, there is need for better collaboration among different actors. Local health authorities and People's Committees play key roles in effectively co-ordinating activities, including through influence on resource allocation to different actors. Normally, interaction between stakeholders is based on the direct vertical relationship in the health system. For example, the GOPFP can direct their subordinate POPFP at the provincial level and the POPFP can direct the DOPFP. However, sometimes, this may not happen. Actors at the provincial level can have relationships with those at commune levels and the dotted arrow in Figure 16 reflects this.

Actor power, illustrated by the size of the bubbles, refers to the extent to which actors are able to affect others' decisions and have an effect on the implementation

of the regulation. Power derives from the nature of the actor's organisation or their position in relation to other actors. For example, the GOPFP bubble size is large as this actor is responsible for designing, guiding implementation, and co-ordinating activities of other sectors as well as allocating the budget within the population system, while the Women's Union bubble is small because this group of actors cannot influence the decision or the behaviour of other actors. They are just passively involved in communication activities.

Collaboration between different sectors was implemented via the Steering Committee for Population Issues at all administrative levels (central, provincial, district, and commune). The level of collaboration depended on the interest and will of the Local Authority (local Communist Party leaders).

The Chair or Vice Chair of the local People's Committee is the chair of this Steering Committee. Whether the regulation is implemented well or not very much depends on the will and determination of political leaders. Once there is clear direction from and effective co-ordination by leaders of the People's Committee, many sectors will be actively involved in implementing the regulation and collaboration among different sectors will be more apparent.

In the ANC case, there are several interesting relationships between different actors. There is a very clear public-private link that affects the regulation processes. One provider assuming dual tasks, coupled with the under regulation of the private sector, can lead to the fact that a provider behaves differently in each context. In addition, the relationship between providers and users is also very clear. Close relationships between providers and users, and pressure to satisfy users' demand for sex determination and selection services, induce providers to violate the regulation.

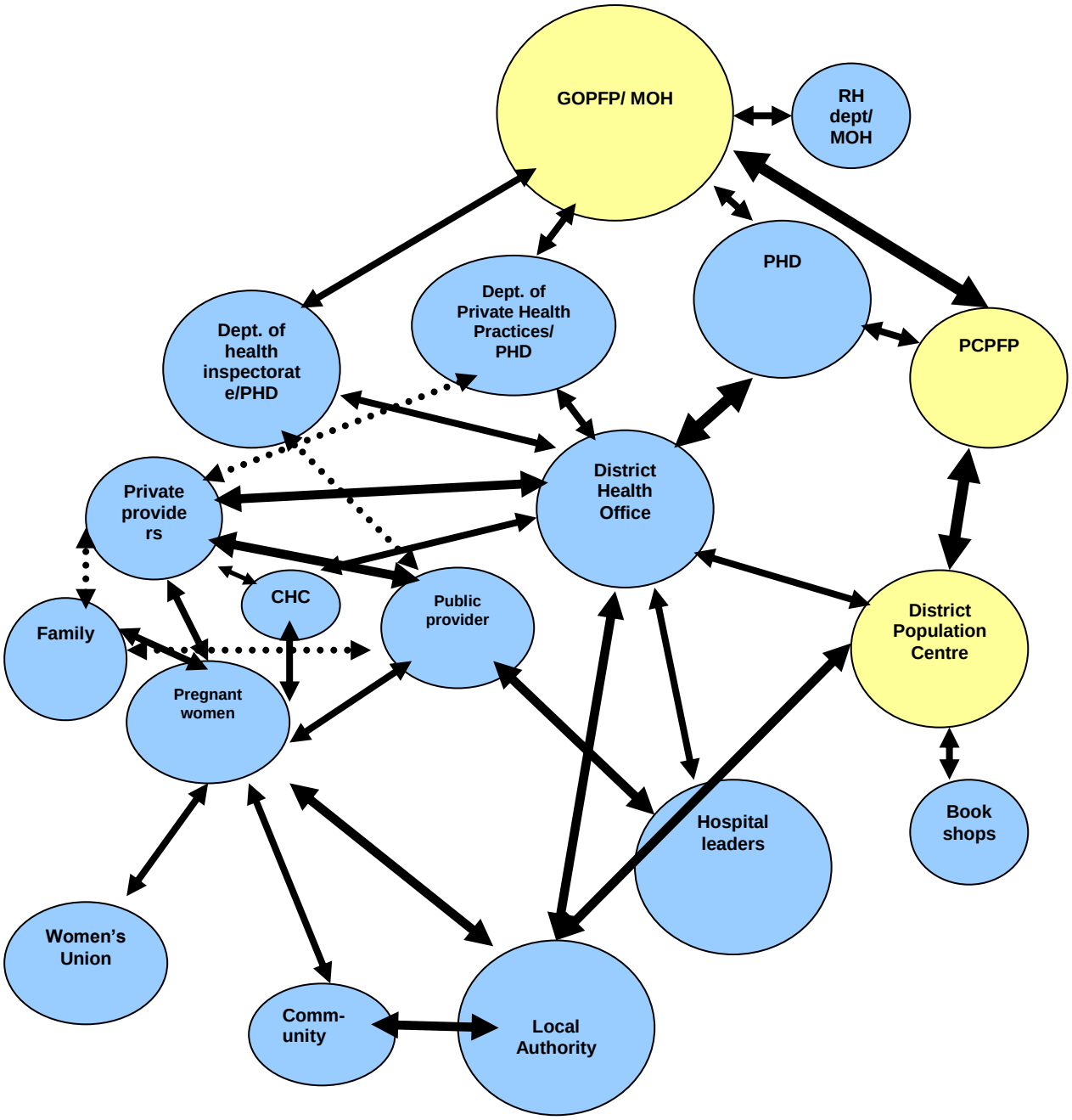

Figure 16: Actor network of sex determination and selection processes in Vietnam

The health and population sectors play key roles in consulting local authorities on population issues as well as implementing population related activities.

All other related sectors (mass organisations, culture and information – including the media –, public security, planning and investment, and finance) collaborate with the health sector in implementing and controlling activities, and conduct administration and implementation activities within their own sector.

Basically, most of the sectors are involved through the operation of the Steering Committee on Population Issues. I think there is not lack of actors here. But the depth of the activities needs to be improved. The collaboration among sectors needs to be strengthened. More resources should be invested to have more effective implementation. (ANC_Administrator08_BG)

Besides the health and population sectors, the Women's Union and cultural and information sectors are more active than others, conducting communication activities and managing population-related publications. However, no incentive or sanctions are applied to other sectors. This also means there is no clear mechanism to assure the accountability of actors.

The involvement of actors from other sectors is basically voluntary. There's no reward or sanction mechanism applied to other sectors regarding this issue. We take the lead on supervision activities, they are just members of the supervision team. If they do not fulfil their task, we just warn them in team. (ANC_Implementer18_BG)

It can be seen from this analysis of actors that numerous actors have been involved in the regulation processes. However, data show that, of these, only the population and health sectors are particularly active. There is no mechanism to monitor and ensure collaboration among different sectors or their performance in administering and implementing the regulation. Even within the population and health systems, there are several constraints regarding human resources: lack of personnel, lack of competence, and lack of training, compounded by low incentives. While health and population actors have high power and high potential, health service providers and users are much less powerful in the regulation process. All these have contributed to poor implementation of the regulation.

5.2.5. Contextual factors affecting the regulation

5.2.5.1. Policy and socio-cultural context: son preference and the small family policy

One of the factors contributing to the increasing trend of SRB in Vietnam is the tension between the goal to reduce family size and the effort to ensure a balanced sex ratio, which are both covered in the government's population policy. The small-size family policy is a population policy implemented by the government to control the birth rate of the country and limit the number of children in a family. In Vietnam, this policy commenced very early in the 1960s. Through the policy, the government expects to prevent a population boom that might jeopardise the country's development and to ensure better conditions for families to take care of their sons and daughters in health, education and personal development by keeping families small. Under the current implementation of the policy, government employees who have a third child are denied access to pay rises and promotions. It has also been proposed that Communist Party members and civil servants should be reprimanded for failure to enforce the policy, as oppose to parents.

At the same time, a social context of son preference is prevalent, particularly in the Northern areas of Vietnam, where Confucian philosophy's influence is strongly apparent. A son-preference culture combined with pressure to keep families small, encourages women and their families to seek sex determination services and sex selective abortion.

According to data from the latest population census in 2009, the highest regional imbalance in the SRB is found at 115.4 for Red River Delta region and the lowest was at 105.6 in Central Highlands (53), (54), (48), (10), (44), (45), (46), (47). This regional difference can be seen in Table 13.

Table 13: SRB trend by year and region in Vietnam 2001- 2009

	2001	2002	2003	2004	2005	2006	2007	2009
All over the country	109	107	104	108	106	110	111	110.5
Hong river Delta	106	110	105	107	108	108	113	115.3
North East	112	107	102	108	105	122	112	
Northwest	110	104	102	111	98	108	106	108.5
Northern Centre	113	102	102	100	98	114	114	109.7
Southern Centre	112	106	118	116	113	111	111	
High Land	96	104	98	107	109	108	111	105.6
South East	111	111	100	111	108	102	110	109.9
Mekong river Delta	111	105	105	107	104	110	110	109.9

Regional differences in the SRB are also reflected in the data collected at the two study provinces. For the past five years, Dong Thap, a province in the Mekong Delta region, has seen a decreasing trend of SRB, which over the years has not been at an extremely high level. Unlike this province, Bac Giang shows an increasing trend of SRB, which has been at a high level for several years (see Table 14).

Table 14: SRB by year in Bac Giang and Dong Thap, 2006-2010

Year	Bac Giang	Dong Thap
2006	123	115
2007	121	110
2008	119	112
2009	122	107.7
2010	119	104.9

(Source: DOPFP of Bac Giang and Dong Thap, 2011)

The fact that in Dong Thap province, considerably fewer activities including supervision and inspection have taken place to enforce the regulation, but the SRB of nevertheless remains at a low level, suggests the socio-cultural context might have a very significant influence.

People prefer sons for many reasons: to continue the family's line, to rely upon when getting old, to take over ancestor worship duties, to have more labour for the family, and, when the son marries, to gain power for the family. The status of the husband is also affected if he does not have a son – for example during communal parties, he is not allowed to sit at the same table with other men who have sons. Whatever women feel themselves, they are also much pressured by their families and the community to deliver a son. If the woman does not bear a son, the happiness of her family may be threatened: the husband may find another woman who can help him to have a son. This situation is particularly acute when the husband is the only son of his family.

> *Everyone does it, despite being poor or rich. If their first child is a girl, they have strong desire to have a boy. Women have to suffer great pressure. For example, one of my colleagues has a husband working for the military. She is also a nurse like me. She has two daughters. When she told her husband about the ultrasound result for the second child, her husband looked sad. When she delivered the child, her husband was working far from home. When he came back, knowing for sure the second child was a girl, he told us that 'Well, my wife again delivered a girl, I will have to find another one' (ANC _user01_ BG)*

Social and cultural reasons for son preference are compounded by economic reasons. Women have less job opportunities than men. Many employers do not want their employees to be distracted by family issues and think that women are physically weaker, have work delays due to maternity leave, and are less competent than men. Sons also can take much larger shares of inherited properties than daughters.

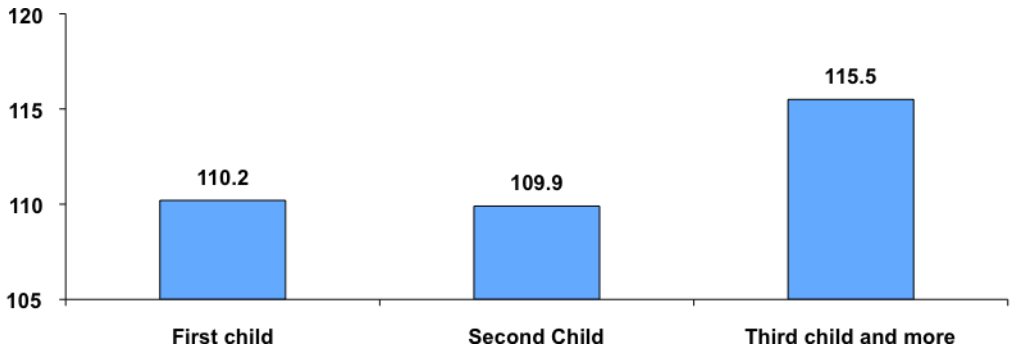

Figure 17: SRB by birth order, Vietnam

It can be seen from Figure 17 that the SRB imbalance occurs right at the first birth, but is highest by the third birth. This ratio is 110.2 at the first birth, and 109.9 at the second, but reaches 115.5 at the third birth. This shows that desire for a son is extremely strong among Vietnamese families, especially if they have failed twice to have a male child.

In this context, Vietnam's policy of population control (small family size) seems directly at odds with the Government's concerns about the country's growing gender imbalance and its firm intention to reach a balanced sex ratio by banning all prenatal sex determination and sex selection services. Unfortunately, there is lack of 'bridge' between the concept of small families and the sex ratio regulation.

5.2.5.2. Poor political commitment

Much evidence in the regulation process reflects that the government has not invested adequate commitment to its implementation. Firstly, resources allocated to implementation are very modest. Some provinces have benefited from the SRB project, however the budget from this for each province is very modest, equivalent to only 10,000 USD per province per year. In the other provinces, no separate budget from the government is allocated to SRB activities. Each province has to reserve parts of their routine budget for these activities. Furthermore, since the regulation was issued, no official evaluation of the regulation's effect has been conducted, and supervision and inspection activities have been inadequate. This is closely related to

the lack of budget and human resources. Although the SRB situation is a general issues that calls for the involvement of many sectors, local authorities in the provinces are not actively involved in the regulation processes. While they have the responsibility to co-ordinate collaboration among different sectors, they have no clear mechanism for this, and they do not allocate funds for these activities. This is the case in both study provinces. Further evidence for poor commitment to the regulation is that, although the GOPFP recognised some gaps in regulation 114 (dealing with sanctions for the violation of legal documents related to population) and submitted suggestions for amendment to the Prime Minister, no feedback has been received even two years after submission. For such sensitive issue like the SRB, the government's commitment is really essential. The above evidence suggests that this is an area that needs much improvement.

5.2.5.3. Abortion behaviour is different among regions

Abortion is very frequent in Vietnam, which has the highest abortion rate in the world (55). The statistical data shows that the total number of abortion cases is equivalent to the number of delivery cases every year, and women now have an average of more than three abortions during their lifetime.

In some cases, sex diagnosis then leads to late stage abortion, although this is more prevalent in the Northern areas. Evidence from a study conducted at an OB/GY hospital at the central level in 2008 on 154 women having abortion at week 17–22 of pregnancy found that 18.2% had the abortion for sex selection reasons (46). The true number might also be higher because women might not report the true reason. This is consistent with the fact that son-preference in the North is stronger than in the South.

> *Those who try to have a third child will keep it secret. In reality we know there are people pregnant with the third child who try to delay the abortion time until the foetus is mature [at late stage of pregnancy]. Only then do they know the sex of their child. If it is not as expected, they would resort to abortion. (ANC_Implementer18_BG).*

By contrast, in the southern provinces such as Dong Thap, people are more reluctant to have an abortion because they believe that it is immoral and will cause serious consequences in the after-life.

5.2.5.4. Features from the wider health and population system

The findings show that the conditions for effective implementation of ANC regulation are not fully met at different stages of the process. Barriers include poor accountability, lack of financial and human resources, lack of feedback loops, system reorganisation, under regulation of the private sector and poor information management. These barriers are discussed in detail in the next paragraphs.

1. At the formulation stage, the senior experts had delegated the tasks to more junior persons to participate in drafting committee, who were unable to contribute a great deal due to lack of expertise. This situation may have contributed to the limited policy focus in the ANC regulation. Gender inequality was also not emphasised in the ANC regulation, and those who are supposed to learn and benefit from the regulation, such as women and health providers, were not invited to the formulation process. Data from interviews suggested that, although the draft of ANC regulation was published on the government website for public comments, few people may have been able to access this information.

2. The administration of the regulation was weak. Information about the regulation was usually announced only once to staff within each institution. Training was not regular, and activities mostly targeted the public sector. Low frequency of information about the regulation may affect providers' assessment of its importance as well as its level of mandate. Besides, pure private providers had limited formal access to official information channels about the regulation, especially information about the sanctions for violation, deriving their information rather from the mass media. Our data revealed that many providers do not know about Decree 114 addressing administrative sanctions, which specifies specific fines for different violation behaviours related to sex determination and sex selection.

3. In the implementation process there was emphasis given to 11 provinces with the highest imbalance in the SRB. This prioritisation was set due to a lack of funds from the MOH. The expansion into 43 provinces only was started in 2011 (43). However, even in project provinces, financial resources were rather low. In other areas, financial resources for implementation had to be drawn from different areas of the health sector budget.

4. Weak feedback loops were identified. Supervision and inspection activities were irregular and were not focused on ANC regulation. There were several obstacles to effective supervision/inspection, such as in the ability of inspectors to prove their evidence, little power in directly applying sanctions for cases of violation, no right to make ad hoc inspection visits, work overload, and a lack of qualified inspectors for managing population issues, due to an absence of training.

5. The organisational restructuring process in 2007 contributed to the instability of the population system. A lack of staff and difficulties in recruitment of qualified people as a result of low incentives to work in the population sector was reported.

6. Since the reform of the district health system, the DCPFP no longer has direct authority for CHCs, and now need to get approval for implementation of ANC regulations from the DHO. This has contributed to decreasing the effectiveness of the regulations.

7. The implementation of the ANC regulation requires the collaboration of different sectors, under the overall co-ordination of the population sector and at all stages. However, it was evident that the involvement of other sectors was quite limited. No clear mechanism for collaboration was established between the population, health, cultural, information and tourism sectors.

8. Poor control of the private health sector was also identified. Lack of HR, and irregular and unfocused supervision in facilities contributed to non-compliance in private facilities. Many private facilities provide foetus sex information to

patients and abortion at late stages of pregnancy. However, no sanctions were applied.

9. The information management system is not reliable, especially for abortion. Most statistics for abortion are based on data from public facilities – data is provided by public hospitals and population and RHCs in the provinces. Even in the public sector, there are no classifications for abortion by the age of the foetus. The reasons for abortion are not recorded, and in the rare circumstances where these are documented, there is a good possibility that the reasons given are incorrect because this remains a sensitive area, especially for sex selection. This contributes considerably to the difficulty in controlling the implementation of the regulation and in evaluating its effects.

5.2.5.5. Globalisation and marketisation in health care

The rapid growth and under-regulation of private health practices in recent years has allowed health facilities to apply a variety of high-tech services for maternal health care, such as ultrasound and quick tests. More wealthy and educated people, who often live in urban areas, have better access to these techniques. According to data from the Population and House Census 2009, ultrasound techniques were first introduced into Vietnam in 1994, but the quality and quantity of the equipment at that time was still very limited. Only by 2006 was the development and availability of ultrasound apparent in Vietnam, and this is consistent with the increase in SRB since 2006 (56). The availability of Internet and other publications allow people easy access to information guiding the selection of foetal sex.

In a market economy, patients can demand services that they have paid for. Therefore, health providers are often obliged to provide services to patients upon demand. Users often preferred private facilities because private doctors are more willing to disclose foetal sex. Both the users of these services and the providers act within the context of the tension between son preference and the small family policy, and in many cases, providers reveal the foetal sex because they understand this tension and want to help women to know the sex of their babies. While this is true of both public sector and private sector providers, private sector providers are also

influenced by market forces and therefore respond more to the demand for sex diagnosis. At the same time, private facilities are less effectively regulated than public ones.

5.2.5.6. Variation in local support to the ANC regulation

The findings show differences in implementation of ANC regulation in two provinces. Better, but inadequate, implementation is reported in Bac Giang, due to perception in Dong Thap that the SRB imbalance is low and son preference is not prevalent.

In Bac Giang, local support was evident when the local contribution to the balancing SRB project was started in 2011, and the need for balancing the SRB was integrated into the local Communist Party's resolutions. This means that this is a mandate not only for the health and population sectors but also for the whole society. However, although local support is of great importance, better support in Bac Giang has not yet brought about the expected effects, in part because activities have mainly been focused on prohibiting prenatal sex determination and sex selection, leaving activities for the general promotion of gender equity out of the picture.

5.2.6. Effects of the regulation

No formal evaluation has been undertaken since the regulation was issued. However, from our findings it can be seen that the regulation has not fully met its objective in terms of decreasing the SRB imbalance, and has not succeeded in gaining the compliance of all the actors involved in sex diagnosis and sex selective abortions. Nevertheless, it has had some effect on changing awareness and attitudes of health providers, health managers and some small parts of the community.

5.2.6.1. Modest compliance with ANC regulation

The regulation was designed to achieve the following:

- Sex determination and sex selection services are not provided (covering both antenatal care services and diffusion/communication of information related to sex determination and sex selection).
- Sex selective abortions do not take place.
- In the long run, a balanced SRB is achieved.

Data collected suggests a low level of compliance among bookshops and publishing houses regarding books on sex determination and sex selection procedures. Publications and websites providing such information remain very common. However It should be acknowledged that whilst the information and guidance on foetal sex selection has reduced on domestic websites, it remains widely available through international websites and had not been contained as of 2009-2011. In this period, population inspectors with the GOPFP inspected 74 publication institutions for compliance with the regulation, and violation was reported in most inspected institutions (52). Results of this inspection are presented in Table 15.

Table 15: Violation of Decree 104 by publication institutions, 2009-2011

Content	Number
Number of provinces inspected	10
Number of institution inspected - Publishing houses - Book publishing companies - Bookshops - Website managing agencies	74 12 11 50 13
Number of violating items detected - Books - Publishing houses - Websites	 48 11 (92%) 13 (100%)

In health facilities in general, some violations were also reported by the GOPFP. During the three years from 2009-2011, the GOPFP inspected health facilities across the country and provided a report on violations, summarised in Table 16

It can be seen from the table that the number of facilities violating the Decree and being detected was very low. The true number of violating facilities is likely to be

much higher: the fact that almost all women know their child's gender before birth (51), (10) suggests that doctors telling mothers the sex of their baby is very common. Data on sex selective abortions cannot be directly retrieved because it is rarely documented. But given an increasing SRB, increasing abortion can be inferred. Although inspections did not report evidence of sex selective abortion, some small scale studies do provide some data on sex selective abortion rates.

Table 16: Inspection results on prenatal sex determination and sex selection in health facilities in Vietnam, 2009-2011

Content	**2009**		**2010**		**2011**	
	Number of inspected	**Number of violations**	**Number of inspected**	**Number of violations**	**Number of inspected**	**Number of violations**
Prenatal sex determination						
Number of provinces	4		3		5	
Number of facilities	28	2	19	2	35	2
Number of ultrasound cases	6361	151	67,751	108	83,192	1 (facility)
Number of consultations on time of sexual intercourse						1 (facility
Sex selective abortion						
Number of abortion cases	3245	Of 27 abortion cases at 12 weeks of	NA	No violation detected	18,496	No violation detected

		gestation or later, 7 were without reason for abortion and are suspected as sex selective.				

Compliance with regulation varies between public and private health facilities. Private facilities are less likely to comply due to their profit orientation.

> *They will definitely find ways to satisfy their clients. If the client has any request, they will at one satisfy her, from printing the child's photo to producing ultrasound clips for them to watch the child's movement inside the mother's tummy. Those are ways to compete and attract clients. (ANC_Implementer20_DT)*

This is confirmed not only by information provided by interviewees, but also by secondary data. Table 17 below compares violations between public and private facilities with data extracted from the same inspection report.

Table 17: Compliance with Decree 104 by public versus private health facilities in Vietnam, 2009-2011.

Year	Public facilities	Private facilities
2009	No violation detected	- 2 facilities provided prenatal sex determination service by ultrasound - Awareness of the Decree was poor
2010	No violation detected	2 facilities provided ultrasound and consultation
2011	No violation detected	2 facilities provided ultrasound and

		consultation

Although the regulation was designed to balance the country's SRB, there has not been a trend towards a balanced SRB since the issuance of the regulation. It should be noted, however, that the trend varies in different regions. The increase in SRB imbalance has been sharp and at a high level in provinces in the Hong River Delta in the North, but the SRB has been fluctuating around the normal level in Southern provinces (56). In 2009, when the most recent census was conducted, after the regulations and guidance documents had been issued, the SRB was still at 110.5, higher that that in year 2003 when the regulation took effect.

Although non-compliance is still prevalent, the regulation still has had some effect in changing the awareness of providers and a small part of the community. Most providers and some people in the community know that disclosing foetal gender is illegal; they do not do it openly as in the past. Instead of leaving evidence in the form of written diagnosis, providers now just relate the result orally, using coded language.

> *At private clinics, they don't say directly that it's a girl or a boy. They just say the child resembles his father or her mother. It's difficult to obtain violation evidence. (ANC_implementer07_BG)*

5.2.6.2. Unintended effects of non-compliance with the regulation

Poor implementation of the regulation might lead to unintended health consequences for mothers. There is a risk that stronger enforcement of the ban on sex determination and sex-selective abortions could endanger access to reproductive health services that are nevertheless in demand, potentially driving late stage abortion users underground. This is especially the case because late stage abortion is only legal at busy public hospitals. Late stage abortions carry greater health risks, and when performed in sub-optimal (underground) conditions, this risk may be increased, and can result in maternal death. Besides, sex-selective abortion goes against medical ethics.

5.2.7. Discussion

The study aims to build a picture of how the prohibition of prenatal sex determination and sex selection has been carried out in Vietnam following the ANC regulation enacted in 2003. Key findings from this study include the following factors:

- The regulation has not achieved its intended objectives with regard to prohibition of sex determination and sex selection behaviours, or a decrease in the SRB.
- Limitations were found in different regulation processes.

This section will try to explain why these limitations occurred, using the four criteria of good governance – information, standards, incentive, and accountability – introduced by Maureen Lewis et al (57).

Lack of information

For optimal regulation, clear information on the definitions of outputs and outcomes and accurate data on performance and results is necessary. Collection of these at regular intervals enables sanctions to be implemented when specified standards are not met (57). Regarding the ANC regulation, the lack of this information was very clear in different processes and contributed to impeding the ANC regulation.

No effective supervision was conducted to ensure compliance with the regulation in health facilities, especially in private health clinics. Regular supervision visits were conducted in project run provinces only. Nevertheless, there was feedback from these visits, including reports of difficulties related to resources and technical methods to implement the regulation, but those who provided the feedback were not sure if their feedback was heard and dealt with by the right people, and do not know how these issues have been dealt with.

The SRB is an important indicator of the success of the regulation and has to be reported to the higher level quarterly by the population system. But these numbers were not used as evidence to develop interventions, nor was there a response from the higher level to the trends suggested by the information. This reflects a failure to optimise these data resources.

Since the regulation took effect, there has also not been any official or comprehensive evaluation of the effects of the regulation. This has prevented timely interventions to minimise gaps and limitations (i.e. weak activity areas, staff motivation, incentives, mechanisms, resources etc.) or to facilitate those areas that have worked well.

Standards variation

Standards are defined as transparent and publicly known criteria or benchmarks used to assess and inform health policy, provision, and performance. In our study, weaknesses were seen with regard to the knowledge of specified sanctions (57). To help enforce the regulation, the government promulgated regulation 114, which specified different sanctions to apply to various violating behaviours. However, most actors at implementation levels including both providers and controllers are not aware of this regulation.

> *I don't know about the regulation on the administration of sanctions for sex determination and selection. There's no such written regulation in our hospital. We know it is not allowed, but know this just to know it. We are not doing anything to deal with violation. (ANC_Implementer20_DT)*

There are also other health regulations besides regulation 114 that specify sanctions for violation of general health legislation (i.e. the Ordinance guiding the provision of private medical and pharmaceutical services; the Ordinance on administrative sanctions in curative services). Various sanctions can be applied to the same violating behaviour, which is sometimes confusing to controllers. In reality, most health inspectors will apply the Ordinance on Private Practice Medicine, which they are more familiar with. Concerns were also raised about the clarity of definitions of violating behaviour. While clear sanctions indicate the level of mandate of the regulation, the fact that implementers and controllers are still confused, even worse are not aware of them, is likely to lead to failure in achieving the regulation's objectives. At the end of the day, it seems that there is no systematic attempt to detect and solve contradictions amongst regulations.

Poor incentives

Incentives are also key factors influencing the effectiveness of the regulation. They are defined as 'any financial or non-financial factors that motivate a specific type of behaviour or action, and can be positive or negative, i.e. encourage a certain behaviour or deter it' (57). On the one hand, for many actors (people working in the population system, health inspectors, and other health managers), who play key roles in the process of the regulation, incentives, including salary, allowance, and transportation vehicles are very poor compared to their workload. The lower the level they work at, the lower the incentives they get. This considerably affects their work motivation, which in turn affects the outputs of their tasks. On the other hand, while poor incentives negatively affect motivation of the managers and controllers, financial benefit is a driving force for private providers to violate the regulation. To attract more clients and to gain reputation, and to recoup the infrastructure investment in their own clinic (e.g. for the ultrasound machine), private providers often tell women the sex of foetus or execute abortion at a late gestational stage.

Poor accountability

Although there were some weaknesses in the formulation, implementation and monitoring of the regulation, in public facilities ensuring accountability to the regulation has been more successful than in private facilities. The central problem is low levels of accountability in private facilities. This is not due to lack of information about the regulation, because many actors in private facilities are also public health sector employees.

For employees in the public sector, compliance is driven by a general threat of sanction, especially to reputation. In the public system, accountability to government directives is recognised as legitimate, and carries known benefits. In the private sector, on the other hand, accountability is more directly geared towards user's wishes, as these drive profitability. Therefore, in this case, regulation compliance remains weak. In a context where doctors often have a choice about the location of their non-compliance to the regulation – because they work in both – it is not surprising that they choose the private location for it. Indirectly, the private sector can be said to be underpinning relatively good levels of compliance in public facilities. Monitoring and the application of sanctions is weak for several reasons, including the

fact that spontaneous visits and use of “test” pregnant women are not allowed, which means that the regulation lacks teeth, especially in private facilities where other accountability mechanisms are also weak.

The regulation displays characteristics of a typically top-down decision by policy makers. While aiming at achieving a balanced population structure, the contexts of implementation were not sufficiently taken into account. The regulation focuses almost exclusively on provider behaviour, i.e. those involved in health facilities providing ANC services. Although reference is made to gender equity in the regulation documents, no follow up has been undertaken in terms of changing user awareness and behaviour, increasing awareness of the consequences of an imbalanced SRB (such as the fate of unmarried men and problems related to the trafficking of women), or in terms of promoting income of girls and women (e.g. with an ‘equal salary for equal job’ policy.

In a situation of non-compliance, especially in private facilities – where the cost of ultrasound services is the same as in public facilities – there remains a choice for the user about whether to access sex diagnosis. In this context, decisions about compliance by users (including women’s families) are very significant. While user’s need to know the gender of their child and their desire for son is still very strong and prevalent, it is not easy to control the behaviours of providers. Moreover, not only users but also providers operate under the influence of this socio-cultural context. Providers may understand the desire of users and help them to do achieve it, even without any financial incentive.

Besides all these factors, the lack of ‘bridge’ between the small size family policy and the intention of the government to reduce the SRB imbalance is also an important element that affects the translation of the regulation into practice. As discussed, strong son preference has existed for a long time in the country. The government has made considerable efforts to deal with it. However, these efforts are limited only to policy documents and unsystematic communication campaigns. Specific measures to reduce gender inequity, i.e. strengthening the roles of women, have not been implemented systematically across the whole country.

The study revealed that compared to the normal process of regulations, there is not much difference in the process of the ANC regulation at each stage of the regulation process. However, due to the sensitive nature of the problem, for this particular regulation, special difficulties exist in monitoring, supervision and inspection. It is very hard to obtain evidence of violations. Nevertheless, although the number of reported violation cases are few, the number of women who know the sex of their baby before delivery is large, indicating that violation is very common.

5.2.8. Conclusions and Recommendations

5.2.8.1. Conclusion

In conclusion, though the regulation has had some effect on changing awareness and attitudes of health providers, health managers and a small part of the community, Decree 104 does not meet its objective in terms of decreasing the SRB imbalance or achieving compliance with the regulation among providers.

Process: the processes of the regulation are similar to those of other health regulations. Transparency is upheld well at the administration stage. However, limitations were seen in implementation and M&E. The compliance of providers is poor and levels of compliance are different between private and public sectors. M&E activities are not conducted frequently and do not properly cover private facilities.

Actors: Actors from the health and population systems play the most important role in all processes of the regulation. However, there is still a lack of quantity and quality of human resources to implement the regulation, and incentives are poor. Poor collaboration among different actors was observed, and this has implications for improvements to the regulation, because lack of collaboration between relevant actors could still inhibit successful outcomes.

The governance reflected in the regulation processes is therefore weak. Poor incentives for actors, poor accountability, lack of information and non-transparent standards all contribute to this weakness. In addition, there are various contextual factors preventing effective implementation of the regulation. These include cultural factors, health system and socio-economic factors, among which cultural factors

(son-preference) is the most influential one. This means while the regulation is necessary and enforcement of the regulation needs to be undertaken seriously, one prohibitive regulation alone is not sufficient. All these influential factors also need addressing.

5.2.8.2. Recommendations

To narrow the gap between the regulation and its objectives, both better governance and gender equity need to be addressed.

Recommendations for better governance

This section presents recommendation for better governance of the regulation against prenatal sex determination and sex selection at all levels. The recommendations are aimed at the government, especially the population system:

- Accountability of actors is a key weakness in the process, therefore it needs to be improved through the following measures: 1) involving local authorities in the processes; 2) strengthening communication on the regulation to all actors, especially towards the community; 3) strengthening monitoring and evaluation by capacity building for inspectors, more supervision visits and by empowering inspectors by allowing them to employ techniques such as 'mystery clients' and secret recording; 4) developing and applying stricter penalties for people/organisations who violate the Decree, and concrete rewards for good performance. 5) authorising unplanned visits to private providers and use of 'test' pregnant women.
- Incentives for actors should be improved through investing more resources to ensure a balance between resources and workload, and through the introduction of a clear mechanism for sanctions and rewards at all levels and for all related actors.
- The regulation is disseminated to all actors through official documents (to government agencies) and through the mass media (to the community). However, awareness among actors depends greatly on the frequency and intensity of the communication activities. There is still a large deficit of regulation awareness among many groups of actors, especially Vietnam Women Union.

Therefore, information and communication activities should be strengthened both in terms of frequency and quality, especially regarding levels, causes and consequences of an SRB imbalance, and lessons learnt from other Asian countries. Information about the regulation including sanctions and rewards should be clearly known to all provinces and relevant actors, including the community.

Besides these, there is a need to ensure synchronicity between the regulation's objectives and the wider cultural context of son preference under the influence of the small family size policy. This can be done by different measures to promote gender equity, which can help addressing the root cause of the SRB problem:

- Gender equity communication: Governments and mass organisations need to work through advocacy, sensitisation and awareness-raising programmes. By targeting special groups, such as health personnel, young women and students, such campaigns should aim at changing people's mindsets and attitudes towards women and girls. One of the major messages should relate to the role of girls and women in society; for instance, by showcasing women's successes and their contributions to their birth family.
- Highlighting imbalanced sex ratios and their consequences including the fate of unmarried young men, and related developments such as trafficking of women and girls.
- Policies preferential to girls to promote gender equity should include:
    - Tuition fee exemption and scholarships for girls of sonless and poor families;
    - More job opportunities for girls from families with all girl children;
    - Social and welfare support for elderly people whose children are all girls.

5.3. Grievance Redressal case study

In 2005, the MOH passed the Instruction on solving complaints (QD 44/2005) for implementation in the health sector. The regulation is aimed at solving complaints from patients in three areas: medical examination and treatment; quality of drugs; and food safety. This chapter will describe and analyse how this Instruction has affected equitable access to quality maternal health services in Vietnam.

Policy environment

The importance of solving complaints and grievance has been recognised by the government since its creation in 1945. The right of citizens to make complaints regarding the violation of regulations by any organisation, institution or individual is clearly stipulated in the 1992 Constitution of Vietnam (58). In order to facilitate citizens to exercise their rights and to create a legal framework for handling complaints and grievance in accordance with laws, the government issued the Law on Complaints and Denunciations in 1998 and amended it in 2004 and 2005. In 2011, the law was again amended and separated into two different laws: the Law on Complaints and the Law on Denunciations, which will come into effect in July 2012. In this study, the Law on GR will be used to refer to the Law on Complaints and Denunciations (see Figure 18).

The Law on GR aimed at solving complaints and denunciations; to protect the benefits of the State and the lawful benefits of the people; to prevent legal violations; ensure social order and political and defence security; and to promote economic development (59-61). The Communist Party and Government also issued different resolutions and directions to strengthen the process by which citizens' complaints and denunciations are addressed. Authorities at different levels are required to receive citizens who carry complaints and denunciation letters, and deal with cases within their scope of competence and in confidence.

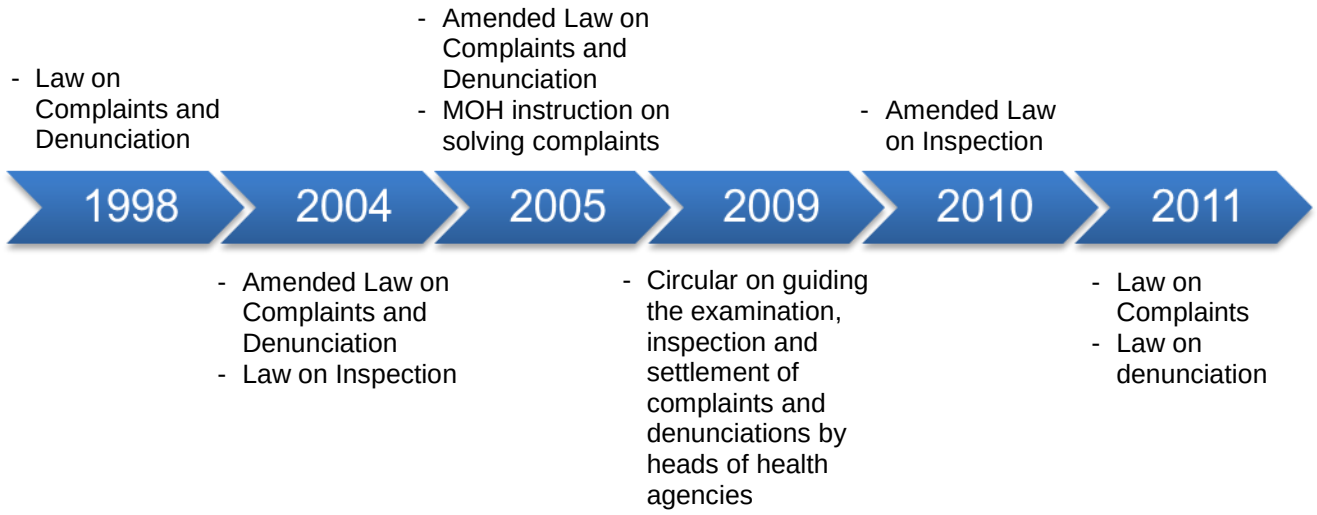

Figure 18: Timeline of the evolution of the GR regulation

The Law on GR addressed complaints and denunciation for all areas, including health, but 80% of complaints related to land management. On average these form some 180,000 complaints directed at administrative agencies per year (62), and trends suggest these figures are rising. Some complaints are collective GR cases, in which a group of people having the same complaint/denunciation act together, but the Government does not allow collective GR. In 2010, the new regulation clarified that each individual should be responsible for their own GR case (63).

With the two amendments, standard elements in the GR process such as the responsibility of different actors and procedures for complaint resolution have become clearer. The person or institution receiving a complaint must respond in writing within 30 days for the first complaint, and 45 days for the second. The person/institution receiving a complaint should inform the complainant in writing whether they accept the complaint or not. The complainant is responsible for the content of the GR case, ensuring the accuracy and reliability of information about the complaint.

Lawyers are now allowed to participate in the GR process. Each actor should be informed about the evidence, and cases must be announced in writing to a public

audience. Although adaptations like these have been made to improve the solution process, the increasingly protracted GR cases related to land complaints have highlighted the need for further improvements.

The Law on GR acknowledges the citizens' right to make complaints about administrative decisions of state organisations, including health organisations. However, in the health sector, there are competing interests between patients and providers, and although patients could make complaints about diagnosis and treatment by medical doctors, these decisions were not formally acknowledged as administrative decision by administrative institutions. In order to strengthen citizens' rights to making complaints about the health services, the MOH was the first ministry to formulate its own regulation for solving complaints (QD 44/2005) in 2005, under the framework of the Law on GR, with the clarification that diagnosis and treatment approved by hospital leaders is equivalent to an administrative decision. By this instruction, the MOH intended to improve the accountability of health providers in providing quality health care services.

To facilitate the implementation of the Law on GR, the Law on Inspection was passed in 2004 (64) and amended in 2010 (65). Inspectors were required to monitor the compliance of state organisations with instructions for settling complaints and denunciations. Citizens' complaints would be reviewed and resolved by inspectors and the benefits of institutions/individuals would be protected. In 2009, the MOH also passed the Circular on Lead Inspectors (66). This circular emphasised the need to nominate a person with this title in each state institution, to assist the existing leader responsible for development and implementation of tasks related to control and inspection, who is also responsible for GR tasks. However, no report on the implementation of this Circular was available at the time of this research.

5.3.1. Processes of the GR regulation

Theoretically, the policy process consists of different stages: development, implementation and evaluation. In recent years, research has shown that under the influence of factors such as globalisation, health sector reforms, decentralisation and the development of public private partnerships, health policy had become less top-down and was increasingly taking people's perceptions, values and beliefs into

account. However, this research on the GR regulation suggests that GR processes can be classified into the stages of formulation, administration and implementation, but no evaluation of the regulation's effects has been conducted.

5.3.1.1. Formulation of the MOH instruction on solving complaints

Main activities

The formulation of the MOH legislation lasted throughout 2003-2004 and consisted of the following main activities:

- The setting up of a drafting committee for the development of the regulation.
- Meetings and consultations with technical experts from relevant departments such as Administration of Food Safety (AFS); Administration of Medical Services (AMS); Administration of Preventive Medicine (APM); and the Department of Legislation to provide comments and feedback on the draft regulation.
- Final approval by the Minister of Health after finalising the draft.
- Financial support from the donor (SIDA, the Swedish International Development Co-operation Agency).

Contents

The MOH regulation has four chapters. The first chapter provides definitions of individuals/ institutions related to the regulation. The second chapter outlines the responsibilities of individual/ institutions under the MOH assigned tasks related to solving complaints. The third chapter outlines the procedures for solving complaints, adapted from the Law on GR. The fourth chapter specifies procedures for solving complaints in the three areas of quality of drugs/medicines; hygiene and food safety; and examination and treatment. Specific activities are recommended for GR cases in health facilities/hospitals, such as the review of medical records, laboratory tests, gathering evidence on the treatment such as the use of drugs and medical equipment, the establishment of professional committees, hearing feedback from patients, and hearing the justification of the medical professional etc. The content of this chapter consists of issues not covered in the general Law on GR and very much focused on the identification of causes of GR issues related to health providers and

health facilities. At the same time, the private health sector was not clearly considered for inclusion in this law, because this sector was supposed to follow the Ordinance on Private Health Practice.

5.3.1.2. Administration of the regulation

The MOH regulation was delivered through the administrative agencies and service delivery facilities in the health system.

At the central level, the chief health inspector/ inspectorate unit was the key person who delivered the GR regulation to the Provincial Health Department (PHD) and other health institutions under MOH management. The main activities for this were:

- Sending hard copies to all related institutions.
- Organising meetings to discuss the regulation (without involvement of the private health sector).
- Discussing the regulation in meetings within the MOH administration.
- Issuing Circular 17/2009/TT-BYT by the MOH on the control/inspection of GR management by leaders of health institutions, and organising a meeting to administer the circular in 2010.

At the provincial level, the chief health inspectors/inspectorate unit at the PHD was the main entity that delivered the MOH regulation to all health facilities that came under the administration of the PHD. Here, the main activities were:

- Receiving and sending hard copies of the regulation to all health institutions: provincial and district hospitals; district health offices (DHO); and other health agencies.
- Organising training on the regulation for related GR officers and leaders. The central state inspector organised training for provincial inspectors, who then organised training for all inspectors in the provinces.

At the district level, usually the head of the DHO was responsible for receiving and sending hard copies of all MOH regulations to CHCs and private practitioners/ facilities in their district. However, key informants in our research could not remember how the MOH regulation on solving complaints was delivered to their

DHOs or how this was delivered to other facilities.

At the provincial or district hospitals also, no one could recall how this regulation was delivered to hospital staff, and hospital leaders and officers did not know the regulation's name. However, they did recall how the Law on GR was delivered and used for solving complaints in their hospitals. According to MOH experts, health professionals do not concern themselves much about legal issues and so do not spend time informing themselves about them. On the other hand, the Law on GR is frequently mentioned in different mass media channels, so they were exposed to it by these avenues.

The central level experts did not know how the lower levels had disseminated the MOH document. According to them, this process varied and depended on the provincial leaders and the person responsible for the document's dissemination. At the provincial level, those attending the administration/ training workshop were not always those who were in charge of GR work at the health facility. In Bac Giang (BG) province, a lack of funding for training sessions was reported as a constraint, especially the costs of lunch and travel.

> *[There was a] lack of budget for training on updated policy documents, except water/tea. [There was] no lunch, no budget for printing documents, especially for the private sector (GR_ Administrator 03 _BG).*

These findings provide evidence that although the MOH administered the regulation to all PHDs, it was not well administered at the provincial health facilities and nobody knew about the MOH regulation on GR.

5.3.1.3. Implementation

Implementation of the regulations on GR consists of four steps related to both the MOH regulation and the Law on GR (see the Figure 19 below). Since no one at provincial health facilities except the provincial chief health inspectors knew about the MOH regulation, these processes are referred to interchangeably under the heading of the Law on GR.

Process of dealing with complaints in hospitals

The four main steps in dealing with complaints are: (1) receipt of the GR case; (2) classification and management of the case; (3) solving and reporting the results of the case; and (4) closing the case. These steps are clearly identified in the Law on GR as well as the MOH regulation (See Figure 19).

Step 1: Receipt of GR case

The MOH, PHD, DHO and hospitals receive different GR cases. Table 18 presents the number of GR cases received at different levels, as reported in annual reports from the provincial health inspection personnel.

Table 18: Number of GR cases at different levels in five years

Year	**2006**	**2007**	**2008**	**2009**	**2010**	**Mean**
Provinces submitted GR reports to MOH	40	32	53	45	42	42.4
Total GR cases in health system	570	539	2219	275	1300	981
GR cases received by MOH	113	134	149	152	289	167
GR cases received by PHDs	457	405	2070	123	1011	813
BG PHD	52	38	36	28	18	34
DT PHD	13	38	19	17	33	24

Sources: Inspection reports from BG and DT provinces (67-71), (72-81).

Table 18 shows that about two thirds of provinces (42/63) submitted reports to the MOH on inspection work. The number of GR cases has fluctuated in the last five years, with highest numbers reported in 2008, at all levels. The number of GR cases in DT province has generally been lower than in BG.

There are different mechanisms for collecting information on GR cases. Within hospitals, the most common channels are the mailbox, direct feedback to a responsible person, use of a telephone hotline and use of the Patient's Council.

Mailbox: the box is set up in all hospitals and wards. It aims to collect feedback from patients on hospital performance. It is usually opened once a week in the presence of different people such as a peoples' inspector, representative from the Board of Directors, representative from the Department of Personnel etc. Mails from mailboxes are then sent to the director for solving cases.

Some mailboxes are useful for getting comments. However, according to many key informants, this had little relevance to the legislation because most of the letters were compliments rather than complaints.

Direct feedback: when the patient was not satisfied with hospital performance, they could report directly to the person in charge, such as the ward head; the hospital director; the hospital board; or administrative officers as well as to the officers in charge of the GR process, who are often located in the Department of Personnel.

Telephone hotline: this was also arranged for in several hospitals. In some hospitals, an on-duty member of the board of directors would be responsible for answering the hotline. In other hospitals, only the director would be responsible for the hotline.

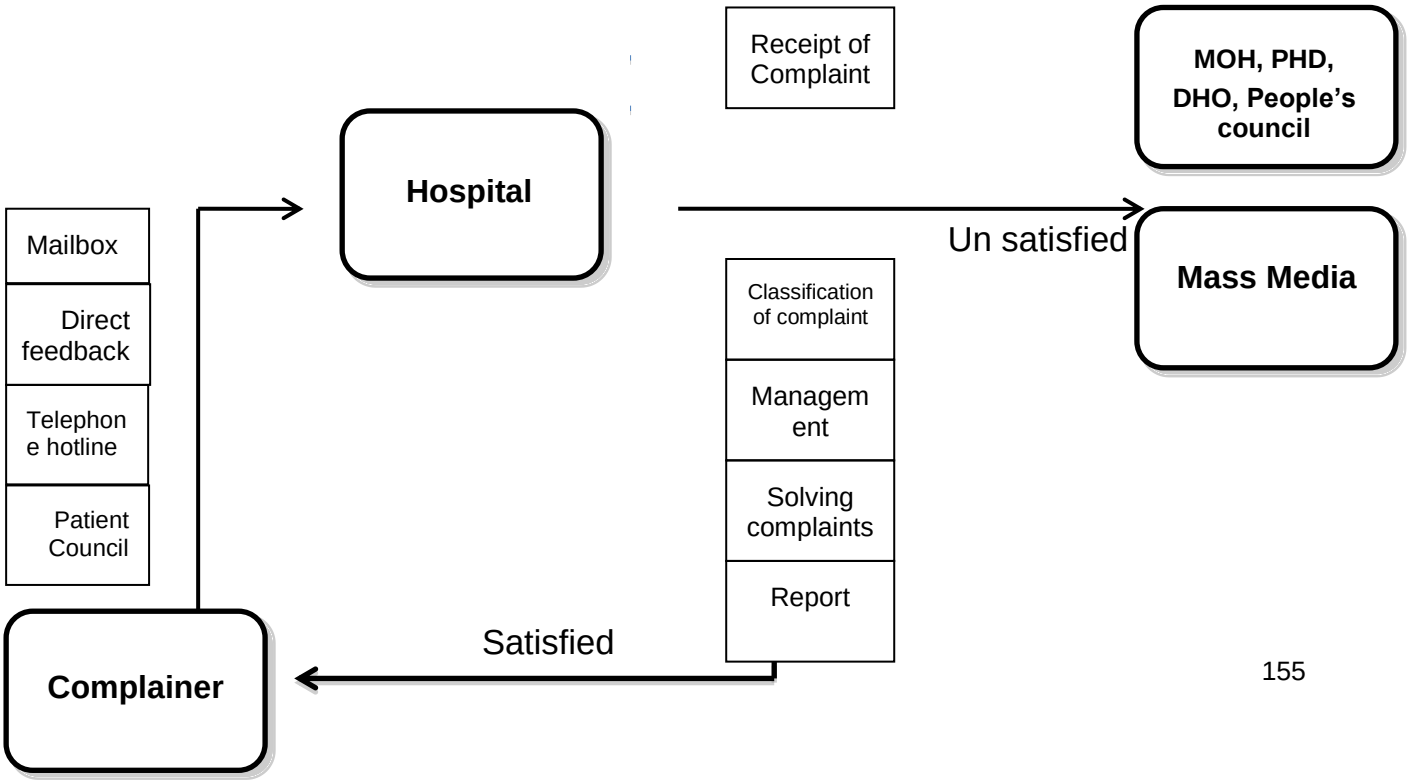

Figure 19: Solving complaints process in the hospitals

Patients' Council: this is set up in each hospital according to MOH hospital regulations with the aim of getting feedback from patients on hospital performance. The hospital nominates one person from the hospital (often a chief nurse) to organise the weekly meeting with patients in the wards to ask their opinions about hospital performance. The effectiveness of the council depends on each hospital, as it is organised and operated variously. According to some hospital leaders and GR officers, the council has more of a token meaning than a genuine value because patients are unable to really complain while still receiving treatment. However, in some other hospitals, the feedback is useful.

Beyond the hospital, information on GR can be received through different channels, such as through local People's Councils or the mass media.

People's Councils, such as provincial, district and commune People's Councils, are administrative organisations which collect feedback from citizens about services delivered in local health facilities. They organise periodic meetings and require official feedback from each institution at their level. Each institution must review the feedback and make an official written report of negative comments/cases.

Mass media is a powerful channel that citizens can use to submit their GR case. According to the regulation, after receiving complaints from citizens, the complainant should received a response within 30 days or at the latest within three months. The institution targeted for complaint should instruct the employees responsible to solve the case or send the case to the inspection agency (82). In practice, as experience reveals, the mass media often sends the GR case to health facilities for a response within 15-30 days. If no response is received within this period, the case will be broadcast through media channels (radio, TV and newspapers). In BG and DT provinces, however, very few cases were reported with media involvement because few people are able to access the media for various reasons, including having no connection or contacts in the media, and for lack of funds etc.

Step 2. Classification of GR cases

Although the Law on GR classifies cases into the two categories of complaints and denunciation, examination of MOH reports revealed three categories in use: complaints, denunciation and feedback. 'Feedback' was an observation of non-compliance with the regulation, such as poor attitudes of health providers towards patients, long waiting times in the hospitals etc., but without a specific complaint/denunciation to a specific institution/individual. This type of complaint was not supposed to be solved within the timeline required by the Law on GR.

Table 19: Percentage distribution of GR categories in the last five years

Year		2006	2007	2008	2009	2010	Mean
Complaints	**MOH**	37.6	33.1	25.7	31.8	27.2	31.08
	PHD	41.7	28.8	28.4	36	39.3	34.84
	BG	11.54	5.26	0	0	7.14	4.788
	DT	53.85	57.89	73.68	45.45	82.35	62.644
Denunciation	**MOH**	15.4	22.9	26.7	28.4	40.9	26.86
	PHD	27.5	34.3	23.9	31	29.8	29.3
	BG	40.38	26.32	30.56	55.56	14.29	33.422
	DT	38.46	31.58	5.26	27.27	0	20.514
Feedback	**MOH**	47	44	47.6	39.8	31.9	42.06
	PHD	30.8	36.9	47.7	33	30.9	35.86
	BG	48.08	68.42	69.44	44.44	78.57	61.79
	DT	7.69	10.53	21.05	27.27	17.65	16.838

Table 19 shows different categories of GR cases by institutional level. At the MOH level, feedback cases are most common, next to complaints and denunciations (42%>31%>26.68%). At PHD level, a similar trend was reported (35.86%>34.84%>29.3%). In BG, feedback cases are most common, followed by denunciation and complaints (61.79%>33.42%>4.7%), but in the past two years in particular, the number of complaints has been very low. In DT, complaints cases are highest, next to denunciation and then feedback (62.64%>20.54%>16.83%) (67-81).

The MOH regulation on GR is specifically designed for the three areas of medical examination and treatment (MET); quality of drugs; and food safety. The classification of cases under each area is presented in Table 20.

Table 20: Content of GR cases by health areas (%)

Categories	Year	2006	2007	2008	2009	2010	Mean
Examination and treatment	**MOH**	45.2	48	53.1	26.8	42.6	43.14
	PHD	38.8	43.3	41.7	41.7	37	40.5
	BG	51.92	23.68	47.22	0	0	24.56
	DT	61.54	65.79	0	0	0	25.47
Quality of Drugs	**MOH**	5	3.3	4.6	6.6	4.3	4.76
	PHD	13.2	11.3	10	9.6	10	10.82
	BG						NA
	DT	0	0	0	0	0	0
Socio-economic policy	**MOH**	46.5	46.3	39.2	60.2	48.7	48.18
	PHD	34	34.5	37.3	38	42	37.16
	BG	8	15	12			7.00
	DT	38.46	31.58	0	0	0	14.01
Food safety	**MOH**	3.3	2.4	3.1	6.4	4.4	3.92
	PHD	14	10.9	11	10.7	11	11.52
	BG						NA
	DT	0	2.63	0	0	0	0.53

NA: not available data

At the MOH level, the highest percentage of GR cases were related to socio-economic policies concerning citizens' rights and entitlements (48.18%) followed by examination and treatment (43.14%); the quality of drugs (4.76%); and food safety (3.92%). At PHD level, the greatest number of GR cases related to examination and treatment (40.5%), followed by socio-economic policies for citizens' rights and entitlements (37.16%); and food safety (11.52%); and finally the quality of drugs (10.82%).

In DT, the highest proportion of cases related to examination and treatment (25.7%),

next to socio-economic policy (14.01%) and food safety (0.53%). The report from BG province offered data on examination and treatment (24.56%) and socio-economic policy (7%), but gave no information for other categories.

According to the GR inspectors and officers, the contents of complaints on MET are mainly related to long waiting times in examination departments; poor attitudes/behaviour of health workers (such as rude, unresponsive behaviour); poor hospital environment (such as a dirty and non functioning WC); medical complications; lack of an evidence-based decision on the sanction of health workers and medical treatment of patients; poor re-imbursements of benefits and the responsibilities of patients related to health insurance procedures. In MET areas, surgery and OBGYN are the main areas for GR complaints. Patients often make complaints following complications or the death of patients (maternal or child deaths).

The contents of denunciation cases, on the other hand, are about corruption in a health institution; poor attitudes and unresponsiveness of health workers; non-compliance with socio-economic policies meant to benefit people; and violations of private practice rules.

According to the GR inspectors and officers, there are very few GR cases related to private practices since patients are generally well treated in private practices. There was also no separate category for recording GR cases in private health facilities. However, in BG, the inspection report contained information on GR cases related to financial violations (3.2%) and private health practices (2.0%). The main complaints about private practices related to over capacity of facilities, lack of licenses/registration, and lack of updated information on private practices at the private sector management unit.

Step 3. Management of GR cases

The GR management process identifies whether cases fall under the responsibility of the institution that received the case. If not, then the complainant should be informed about this in writing (72-81) (See Table 21).

About one fourth of GR cases received by the MOH fall under their authority for solving cases, while the proportion was higher at the provincial level (60.8%). The data shows that although the MOH received many GR cases, two out of three are feedback cases without a complaint or denunciation to a specific institution/ individual. Therefore, the MOH has no specific role in solving these cases. More GR cases are specifically addressed to the PHD level than the MOH level. This is also evidence of citizens' low awareness on GR case procedures.

Table 21: Percentage distribution of authority for solving GR cases

Year	**2006**	**2007**	**2008**	**2009**	**2010**	**Mean**
MOH authority for solving GR cases	17.9	25.6	22	30.5	30.9	25.38
PHD authority for solving GR cases	71	53.9	59.1	61	59	60.8
BG PHD authority	25.21	47.50	37.23	50.00	52.37	42.46
DT PHD authority	92.31	81.58	78.95	76.47	87.88	83.44

The GR cases received by DT that fall under their authority for solving cases were a higher proportion than in BG (83.4%>42.46%). In both provinces, this means that the remaining cases have either been sent via incorrect channels or could be feedback cases, without specific complaints/denunciations to any institution/individual.

Table 22: Percentage distribution of anonymous GR cases

Year	**2006**	**2007**	**2008**	**2009**	**2010**	**Means**
Anonymous cases received by MOH	18.8	18.4	27.9	18.1	11.6	18.96
Anonymous cases received by PHD			25	34.5		11.9
Anonymous cases received by *BG PHD*	15.38	28.95	19.44	28.57	22.22	22.91
Anonymous cases received by *DT PHD*	30.77	21.05	0	0	0	10.36

The proportion of anonymous GR cases received at the MOH was higher than at provincial level (18.96%>11.9%), and the proportion in BG PHD was much higher

than in DT PHD (22.91%>10.36%) (See Table 22). Although anonymity could be an indication of the user's fear of retaliation for making a complaint, according to the law, institutions are not required to proceed with anonymous cases. Nevertheless, DT PHD does proceed with anonymous complaints, and announces the results of these cases on their website.

Step 4a. Solving GR cases at local health service delivery facilities (hospitals)
Interviews with key informants in two provinces showed that the main policy used for solving GR cases is the Law on GR. Although the provincial chief health inspector confirmed that they received the MOH regulation on GR, they do not use this document because the government-enacted Law on GR is more flexible and has more power.

> *The main policy GR document used for solving GR cases in BG was not the MOH regulation 44. (GR_Administrator05_ BG)*

> *All GR cases are managed using the Law on GR. (GR_Administrator12_ DT)*

By law, solving GR cases is the responsibility of the leader of an institution. The leader will assign a GR officer or manage the case himself. The conclusion of a case should be officially communicated to all relevant stakeholders who would have received details of the case, such as the MOH, PHD, PPC, DPC or the media.

At each institution, different activities might be implemented depending on the nature of the case, such as visits to the family, establishing a technical professional committee to review the case, consultation with other people, etc. Often, a team is established to review cases and meet with the patient/families, consisting of members of the People's Council, inspectors, labour unions, the youth union, chief nurses, members of the Board of Directors, and technical experts. This makes the process more transparent. The establishment of a technical professional committee is sometimes necessary to verify the context of GR cases, but this depends on the complexity of cases, and is very difficult to achieve in remote areas due to a lack of highly qualified staff.

This could be done in Hanoi easily because of availability of experts in different fields, but this is different in other provinces (GR_intepreter1_HN)

According to the MOH regulation on GR, the use of medical records is important in reviewing cases. When proceeding with a case, all relevant medical records are required to be sealed, but this is not done rigorously in all institutions. There is a concern about the retrospective completion of medical records in many GR cases, especially in emergency cases when the time allowed for completing records is up to three days following the incident (83).

According to administrators and implementers of GR there are a variety of causes of GR cases. The BG chief inspector, for example, shared experiences of dealing with cases that could be associated with 'internal' causes, such as conflict between health workers, by meeting with the head of the institution to find out who the real 'trouble maker' in that institution is. Following this, the head of the institution is expected to solve the GR case with the apparent 'trouble maker'.

Step 4b. Solving GR cases in the administrative agencies

If a case cannot be solved at a local institution it has to be sent up to a higher level such as the MOH, PHD and DHO, where the procedures for solving the case are started again. The agency reviews and adjudicates the case and draws a conclusion. The agency can conduct various actions such as authorising visits to the local institutions to identify and verify the causes of the case, with the participation of other actors if necessary. It can also report the final conclusion of the case and apply sanctions if and where necessary.

Step 5. Close the case and report results

In practice, it was shown that most institutions try to resolve cases at the local level by meeting, negotiating and offering compensation. The case is considered solved and closed when the complainant accepts the explanation/justification and compensation and removes the GR letter. In the conclusion, there should be a clear statement about non-complaint behaviours on the part of medical staff and the respective sanctions to these behaviours. These sanctions depend on the specific facilities and context, but the most common are removing persons to another post,

making a formal statement about the GR case (reproof) in staff meetings, rearrangement of services, and reduction of the monthly and/or yearly allowance. However, several difficulties in applying sanctions were identified by interviewees. These included difficulty in providing conclusive evidence, for example of a health provider being rude to a patient; difficulty in choosing the priority non-compliant behaviour to apply sanction to (too many priorities); and overlapping tasks among sectors in managing cases, for example in food safety cases.

When GR cases cannot be settled within local institutions including the provincial level, the case can be sent to a higher level following the procedures stipulated in the Law on GR or even sent to court following the procedures identified in the regulation. Although the involvement of lawyers has been allowed from 2005, GR cases with legal involvement are not common because Vietnamese people are not familiar with using legal services, or because of cost barriers. Very few people sent complaints to the courts. Moreover, hospital officers (implementers) confirmed that health facilities do not want to involve a lawyer in this process, because this could make the process much more complicated.

Procedures for GR cases with media involvement are quite different. The mass media always informs a hospital of a case for response within 30 days. If the hospital does not solve the GR case within this period, the media will release the case to public media channels. In a very few cases, information about a case has been immediately broadcast to the public.

The case study (Box 2) summarises the main activities from one GR case related to a neonatal death, in a district hospital in Bac Giang province. The open access records relating to the case and meetings with the complainant, as well as the health providers targeted by the case, provided the information for the case study. This case shows that one family received 10 million dongs for receiving poor quality care in a district hospital because of lack of skilled staff. Reviewing the case, it can be seen that there was clear implementation of procedures as described in the Law on GR. The complainant operated through the appropriate channels:

- 1st complaint: direct contact with the director;

- 2nd complaint: sending GR complaints to a higher level (PHD and other broadcasting agencies).

The PHD and district hospital also followed the procedures to solve the GR case as stipulated in the Law on GR:

- It confirmed receipt of the GR case in writing;
- It sought classification of the complaint as denunciation.

Box 2: GR case study in one district hospital in 2010 (35, 84-98)

GR Case Study at BG Province

November 18, 2010: A pregnant woman went to the CHC at midnight because of pain and was sent to the district hospital at 2.30 am. She was examined 3-4 times in the hospital ward but no medical record was written. At 7.00 am the new doctor in charge came and sent for the laboratory tests, but no ultrasound was done. At noon the woman was in great pain, and doctor checked and discovered that she was having a hemorrhage. He sent the woman to BG provincial OBGYN hospital for an operation. In critical condition, she was later sent the National OB/GYN hospital for treatment. Her child was dead; the woman recovered but has spent a lot of money on treatment.

The family met the director of the district hospital to ask about the causes of the complication and was told that her illness was very rare and the hospital doctor had no competency to make a diagnosis of this kind. The family was not satisfied with the director's responses and sent complaints to different levels (PHD and chief inspector of the PHD, BG radio and TV and local newspaper) on December 4, 2010.

On December 13, the PHD inspector met with the family, and informed them that no signature had been given in the GR complaint letter. The family signed the letter and resent it to the inspector. On December 21, the inspector met again with the family. The family confirmed the GR was an accusation regarding the behaviour of two medical doctors working in the district hospital, which led to the death of the newborn and severe morbidity of the mother. The family requested for clarification of the causes and that the responsible person should be treated according to the law.
On December 23, the PHD sent the letter to inform the family and the district hospital about the case and requested the district hospital to proceed with the case.

On December 24, the PHD inspector met with the CHC where the pregnant woman first went for delivery, and the district hospital. The official correspondent was sent to BG broadcasting centre (radio and TV) to confirm the receipt of the official correspondence from centre on December 16 and inform them about progress of the case.
On December 26, the official correspondent from BG broadcasting centre went to the PHD to remind them to proceed with the case and give feedback to the public.

On December 27, the official dispatch was sent by the district hospital to the family to inform them about progress: the GR case was accepted and will proceed, and the family was requested to collaborate during process.
December 27: the hospital set up a meeting with related stakeholders (two doctors and the team on night duty on November 18) and asked for justification of the case. The justification letter was submitted on December 29. The hospital made the decision to set up a team to verify the GR case within 30 days, with participation of the vice director, a representative from the Labour Union, a people's inspector and a representative of the Department of Personnel. The team met with the commune health centre, BG OBGYN provincial hospital and the family to review the case again.

December 29: the team reviewed the case. The BG OBGYN hospital confirmed that woman was admitted in a very severe condition and was diagnosed as having toxemia. The family was told by one doctor in BG OBGYN hospital that if the case had been detected earlier, the child could have been saved. However, there was no doctor with a name that the family identified.

January 5, 2011: the team met with the family, explained the case, requested understanding and asked the family to remove the GR complaint. The family said that they wanted the hospital to visit them. The hospital provided 10,000,000 VND to the family to share their loss. The family sent the letter to PHD, BG broadcasting centre, BG newspapers and OBGYN hospital to inform that they had received care by the district hospital, that they were in a hurry when making the GR case, and they removed the complaint.

January 10, 2011: The team reported back to hospital about the case.

January 19, 2011: The final conclusion of GR case was made by the hospital director. The midwife and medical doctors had not behaved irresponsibly. However, they had limited skills in the diagnosis and management of the case, which lead to severe consequences. The doctor's additional allowance for six months was cancelled by the hospital and an official statement about the mistake was made in a staff meeting.

January 24, 2011: The final report was submitted to the PHD, BG broadcasting centre and BG newspaper and the family about the conclusion of GR case.

- It began procedures to solve the complaint by assigning it to the district hospital, which then established a team to verify the case with the participation of different people including the GR officer, people's inspector, labour union representative and member of the board. The team reviewed the case records and the evidence, meeting with different actors at both the higher and lower levels (the BG OBGYN hospital and the CHC), and with the health providers in receipt of the complaint and the family of the patient.

- The district hospital director then concluded the case, reporting the conclusion to a higher level and closing the case after the family had removed the complaint.

Feedback loops

Different activities are implemented providing feedback loops in the GR regulation, such as supervision visits, reports, and official comments/feedback in different forms.

Supervision

There is no official supervision on GR work organised in the health system for various reasons, including the lack of budget and personnel. GR officers from the administrative agencies often organised supervision visits to public institutions in integrated visits. According to one key informant, a maximum of one visit per institution per year is conducted, including the annual exchange evaluation. However special attention is paid to institutions with a high number of GR cases or those with cases that are awaiting a response within the required deadline. Additional meetings, visits or telephone calls with those institutions are applied. Supervisions are thus understood as control and not as in-service training procedures.

Inter-disciplinary inspection visits to private facilities (one visit/facility/year) are also conducted to ensure that the practice is following the licenses/registration rules. If there are any violations, such as a extending the practice beyond capability, practicing without a license, or evidence of poor satisfaction of clients, then sanctions will be applied.

The regular annual supervision visits by a provincial state inspector is intended to

help the provincial health sector to improve knowledge and skills on GR functions. Staff meetings at local health institutions are also regularly undertaken as the main mechanism for supervision of activities implemented at that level.

Constraints noted included a lack of funding for the costs of travel and allowances, and poor collaboration among sectors. These limit the performance of actors in supervision activities.

> *[There is a] lack of budget for petrol for supervision visits. Therefore, we could not organise the visits to lower levels as planned. There is also no budget for verifying traditional medicine. (GR_Administrator03_ BG)*

Reporting system

The MOH and PHD receive annual reports on GR cases from health institutions at lower levels (district and commune). The implementation of GR cases at these institutions is reflected in these reports, including the number of GR cases and those that were solved, but not how they were solved.

> *They report how many cases have solved per year and how many cases were not solved. (GR_central_developer_2)*

However, informants did not know details about cases that were not associated with written complaints. These cases are often concluded by dialogue and reconciliation between providers and users of services.

> *[There is a] difficulty in knowing all cases: the facilities will solve all cases that do not develop to complaints cases [though dialogue]. (GR_central_developer_2)*

Many institutions, however, did not sent these reports. This reveals a lack of concern on the part of the higher tiers. Only two thirds of PHD institutions submitted reports to the MOH inspectorate department (see Table 18 under Step 1: receipt of GR cases). In many cases, the PHD could report only the cases that they solved at their agency. At the time, no enforcement was being applied for not submitting reports, especially

in the case of private health institutions.

Other feedback channels

Feedback from local health institutions to administrative agencies can be collected through reports or through field trips/meetings/training. In response to feedback, some actions are sometimes taken. For example, after a series of GR cases related to poor ethics of health providers in DT, the PHD tried to improve the situation by developing special instructions to guide the lower levels on a code of conduct for health providers.

Feedback from administrative agencies to the MOH also occurred, mainly through different meetings/field trips on GR. Although official feedback on GR policies could be sent to the MOH in writing, actors at lower levels were not sure whether these written comments were 'heard' or not by the MOH. At this stage, no formal evaluation on the MOH regulation has been carried out at any level.

5.3.2. Regulation approaches

The evolution and implementation of the GR regulation incorporates two kinds of policy approaches. In some aspects, it embodies a state command approach. At the same time, it also includes aspects of a client oriented and enabling approach.

5.3.2.1. State command approach

The Law on GR and the MOH regulation were issued by the Government and the MOH, and followed all required legal procedures. The MOH regulation targets mainly public health agencies responsible for administrative decisions. By this law, all public health agencies should comply with the regulation, assuming that all necessary resources and conditions are in place.

5.3.2.2. Client-oriented approach

The GR regulation is aimed at ensuring the patient's right to make complaints about the health system. There are different channels that allow patients to express their grievance. The regulation also specifies different procedures that ensure complaints/denunciations are solved at different levels (within local facilities and at higher administrative agencies).

5.3.2.3. Enabling approach

The GR regulation is aimed at creating different steps to ensure citizens can redress their complaints. If complaints are solved, the quality of health services would be improved, partly through the application of sanctions when a grievance is deemed relevant.

5.3.3. Actors

5.3.3.1. Description of actors

Table 23 provides information on the number of actors involved in processes of GR regulation. It can be seen that some actors are involved in several different GR processes, especially those from the administrative agencies – the MOH, PHD and DHO, and directors of hospitals. Other actors are mainly involved in the implementation process.

Our analysis will focus on inspectors at different levels, as they are the main human resource for solving GR cases. However, other actors, as supportive personnel or collaborators in the GR process, will also be explored.

Table 23: GR Actor analysis

Actors	Tasks	Objectives	Remarks
MOH inspectorate (chief inspectors and staff)	Developing MOH regulation on GR; Administration, implementation and M&E of GR regulations over country and at MOH level	Striving for equity and quality improvement of health services in Vietnam	Lack of personnel with sufficient capacity on GR work Low allowances and motivation
Inspectors in PHDs (chief inspectors and staff)	Administration, implementation and M&E of GR cases in province and at PHD level	Striving for equity for patients, and also trying to protect the reputation of health system and health providers	Lack of inspectors with sufficient capacity on GR work Low allowances, incentives and motivation Chief inspector guides the lower level in implementation of regulation in order to protect health providers' interests Several constraints identified in GR work, including organisational structure, corruption etc
Department of private practice medicine	Making comments on conclusion of GR cases in private practice; Involved in inter-disciplinary supervision team to private practice facilities	Striving for equity for patients, and also trying to protect the reputation of health system and health providers	Lack of regular supervision due to lack of personnel; Low allowances, skills and incentives to work in private practice medicine
Provincial health department (Director)/ District Health Office (Head)	Making final conclusion to GR cases received by PHD	Striving for equity for patients, and also trying to protect the reputation of health system and health providers	Involved in inter-disciplinary supervision team for private practice Low allowances, lack of time, skills and incentives to work in GR areas

Public hospital (directors)	Making the conclusion of GR cases received; Administration, implementation of GR cases, making compensation	Keeping good reputation of hospitals, attracting patients and incomes and equity for patients	Variation in priority given to GR works Poor accountability (incentives and sanctions) due to various reasons, including lack of resources, autonomisation and other social influences
GR officer at hospital	Investigating GR cases under assignment of hospital leaders Making recommendations on conclusion of GR cases to the leaders.	Striving to protect the hospital reputation as well as the equity for patients	No permanent staff working on GR in hospitals Lack of skills, allowances and incentives on GR work Low priorities for GR work by health professionals
Local People's Council	Collecting grievances from local citizens that voted for them; Inquiring at hospitals for justification of complaints and improving health service	Should be accountable for local citizens that voted for them: equity and quality services	Powerful influence because they make decisions regarding resource allocation in the local areas
Media	Broadcasting reliable information of GR cases	Getting public attention on issues of equity and quality services	Very fast growth of media Powerful in sensitising public opinion on GR cases Not very welcomed in the hospitals
Lawyers	Helping citizens cope with GR processes and protecting citizens' rights	Getting payment for services and also concerned about citizens' equity	Limited involvement in GR cases due to lack of culture and costs
Courts	Handling GR cases; Enforcement of GR cases	Ensuring citizens' equity	Limited involvement in GR cases due to lack of culture and costs
Local state inspector	Supporting local health GR activities M&E of local health GR cases	Ensuring citizens' equity	Lack of knowledge on health problems
Technical	Reviewing GR cases and verifying	Protecting citizens' equity and the	Not always available, especially in remote and

committee for verification of cases (if needed)	true causes	reputation of health system	difficult regions
Patient	Exercising citizens' right to make complaints	Getting compensation and also ensuring their own equity	Low awareness on GR processes Compensation driven
Patients' Council	Exercising citizens' right to make complaints	Striving to improve quality of health care service	Low effectiveness due to various reasons including fear of expressing complaints while in hospital

Table 23 provides information on actors according to rights, responsibilities, and in some cases according to revenues/incentives. It can be seen that there are various revenues/incentives for different actors in the process.

Inspectorate at MOH

At the time of research, a total of 70 persons were working as health inspectors at the inspectorate level at the MOH, AFS and GOPFP. Health inspectors include both administrative and technical inspectors (36 at the MOH, 16 at AFS and nine at GOPFP). The chief inspector and inspectorate unit of the MOH initiated the development and finalisation of the GR regulation. They are responsible for administration of the regulation at lower levels, and the implementation of GR cases sent to the MOH. They also undertake supervision and coaching for the lower levels in the provinces, receiving and making reports on the GR situation. However, key informants indicated a lack of personnel with sufficient capacity and low motivation for GR work among selected staff, due to low allowances and incentives.

Inspectorate in Provincial Health Department

Among inspectors at the provincial level, several issues were raised. All GR work at the PHD is the responsibility of the director of the PHD. However, the tasks are assigned to the inspectorate unit. The provincial health inspectors are responsible for administration, implementation, M&E and reporting of GR cases in the provinces. A total of 300 health inspectors are working in all Provincial Health Departments but with very few administrative health inspectors among them. In addition, few health inspectors have a background in law.

In BG, there are two senior inspectors and one middle level inspector working at the inspectorate unit in the PHD. In DT, there are five inspectors, including one chief inspector and two middle level inspectors. The other two inspectors had no prior training on inspection. In order to be nominated as health inspector, the

person needed to study for two months at a school for inspectors. In order to be nominated as chief health inspector, the health inspector should study a further two months in the same school. So far, there is only one school for inspectors in Vietnam. No inspectors received special training on how to use the GR regulation.

In both provinces, there were no health inspectors at district or provincial hospitals or District Health Offices. Inspectors, however, acknowledged the importance of GR for improving the quality of health services. Besides regular government salaries, inspectors receive occupational allowances of five percent of their salary if they had worked for five years as a health inspector and one percent in subsequent years, together with a free uniform and raincoat annually. However, no travel allowance is provided. These allowances are too low according to all key informants, and are insufficient to motivate people to work in the GR field.

The chief health inspector raised concerns that the MOH also had no power to order the provinces to follow the MOH regulation on solving complaints, since following recent political administrative reforms together with decentralisation in 2001, the ministries and provincial authority fell in the same administrative rank. This has caused some difficulty in achieving structural improvements in the health system.

> *[There is] conflict of ranking among institutions. Lots of policies issued by the MOH were not accepted by the provincial People's Committee because they are in the same administrative level (ranking) and the provincial level only needs to follow government documents. (GR_Administrator03_ BG)*

The provincial chief health inspector often guided the lower level towards classification of GR cases in hospitals as 'denunciation'. According to chief inspectors, denunciation procedures do not necessarily require providers to pay

compensation even if health providers are found to be in non-compliance with the regulation.

> *The complaints cases can involve taking the doctors to the civil court and this is a very time consuming process. Not all policies now protect the doctors. A denunciation case does not guarantee compensation - this depends on policy makers (and may be better for the doctors but this is not clear). (GR_Administrator05_ BG)*

The chief health inspector also guided the lower levels not to conclude that medical practitioners made a technical error, because then the case would be taken over by the courts and the health provider would need to pay compensation.

> *The chief inspector (BG) never advised the director to make a conclusion on fault related to technical errors. If this happens, the police will take over the case (if the patient has been identified as having at least 11% loss of health as a result of the error) and the doctor will be sent to the court and will have to pay compensation. The health sector should protect our professionals. (GR_Administrator05_ BG)*

According to key informants, there are many difficulties in proceeding with GR cases. Health inspectors cannot make straightforward decisions regarding sanctions for violations for several reasons, including that of corruption. In the past, health inspectors were under direct management of the provincial People's Committee and therefore had some independent voice. Nowadays, all health inspectors are under the direct management of the PHD and therefore do not have a voice independent of the leader of PHD. These constraints de-motivate health inspectors to work in the GR field.

Health inspectors in the MOH and PHD have dual responsibilities: to ensure

equity for patients and to protect the reputation of the health system, including of the health providers. In their view, health providers do not aim at harming people and therefore also need protection.

Department of Private Practice Medicine, PHD

In the implementation of the GR regulation, there is active involvement of the Department of Private Practice Medicine. However, the structure of private practice management varies across provinces. In BG PHD, an independent Department of Private Practice Medicine management has been created, while in DT PHD, the department is only small unit under Department of Professional Medical Management.

In BG, the department is involved as part of an annual inter-disciplinary inspection team for private practice, while there was no involvement of this kind in DT province, possibly due to a lack of human resources in this province. The chief health inspector from the PHD is responsible for the process of addressing GR cases in private practices. The Department of Private Practice also faces constraints such as lack of staff, low salaries and incentives, especially because the topics involved are sensitive and complex and addressing them requires skill and experience – for example, regarding procedures for registration of a health facility.

Head, District Health Office

The head of the DHO is responsible for private practices in the district. Heads are involved in inter-disciplinary inspection teams for private health facilities which oversee whether they are complying with the Ordinance on Private Practice Medicine. They are also responsible for implementing GR cases at the local level, but are generally not motivated towards GR issues due to lack of allowances, limited time for GR work – which is a part-time task –, and they do not receive training on the processes and procedures of GR.

Both the directors of the PHD and the head of the DHO are working to solve GR cases with objectives for ensuring equity of patients, and protecting the reputation of health system and health providers.

Hospital directors

Hospital directors are responsible for both administration and implementation of GR work. They are all aware of the importance of GR work, but fieldwork suggests that the implementation of the regulation is very varied among hospitals. Much depends on the how much priority the director gives to GR. In some hospitals, the head supports GR as a top priority while in others there is no such commitment. This has an influence on GR work and in particular on the officers who undertake the work.

> *The leaders and people trust the GR officers to take this job. However, they do not care how you manage to do the work: money, travel, food etc. (GR_Implementer14_ BG)*

The directors should be responsible for rewards and sanctions in the implementation of GR work. However, this is not always straightforward due to the inter-relationship among actors. A director, for example, might not apply sanctions whenever needed. Corruption is also a reason for this failure.

> *Corrupt behaviour and environment is very prevalent in Vietnam. The law on anticorruption is aimed at the corrupt person and not towards the corruption environment. (GR_Administrator05_ BG)*

People undertaking GR work in hospitals

No permanent full time staff work on GR cases in the hospital. This work is often assigned to a person in the Department of Personnel as an additional task. This person often does not have training in the field. Most of their work is based on the experience and learning from a predecessor. Performance depends on the

individual, and is often difficult to assess.

According to senior health inspectors, the practice of GR requires special communication skills and sympathy towards patients who make complaints, especially those who have lost their loved ones. Therefore, GR officers are expected to ask about and learn from other people's experiences of how to deal with GR cases. The need for good communication skills is not equal for all cases. Some patients and their families only require one meeting or an explanation, while others might require a series of meetings, visits, reconciliation steps and compensation. In solving complaints, the attitudes of related and responsible actors are important in deciding what action is needed for the people who have made complaints.

> *Required skills from those actors include: collaboration, loyalty, accountability of each person and capacity of the inspector to get information from the relevant people – knowing how to ask the question to get the answers – and knowledge of the local context (because the people might be too tired; or might not want to answer). (GR_central_developer_1)*

> *Solving GR case requires experience not only in following GR procedures, and some of the tasks are difficult. When people have died, the officer needs to visit the family's house and have sympathy with this. (GR_Administrator10_ DT)*

GR officers do not receive sufficient allowance. Unlike health inspectors, there is no official allowance for the GR officer at the local institution. The actual allowance is therefore very varied, depending on the specific institution.

> *At this stage, there is no regulation on official payment to inspectors. Payment for inspectors is various, depending on the local decision. If the director feels it is necessary, inspectors can be paid extra from office*

funding (reporting etc); or get a DSA for field trips [undertaken for verifying cases], but these payments are very low: not enough for beef noodle soup. (GR_central_developer_1)

Besides the low allowance, people do not want to work on GR areas because it is not seen as technical work. In the health sector, most GR officers are health professionals and GR tasks are only temporary work for them. If complaints are received, they will work on them, and after the case is solved they return to normal duties. Therefore they do not spend much time studying related laws and regulations and have quite limited knowledge about the issues involved.

Training is organised for lower levels to learn about policies. However, time is too short and people do not care about the policies. (GR_Administrator03_ BG)

Since health professionals are not interested in GR work, turnover is high for these assignments.

There are often changes of officers in GR; after training they move to another job. (GR_Administrator05_ BG)

The new GR officers take time to learn the GR work and then quit the job again. This cycle creates difficulties for the institution because few people have good knowledge on how the GR process or the regulation works.

In public hospitals, there is a structure with a named peoples' inspection committee that consists of three to five persons, which may or may not include the GR officer. This committee is selected for a three-year term by staff and it works under Labour Union guidance. This structure is designed to protect the rights and benefits of Labour Union members. It is a voluntary, part time job, with no training or incentives, and no specific competencies required on how to

handle GR issues.

Other actors involved in GR work in hospitals

A new position required by government and MOH since 2009 is the lead inspector for GR. This is part-time job, and this and the rotation of staff within health agencies are reasons for the shortfall of staff in this position.

According to a key informant, the requirement for a lead inspector is not in effect in BG at all. In DT, the post is operational in only one district hospital (TN). However the main task of a lead inspector is to monitor the progress of GR implementation activities, rather than actually doing GR work.

Besides the peoples' inspectors and lead inspectors, the Vietnamese Communist Party inspector and Labour Union representative have also participated in GR processes when needed. All staff in hospitals, including directors and GR officers, have to ensure equity for patients as well as ensuring the reputation and income of the hospital.

Box 3: GR case study – Personnel handing the case

A case study in one hospital showed that the person in charge of GR came from the Department of Personnel. He had no training on GR cases and no allowances for this work. The officer thus took a self-learning approach to the process. However, it seems he had experience of many GR policies but according to him, there have not been many GR cases in the hospital. Those that have happened are due to a lack of attention to patients on the part of the hospital.

The motives of the complainants are to clarify the fault of the person responsible, to try to avoid similar mistakes the next time, and to make the public aware about their case. There was no one from hospital to visit the family after the case because they were all too busy. (GR_Implementer16_ BG)

In the hospital, there is a Patients' Council created by the MOH for

comments/feedback from patients about hospital performance, but this has some limitations (see Section 5.3.1.3). The objective of the Council is to improve the quality of health services in the hospital.

The GR complainant in the hospital is the patient who is not satisfied with hospital performance, i.e. diagnosis, treatment or the responsiveness of health providers. Patients want to get compensation for poor service or losses and also see this in the context of improving quality of services and equity for citizens.
The patients know their responsibilities and benefits while in hospital. Their knowledge on GR varies – in many cases, patients do not know about the Law on GR, but they know how to express their complaints to different channels. Many know they can go to meet the director or person in charge in the hospital when facing a difficult situation.

> *I know that I should first go to the director of hospital. If the case is not solved, then I will go to the provincial department of legislation, and VTV1 [Vietnamese TV station]. I know that I could ask for the hotline telephone to find out how to make a complaint. I know that doctors love their patients and they will tell me this information. I do not know about our Law on GR. (GR_User05_ DT)*

> *Complaints are addressed directly to the doctor in place if patients are rudely treated. The complaints could be sent to higher level: directors, district, provincial and MOH level and also to the police. But there are very few GR cases here. Patients do not know about any legal documents related to GR complaints. (GR_User02_ BG)*

Interviews revealed that knowledge in the local community about other channels for sending the GR complaints is still limited and this has an impact on GR processes. When people have better knowledge of the law and regulations, the hospital can proceed with dialogue and reconciliation and the process is much

easier than when people have limited knowledge on GR issues.

> *The level of knowledge is very different. Those who know the topic well, after listening to the explanation, they can understand. For those who have low levels of understanding, we need to convince them. (GR_ intepreter1_HN)*

> *If they know the regulation then everything will be very easily solved, otherwise it will be very difficult. (GR_intepreter1_HN)*

If the knowledge of GR varies across people, is there any possibility of characterising socially those who have good knowledge of GR as opposed to those who do not? There is the beginning of an answer here below.

Box 4: GR case study- Users' view

In the case study described in Section 5.3.1.3, after receiving compensation, the family was asked by the hospital to remove the complaint letter. Afterwards, they received a letter from hospital with a conclusion indicating that the health providers were not responsible for poor medical treatment because the case was complicated, above their capacity at district level and this very much related to the family's fault. The complainant was very upset about this conclusion. The family lost a child, a huge loss to the family, with physical, mental as well as financial costs, but this seemed to mean little to the hospital.

[The compensation] was nothing compared to the costs paid to the hospitals (at provincial and national level). The man was asked to remove the GR complaint letter and later they sent feedback stating that all failures were family related. This caused the family to feel angry. (GR_User03_BG)

However, the family accepted the conclusion because they are a 'low status' family and could not take the case to a higher level. They wished that, since the hospital knew that they could not handle the medical aspects of the case, they had sent the women to the higher level much earlier. This could have saved the child. The complainant felt very powerless and had lost trust in the health system.

Other actors

Numerous different actors were also involved in the different processes of the GR regulation, and their participation was similar across provinces.

The media

The media has been an increasingly important tool in the fight against corruption. This was emphasised clearly in the Law on Anti-Corruption, the socio-economic development plan and the national anti-corruption strategy (99). The growth of the media in Vietnam has been a fascinating process, including the evolution of newspapers and magazines, in print and as online newspapers.

The media in Vietnam is influential in the implementation of GR because, in principle, it is designated to receive complaints directly from complainants or find out about the case themselves. They can also send complaints to administrative agencies in the health system or broadcast the case in the mass media even without informing the particular health institutions. They often get into direct contact with complainants and publicise the case through the media: TV, newspapers etc. GR cases with media involvement can take a longer time to solve because more stakeholders may be involved when the case is released in public spaces.

In the past three years, the total number of maternal complication cases which appeared in online newspapers and other websites is only 27, including cases of maternal and infant mortality. This suggests that if this mechanism can occasionally solve an individual problem, it is not one to address collective issues. Readers often add their comments on GR cases to online newspapers to share their experience and sympathise with patients and relatives, and are able to criticise health providers. Some also express their understanding of the difficulties people face with the health system. Some cases appeared once, while others have appeared several times in the newspapers. Depending on the

sensitivity of the cases, there are different responses from the government and the health system. Some cases received attention from the Government Office, while others got attention only from the MOH and PHD. Most of the cases, however, do not reveal the outcome or final result such as who was fined or what happened following the complaint.

In most cases, the media sensitises the public towards any lack of or poor response from the health system. Health institutions in receipt of GR cases have a poor image in the public audience.

Journalists and other media actors are generally not welcome in hospitals for various reasons. The media is often perceived to be making a 'big case' out of something, which puts pressure on hospitals and affects their reputation. There is a view that many journalists want to make ‘profit’ out of GR cases.

In the experience of key informants, it is better if the health sector avoids getting into discussion with the media and should wait until a case is finalised and closed. The final decision on and conclusion to the GR case should only then be sent to the media for public announcement.

> *Experiences have shown that it is better not to discuss with the media and keeping silent is best. When there is no final conclusion to a GR case, there should not be any information appearing in the media. (GR_Administrator05_ BG)*

The media aims to get public attention by discussing/broadcasting different stories/cases. Their objectives are also related to equity and quality services provided to patients. However, there have been very few cases with media involvement in both our study provinces.

Lawyers

Since 2005, lawyers have been permitted to be involved in GR cases. However, since this change, there has been little involvement of lawyers because people are not used to this service. On the other hand, a lawyer is usually not welcomed by the health sector because this can make a GR case more complicated. It is assumed that a lawyer's primary purpose is self-benefit (i.e. to gain from the costs of legal services). However, by providing services, they can also ensure equity for patients. There were, however, no cases reported from either study province where lawyers had been involved.

People's Council

The local People's Council often organised meetings and reported community feedback on the performance of the health system to the directors of hospitals. Hospitals also have to review comments and send official feedback to the People's Council.

This structure has strong voice in local communities because the Council can make comments to the local People's Committee, which is responsible for the health programmes in the local area and can also mobilise resources, including for promotion to key positions at local level.

The local People's Councils have strong incentives to be accountable for citizens, and equity and quality services are important objectives for them.

Courts

Courts can be involved in GR processes if the case was not solved by the health sector. However, according to key informants, there have not been many GR cases associated with court involvement. No cases with court involvement were detected in either province under study.

State inspectors

State inspectors often collaborated with health inspectors in the administration of

legal documents for the health sector. They also support health inspectors in solving difficult GR cases. The main purpose of a state inspector is to ensure equity for citizens. According to local health inspectors, there is good collaboration between state inspectors and the health sector in proceeding with GR related issues in both provinces.

Professional technical committee

In solving complaints, the establishment of a professional technical committee for reviewing cases is sometimes necessary. There is sometimes a need to have this expert committee make the initial decision in the hospital where the complication occurred. The primary purpose of a technical committee is to ensure equity as well as protect the reputation of the health system. But this structure also has constraints because it depends on the availability of experts, and their ability to give time. In difficult and remote areas, it is quite difficult to establish this structure. No case with involvement of a professional technical committee was reported during the study in either province.

5.3.3.2. Actor power

Table 24: GR Actor power

Power/Potential	Low potential	High potential
High power	- Public / Private hospital (director and GR officers) - Local People's Councils	- MOH chief inspector - Provincial Health Department (director, chief inspector) - Head, District Health Office - Media - Courts
Low power	- Patients making complaints (GR users)	- Technical committee - Lawyer - Local state inspector

	- Patients' Council	

The analysis of actors according to their 'power' and potential is shown in Table 24. Actor power refers to the extent to which actors are able to persuade or coerce others into making decisions and to follow a certain course of action in GR processes (100). Power is derived from the nature of an actor's organisation or their position in relation to other actors. Potential is the extent to which an actor will affect or be affected by others. Both knowledge and rights affect the potential of actors in influencing the GR process.

It can be seen that most people in the administrative agencies of GR processes, such as the MOH and PHD chief inspectors, directors of the PHD and the head of the DHO have both high power and high potential. Their working position and their knowledge and rights give them both power and potential. For example, one chief inspector in BG PHD with good awareness on GR work guided the lower level to classify the GR case as a denunciation case and not to draw conclusions in terms of technical errors, in order to protect health providers' interests. This power has consequences on the GR process: guidance of this kind means patients cannot negotiate with health providers for compensation because the providers do not have to pay even if they are proven to be in non-compliance with the regulation. In contrast, patients can ask for compensation in complaint cases.

Although in this study, no case with media involvement was detected, analysis of the media's involvement in maternal health issues showed that it has a strong ability to sensitise public opinion, which therefore makes it powerful. Journalists can work directly with patients and broadcast GR information in the mass media. Many media actors also know a lot about GR process from other sectors, as well as the health sector.

The courts make the final decision on some GR cases, which makes them very

powerful in GR processes. However, not many people opted for court action because of a lack of litigation culture and because costs represent a significant barrier.

In contrast to actors with high potential and power, hospital directors, GR officers and the local People's Council have limited power. For example, a hospital leader has the right to make the final conclusion of a GR case, and can decide different sanctions for health providers with similar non-compliant behaviour. However their knowledge of GR is limited and they deal mainly with health providers' sanctions.

The technical committees, lawyers and local state inspectors have limited power because they are not in a position to make final decisions on GR cases. However, they have potential because they are knowledgeable about GR regulations. They can verify the causes of GR cases, and can have a direct impact on sanctions allocated.

The patients and Patients' Council have low power as well as low potential because they are not in the position to make decisions and are affected by others' decisions. Furthermore, they have limited knowledge on the GR regulation, such as about available GR channels or about how to make a case in writing, and do not make much contribution to GR processes.

5.3.3.3. The actor network

The network of actors involved in GR processes is illustrated in Figure 20. This also illustrates the relationships and characteristics of actors described in Table 23. In the figure, the size of a circle indicates power in relation to the GR process; the arrow indicates the relationship between actors in GR process and the thickness and direction of the line indicates the strength and direction of influence of one group on another.

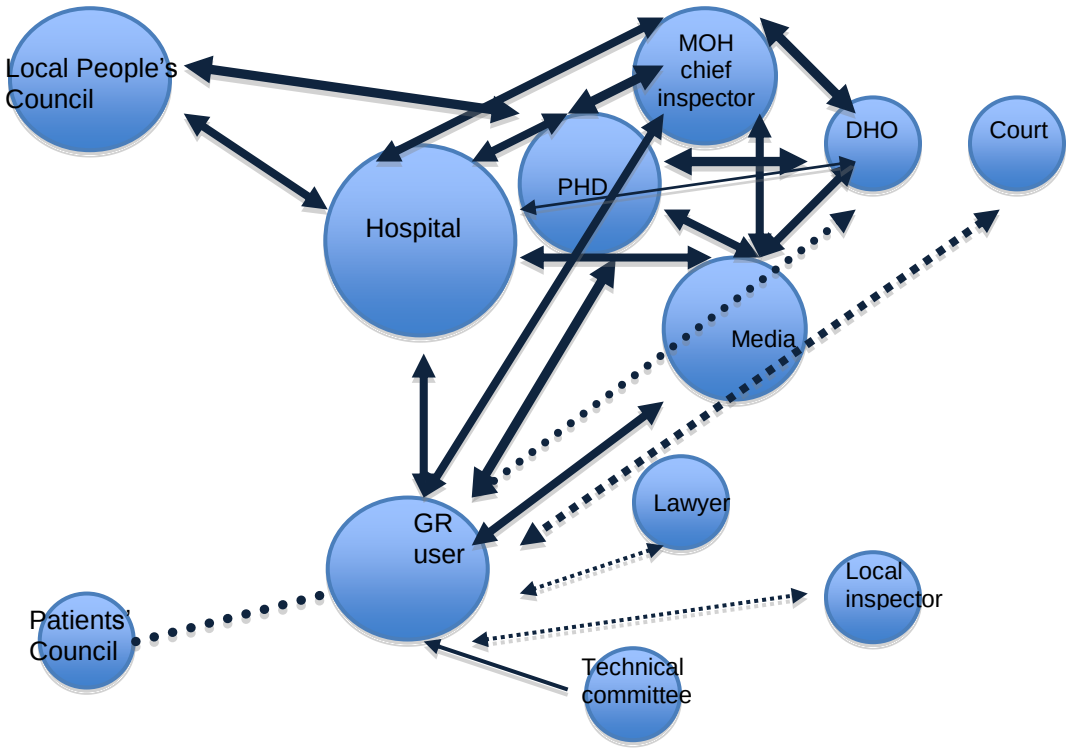

Figure 20: Actor network of GR processes in the health system in Vietnam

This figure shows that the network of actors involving in the process is broad and complicated. The relationship between two actors could, for example, be direct and very influential or indirect and not influential. The relationship depends on the power and potential between actors in a GR process. The relationship is also influenced by the context. Overall, good collaboration among the different levels in solving cases is shown in this figure. The hospital often asks for support from a higher level in guiding the case, and there is often good collaboration between related institutions (DPC, hospitals, home affairs, state inspectors etc) through meetings, telephone calls, visits and coaching.

Box 5: GR case study - Involvement of actors

In the case study presented in section 5.3.1.3, it can be seen that different actors were involved in the GR implementation process. People knew the GR case procedures well, both users and providers. Evidence used in the process was cross-referenced to different sources. The person targeted for complaints received a sanction through a reduction in their extra allowances for six months and the case was made public in the hospital and in the broadcasting network. The health providers agreed with the hospital's decision. They knew their weaknesses and lack of competency. Although the complainant family was not happy with the hospital's decision, it accepted the compensation.

Although this GR process was good, it can be seen that generally insufficient efforts are made for GR processes in hospitals. Involvement remains a part-time job, with no training and few incentives and therefore there is little motivation to work on GR cases.

5.3.4. Contextual factors affecting the regulation

In analysis of GR processes, a clear link can be seen between the context and the process. Typical contextual factors influencing GR processes are the health system as well as regional socio-economic and cultural/behavioural factors.

5.3.4.1. Lack of resources for GR work at all levels

Interviews noted a lack of human resources for GR work at all levels, but especially administrative inspectors in the MOH and PHDs. At the local health facilities, there is no official post for GR work. GR cases are most often taken on as a part-time job. Most people who handle GR work are health professionals, who do not care much about regulation in general. Therefore, many of them are

not dedicated to the job.

Furthermore, resources spent for GR work are insufficient. Feedback at all levels showed that people received very small allowances and have to do other jobs to make a living. They do not receive enough financial support for organising training courses for the administration of different health regulations, including GR, and they do not have training on GR work. The lack of resources, both material and human, has contributed to poor conditions for GR performance.

5.3.4.2. Hospital autonomisation and marketisation in health care

There are two government decrees – Decree 10 (effective in 2004) and its replacement, Decree 43 (effective in 2006) – aimed at improving the quality of public services by providing greater financial and managerial autonomy to public service delivery units. These decrees grant greater discretion over service organisation, the allocation of financial resources, and the management of personnel. The implementation of these decrees is thought by the MOH to contribute to reducing reliance on the central budget and to freeing up scarce budgetary resources, which can then be channelled to those sections with the greatest need (3). However, interviewees felt that the implementation of these decrees in the context of the commercialisation and commoditisation of health services was resulting in the worsening of health sector inequalities.

The implementation of the GR regulation showed that the directors of all public hospitals are under pressure from autonomisation. More than ever, hospital directors need to be aware of, and protect the reputation of the hospital and make an effort to attract patients into public hospitals in order to generate incomes. This suggests an increasing marketisation of the public health system and concurrent threats to patient well being (3).

The market economy and hospital autonomy have contributed to income

generating activities. They have also created the need to protect the hospital's image and reputation among the public. So public hospitals and/ or private practices attempt to solve all cases at the local level. Only a few cases that cannot be negotiated and solved locally go up to the higher level.

> *Very few GR cases go to the higher level since the hospitals try to solve the case themselves by offering compensation. The hospital sees the needs of patients in terms of compensation, and where they can pay to solve the case, they do. However, public institutions do not have a clear compensation level, so if for this reason the case cannot be solved, then the case does go up to the next level. (GR_Administrator10_ DT)*

This practice is more applicable to private practice, because private practice is more flexible than the public sector and can negotiate compensation better.

> *Few GR cases come from private practices. If there are cases, the GR officer directs the people to meet and negotiate amongst each other. Mainly cases are related to practitioners not having licenses, but the fines are very low – three million [dong]. (GR_Administrator05_ BG)*

Many people do not want to make formal complaints while they are in the hospital, or realise they may need to come back to the facility at some point in the future, and this can constrain their motivation to make complaints. On the other hand, most GR inspectors and hospital leaders confirmed that users have become much more demanding in standards of service. It can also be seen that the number of GR cases has not been declining in recent years, even while registered cases remain limited in number, and there are many complaints made in direct meetings with persons in charge of the services. Especially if a case has ended with severe complications or the death of a patient, people also want compensation for their loss, which is true for both private and public facilities:

Our economy is socialist with a market orientation. This leads the country to move towards this direction. The law should also clearly state whether doctors' behaviour is considered administrative behaviour or market behaviour, so doctors will know when they need to pay for their non-compliance or mistakes. This should be very clear, but it is not so clear at this moment. (GR_Administrator05_ BG)

According to the GR inspectors and different administrators in charge of private health management, economic competition among providers is the main cause of GR cases in this sector, for example in cases of denunciation of a facility practicing without a license or registration, or practicing beyond their registered scope.

5.3.4.3. Ineffective management of private practice

Private practice is managed by the DHO. In DT, private practices send reports to the CHC which forwards these to the DHO. In BG, all private practice sent reports directly to the DHO. However, the DHO lacks human resources and they do not have sufficient resource to manage all private health facilities. Therefore, GR cases involving private facilities are not followed by the DHO, unless the cases were specifically sent up to the DHO or PHD.

The DHO officers would like to go back to the old model, where the district health centre consisted of a hospital, preventive medicine services and was responsible for CHCs in the district.

The split of three DH models created so many problems: lack of human resources, poor competencies, and competition among the leaders of the three district institutions which do not collaborate well. This is a waste of resources. (GR_Administrator09_ DT)

5.3.4.4. Different behaviour among Northern and Southern people

Respect and trust for the health profession is very common in Vietnam. People understand its value in saving people's lives. They sympathise with the difficulties facing the health system. People start making complaints only if the health problem or incident is severe (in terms of complications or death). Moreover, people are now also much more aware about their right to make a complaint and as a result do often make direct complaints to the person in charge in the hospitals. Direct and straightforward behaviour is more evident among Southern than Northern Vietnamese people. This is illustrated, for example, by the fact that the majority of GR cases received by DT-PHD are related directly to the PHD authorities. In BG province, by contrast, only about 40% of cases are related in this manner.

> *The culture of southern people is very direct. Therefore, they often make direct meetings with the director. (GR_Implementer19_DT)*

In BG, on the other hand, a majority of cases identify a problem without naming the complainant. Sometimes in the Northern province, anonymous GR cases are also used to accuse people with whom the complainant is in conflict. Complaints can be used to prevent the promotion of other people by making complaints against them before the Party Congress or promotion process:

> *There are different types of complaints: some are related to sensitive periods, like before the Party Congress or during someone's preparation for promotion. (GR_Implementer09_ BG)*

This behaviour has contributed to the variation in the governance of GR cases in different regions. Health inspectors, hospital leaders and related people have learned from experience and have applied actions appropriate to the situation. For example, the DT PHD reported the results of anonymous GR cases on their

website and BG PHD applied specific tactics for solving GR cases with ‘internal causes’.

5.3.4.5. Corruption

Corruption is widespread and could be considered as endemic in Vietnam despite Government efforts (101). The issuance of the Law on GR was the first governmental strategy to fight corruption, to give the citizens the right to lodge formal complaints over administrative abuses and to ‘denounce’ corrupt officials. Later, the grassroots democratisation decree was promulgated to mandate local governments to take all necessary steps to ensure that procedural democracy is respected at the local government level. Both regulations aim to regulate the interface between citizens and the local state. However, both the Law on GR and grassroots democratisation decree have had limited effects on anti-corruption measures due to low incentives for local government officials and weak civic engagement (102).

Later, the Anti-Corruption Law in 2009 was enacted with a set of decrees and other legal documents to give guidance on the implementation of the law. The responsibilities of the heads of government agencies were clearly defined in one decree. All government officials and civil servants are required to disclose their assets. However, the effects of this law are also limited (101).

Informal payment is quite popular in the health sector in Vietnam. Petty corruption through the envelope-giving practice is considered as normal as tipping by many people within the health system, partly because of the low salaries of health providers (101).

In GR processes, the chief inspector emphasised the influence of the ‘corruption environment’, which undermines the ability of leaders of health facilities to make straightforward sanctions in cases of violations in private practice, because

personal relationships can play an influential part in reducing the level of the sanction.

Low awareness of laws and citizens' legal rights has created obstacles to fighting corruption. Citizens do not know about the Ordinance on Grassroots Democracy, a fundamental piece of legislation establishing the rights of information and participation. Furthermore, executive dominance, bureaucratic fragmentation and the lack of an organisational platform for an independent watchdog within civil society, along with lack of correspondence between the delegation of authority and the new accountability mechanisms at the local government level has contributed to the limited effects of anti-corruption measures (102). To prevent corruption, support should be given to the agencies involved directly in anti-corruption activities, like the Government Inspectorate, State Auditor and Courts.

5.3.5. Effects of the GR regulation

Our study explored the broad question of how the health system redressed the grievances of patients. The study has shown that the implementation of the specific regulation formulated by the MOH on solving complaints under the framework of Law on GR was rather limited. The patient's complaints were redressed using the Law on GR instead in many health facilities. Different reasons were given for this. Therefore, the effects of GR regulation explored by the study are more likely to reflect the effects of the Law on GR than the MOH regulation.

Nevertheless, this does not change the broad research question on how the health system redressed patients' grievances. The primary objective of the GR regulation is to ensure equity for citizens in making their complaints. Effective implementation of the regulation will contribute to improved accessibility of quality health services, including maternal health.

5.3.5.1. Introduction of clear procedures for solving GR cases, with variation in implementation in different provinces and health facilities

The objectives of the GR regulation are to ensure equity for all patients in making complaints. This is a guiding principle for solving GR cases in all facilities and is clearly reflected by the key informants:

> *Equity is the guiding principle for solving all cases. Although there is not absolute equity, there is always attention to making this better. (GR_ manager1_HN)*

> *This regulation protects the client's right. They pay for the services and they should receive the respective services. The hospital should be responsible for answering queries from the people. The client's right should be ensured. (GR_central_developer_2)*

With this aim, the GR regulation provided clear procedures for GR cases with four steps identified, from receiving to solving and closing the case. However the implementation of these steps is greatly varied among the provinces and depends on several contextual factors.

Citizens can exercise their right to make complaints through different channels inside the hospitals (via mailbox, direct feedback etc.) or outside hospitals (via People's Council or the DHO/PHD/MOH). However, many of these channels remain ineffective and not all people know about them.

Although the GR regulation requires all complainants to identify their names and address details, many patients use an anonymous approach to address their complaints to the heads of hospitals or the DHO/PHD/MOH, in order to protect their confidentiality and avoid 'bad effects' if they should use the services in that hospital again. In addition, not all complaints are addressed because they are not considered significant, although DT PHD still reviews these cases and publishes

results on their website.

Through the assessment of the different processes of the GR regulation, it is clear that human and financial resources, as well as other kinds of necessary support, are lacking. People undertaking GR are often not competent or dedicated to the work. Thus, one cannot expect good governance of the process at all levels.

Our findings show that the GR regulation has had limited effects in ensuring equity for patients.

5.3.5.2. Limited effects in improving quality services

Our exploration of implementation of the GR regulation in hospitals showed that most GR cases were solved at the local level. Hospitals try to negotiate with patients and provide compensation where necessary. Hospitals prefer not to send cases to higher levels or to the media, because this could affect the hospital's reputation in the market economy. Procedures for solving complaints have also allowed people to invite lawyers or bring the case up to different levels including to the courts, if they are not satisfied with the decision at a lower level in the health system. However, few people are using these options because people are not used to this practice. This finding provided evidence to show that the GR cases are not open to public scrutiny. Therefore, feedback loops do not function effectively and this affects quality of services by inhibiting the process of lesson learning from GR cases.

According to a key informant, health providers would be more responsible for their behaviour if GR cases were managed well and equitably. Good GR case management can contribute to an improvement in the quality of services through a regular 'reminder' mechanism of responsibility issues in different channels, including staff meetings, direct meetings with complainants, visits to the

households etc. Health providers will absorb lessons learned and become more responsible for the health services. In some hospitals, there was awareness of this process, and improvements in quality service were evident.

> *GR case management has good effects on health worker performance. They become more educated on GR procedures, and pay more attention to technical responsibilities according to the Law on Examination and Treatment (LET). If they make mistakes, they are responsible for these. (GR_Implementer18_ BG)*

Health providers generally did not want to repeat the same mistake because this would affect their professional integrity and satisfaction. They might also receive more severe sanctions for a second error.

> *Health workers do not want to have a GR complaint again, because this is not good, they will get a more severe punishment. (GR_Implementer37_ DT)*

However, sanctions in hospitals could not be straightforwardly applied to staff responsible for mistakes for various reasons, including corruption and a shortage of human resources for health. The sanctions applied to staff are modest, such as a reduction in monthly allowance, and therefore do not necessarily have much resonance for changing the behaviour of other health providers.

> *[There have been] no repeated cases by the same person, but similar cases have happened to new people.. (GR_Implementer22_ DT)*

There were also no sanctions for PHDs or institutions that had not submitted reports on GR cases to the higher levels (only two thirds of provinces submitted reports). The PHD only can report the cases that they are in receipt of information about.

The limited feedback loops, accountability and sanctions are constraints to the effects of GR in improving quality of services, including maternal health.

5.3.5.3. Unintended effects

There have been some unintended effects of the GR regulation for both providers and patients. Results showed that one motive for making complaints is that complainants want to receive compensation to cover their economic losses, especially in BG where the chief health inspector puts this tendency down to poverty. To protect their reputation, hospitals are also inclined to negotiate with patients by paying compensation to avoid a written GR complaint or having the case sent to a higher level. This is an unintended effect of GR regulation in the health system.

> *The main reason is that BG people want compensation on GR cases, because they are very poor. After getting compensation, they will remove the GR complaint. (GR_Administrator05_ BG)*

In other cases, the relatives of health workers who have conflict/competition with other health workers have submitted complaints against those workers at sensitive times, such as shortly before a five year Party Congress, or when the complaint receiver is preparing for promotion.

In some hospitals, sanctions such as reduction of the monthly allowance applied to staff guilty of misconduct or malpractice has had some unintended influence on the behaviour of other staff. According to one hospital director, many nurses do not want even to speak with patients because they do not want to receive complaints. This is an important and unintended effect of the GR process in hospitals.

Hospital staff members now take a passive position. They do not respond to patient's queries because they do not want to lose their allowance/grading ABC if any complaints toward the staff arise. They are so patient now. They are nurses, and do not speak in a very diplomat way generally, so they try to be silent in meeting with patients. This is not good for the health services because their job is to listen and to interact with patients. (GR_Implementer19_DT)

Box 6: GR case study - Unintended effect

In analysis of the case study, it can be seen that poverty is a driving force for making complaints, in the hope of getting compensation – in our study, the family said they had spent a lot of money. The chief GR inspector in BG asked the family to identify the person responsible (make an accusation/denunciation). If the case is a denunciation GR, this means the family are not entitled to ask for compensation, thus reducing the burden to the hospital. Unlike in a complaint case, if the hospital decides to pay compensation anyway, this is through 'good will' rather than by compulsion as it is not required by the law.

5.3.6. Discussion

The study provided information on how patients' complaints at hospitals were addressed by the health system. Given the special nature of the health profession in dealing with people lives, the MOH suggested certain steps/actions for solving complaints in three areas (quality of drugs/vaccine; food safety; and medical examination and treatment) in the MOH instruction on solving complaints in 2005.

The main findings were revealed by the study, as follows:

1. The intended effects of the GR regulation on redressing patients' complaints were modest with regard to equity and quality of health services. Although clear procedures for solving GR cases have been introduced, implementation is varied among the provinces and health

facilities. Improving the quality of services through GR experience does not receive sufficient attention in the GR processes, because hospitals are afraid of damage to their reputation, and so there is a lack of public reporting on GR cases and ineffective feedback loops.

2. Unintended effects are revealed as, amongst others, emerging evidence of some patients taking advantage of compensation possibilities through making complaints. The private sector is not affected by the MOH regulation on GR.

The following discussion will try to address factors related to approaches, processes and actors that influenced the intended or unintended effects of the GR regulation.

The study has shown that the MOH regulation was developed with considerable effort from the inspectorate unit in the MOH with a very clear intention to help the health system to redress complaints in the three most common areas (drugs/vaccine; food safety; and medical examination and treatment).

The regulation was well administered by provincial chief health inspectors – all confirmed receiving this regulation by hard copy and informed others in meetings. However, there was evidence to suggest that the regulation was not administered and implemented in the health facilities, including in the DHO. All key informants in these facilities confirmed the Law on GR was used as the only reference for solving complaints. The question is why the MOH regulation was not administered and implemented in local health facilities. Different factors could be said to contribute to these findings.

Approaches, processes and actors

The MOH regulation on GR has a typical state command approach, in that it was designed by the state organisation for application mainly in the public health

sector. The necessary procedures and mechanisms were designed for receiving GR cases, classification, managing, solving and closing cases. Different obstacles for effective implementation of GR regulation were identified in the study, such as lack of resources for GR work at all levels, ineffective feedback loops, the influence of the process of achieving financial autonomy in hospitals, ineffective management of private health facilities and also corruption.

The low legality/utility of MOH instructions on solving GR limited its use at the provincial level. According to the hierarchy of legal documents in Vietnam, a law is the legal document passed by the National Assembly and all levels, including the MOH, must comply with this. The ministerial level, including the MOH, has the responsibility to enact a circular of detailed guidelines for implementation in the ministry's sector. The guidelines developed by the MOH, as described in Chapter 4, included recommended activities for solving complaints in hospitals, such as review of medical records, laboratory tests, seeking the opinion of professional experts. The case study revealed that some of these activities were applied in GR cases in district hospitals. However, this happened very much under the guidance from the provincial chief health inspectors and experiences from other people. The guidance provided in MOH regulation was not cited as being used for solving cases.

The MOH regulation is only a detailed guideline for implementation in the health sector. Although it gives the flexibility to decide which implementation level to choose and whether or not to follow the regulation, there are limited incentives for chief health inspectors to use it and they did not guide the health facilities to use the MOH regulation for solving complaints.

The chief provincial health inspectors perceived the Law on GR as important as providing a mandate in solving complaints. They organised training on the Law on GR for different actors in the provinces, with assistance from provincial state inspectors. They directly interacted with other officers/bureaucrats assigned to

the GR case at lower levels, and guided them in solving complaints. In BG, the chief health inspector gave guidance and advice to the lower level on classifying complaints as denunciations, which has resulted in a decreasing number of complaint cases in BG in the last year (see Section 5.3.1.3). This was done based on the perception that health providers do not aim to harm anybody. Often complications occurred which were not merely due to health providers themselves. In the denunciation case study, even the violating person was not identified as responsible for paying compensation.

It may be significant that it is only the Law on GR that allows this flexibility in solving complaints and denunciation cases, not the MOH regulation. The provincial chief health inspector used this flexibility to arrive at a coping mechanism to control the stress and complexity of day-to-day work in solving GR cases in health facilities. This strategy is helping to avoid the unintended effect of the GR regulation of abusing hospital compensation systems. This explains his preference for classification of GR cases as denunciations and guiding the lower level to use the Law on GR to solve GR cases.

These findings explain why the Law on GR was used for solving complaints in all health facilities in two provinces. This is a typical failure of a top down approach to policy implementation (103). The central chief health inspector sees implementation of the MOH regulation as a rational process that can be pre-planned and controlled by health agencies, particularly those responsible for the formulation of the regulation. The failure in implementation of the MOH regulation indicates the gaps between the regulation's objectives and achievements, as well as the results of failing to plan adequately for implementation. If the mandate is not very high, it allows some flexibility in choosing whether or not to implement it. This could be seen as a variation of street level bureaucratic action, whereby typical bureaucrats often interpret and implement regulations in the way that suits them (42). In the case of GR cases, the provincial chief health inspectors facilitated GR implementation in the provinces by making the Law on GR into

public policy, rather than the MOH's guidance for GR implementation in the health sector. The developer of such regulations should consider the level of regulation before the formulation stage: if it is only at guidance level, not much can be expected in terms of compliance.

This finding emphasises the need to understand implementation systems and the actors responsible for implementation in order to understand why policies do not achieve expected outcomes. The provincial chief inspector is the key person who should have received more attention in the study. In order to strengthen the implementation of MOH regulation, feedback loops between different levels should be improved. In order to achieve this, inter-personal confidence and trust between central – provincial – lower levels in the health system is necessary.

Governance of information

This section sets out to explain, based on the above analysis, why the effects of the regulation were limited, using the four criteria of good governance introduced by Lewis et al (57): information, standards, incentives, and accountability. In order to ensure the intended effects of a regulation, its good governance in the health system is necessary (104). Good governance in solving GR cases will raise the level of health outputs (the number of solved GR cases), and can contribute to improved health outcomes (the quality of health services and improved health status).

In the study, it can be seen that information on the GR regulation (how many cases were solved, and which sanctions were applied to which cases) was rather scarce at all levels. The annual MOH report on GR regulation was considered confidential and was not disclosed to the public. Limited feedback loops on supervision, reporting and other feedback channels illustrate a lack of information on GR to all relevant actors. The reports received from the lower level did not include information on GR cases solved at that facility's level, which made up a large number of GR cases taking place at health facilities. The involvement of the

media and lawyers is limited due to cultural behaviour. Cases occurring at local health facilities are often not disclosed to the public. Therefore, transparency of information on GR is missing from the agenda. The public cannot access reliable information on which hospital is good and which is not, or on actors within them.
Significant differences in the governance of information between BG and DT province were also revealed. DT province proceeds with anonymous GR cases, while BG province does not. This could be related to the different behaviour of Southern and Northern people – anonymous cases are much more common in the North, and this may be why BG province does not want to deal with them.

Transparency of information

Technical information is not always made transparent to patients, because of a perceived need to protect health providers.

> *Transparency is important. However, not everything could be transparent in solving GR cases, especially when things are related to a health professional's performance (malpractice). This is necessary to protect the health professions. (Administrator 09_GR_DT)*

The case study clearly illustrated this aspect. The patient was told the cause of foetal death was a severe illness that the hospital was not able to cure. Whether this was the true cause or not, nobody was able to find out because no technical professional committee was set up. This is an indication of limited 'standards' in the governance of GR regulation. It could also be related to the common characteristic of 'information asymmetry' between health providers and patients in heath care delivery (105). Patients may be able to provide a description of symptoms, but they have inadequate information to relate their condition to a particular type of treatment or course of medication. In the case study, the hospital said the problem was related to an incurable condition of the pregnant woman. However, the family was uncertain whether it was related to incurable illness or the consequences of delayed treatment. The hospital's answer was not

satisfactory but the family had to accept it.

Furthermore, clear benchmarks or criteria are necessary to inform the public on certain procedures in solving GR cases. Hospitals' preference of denunciation over complaints was made possible by the lack of clear criteria for each, which in turn gives an advantaged position to health providers in relation to patients.

In Vietnam, GR complainants have limited knowledge of both health care issues and of the GR regulation. They respect and trust health providers. At the same time, they do not know much about citizens' rights and are not familiar with the possible litigation process. Though the Vietnam Women's Union, users can voice concerns through meetings with the local Peoples' Committee, where the health sector is one of the members. However, at the individual level, the ability to ask for transparent information from health providers is limited, making the asymmetry of information more severe. It also creates unequal power between health providers/hospitals and patients, which the former may exploit in their own interest (105). This was also clearly illustrated by the advice given by provincial chief health inspectors to the lower levels to avoid drawing conclusions on medical treatment errors, because this will lead to court involvement. Patients will never know the real causes of complications or deaths because they have insufficient knowledge of the possibilities open to the health providers.

Incentives

It is clear that health officers doing GR work at all levels are not happy with the allowance, training and development that they received. The resources invested for GR works are less than desirable, including for M&E, reporting, coaching activities and training etc. Most people expressed concerns about low motivation/incentives to work in this field. These low incentives partly explain the use of coping mechanisms such as the street level bureaucrat activities mentioned earlier.

Accountability

It is clear that the sanctions applied to violating behaviour/persons are critical, because they are significant for educating health providers and in ensuring quality health services. However, for several reasons (such as lack of human resources for health, hospital autonomisation and corruption), sanctions applied by the leaders of hospitals are very limited and not straightforward. Very few kinds of sanctions were applied, the most common being the reduction of the additional monthly allowance. This sanction has very limited financial significance, amounting to about 30-60 USD), and therefore has little effect on the violated behaviour/person. This reflects poor accountability in the governance of GR regulations. Similarly, no sanction was applied for failure to submit reports on GR in both public and private sectors. We can conclude that, in the current sanctions environment, the improvement in quality of health services through the GR regulation will be very modest.

Difference between maternal and general health

The study revealed that there is not much difference in the administration, implementation and evaluation of regulation between general health care and maternal health care. The common modality of administration is receipt of a document, classification of document, sending it to a department in charge of document, and taking subsequent action, such as developing a plan for implementation, photocopying the document, sending it to related actors by post, email, or website depending on the context of the local institution, and disseminating the regulation in the staff meetings. The speed of responses depends on the nature of the topic – whether it is an emergency or not. However, maternal health regulations are administrated within the MCH network: regulations proceed from the MCH department to provincial reproductive health centres and to lower levels through conference/meeting and M&E mechanisms.

The study, however, revealed a difference in administration, implementation and evaluation between the public and the private sector. There is lack of attention by the administrative agencies to the private sector due to lack of resources (human

and financial) in administration, implementation and M&E activities. Less private health facilities are invited to attend the administration of key regulations. Therefore, there is poor compliance in the private sector with reporting and ensuring quality of services. Moreover, no sanctions were applied to this poor compliance. The ineffective management of private health practice explains this situation. According to the health administrators, the private sector also receives fewer complaints on poor attitudes by health providers compared to the public sector. There have been almost no GR cases from the private sector sent up to higher levels because private practices try to solve these at the local level.

5.3.7. Conclusion

In conclusion, the MOH regulation on solving complaints has provided clear procedures for GR cases. However, implementation was varied among provinces and health facilities. Limited effects were evident in ensuring citizens' rights and equity in making complaints and improving the quality of services. However there is very limited use of the regulation in health facilities. Some unintended effects were shown, such as the common practice of negotiation and settlement between health facilities/providers and users and no application of the regulation in private health facilities. Contextual factors influencing the GR processes have been identified, such as health system factors (reform, lack of resources), marketisation/ autonomisation, ineffective management of the private health sector, and corruption.

The governance of the regulation on GR is weak. Inadequate incentives for GR work; lack of information on GR regulations at all levels; lack of standards on GR regulation; lack of authority to hold hospital leaders accountable for GR sanctions; together these undermine the performance of the GR regulation.

Although the awareness of GR by service users has improved, many barriers prevent effective implementation of the GR regulation, such as information asymmetry between providers and patients and the influence of street level

bureaucrats. Patients are in a much less powerful position than health providers, which gives the latter opportunities to exploit the former in favour of their own interests. The complexity of GR work, influenced by different contextual factors, has pushed GR officers into a strategy of acting as street level bureaucrats.

In order to improve the situation, there is a need for extensive social and political change at the macro level. The government, MOH and leaders of local health facilities should have clear tools to reward and penalise behaviour. Continued improvements to quality, the client centred approach and advocacy is the best solution. Re-design along these lines will better equip health providers to prioritise client's needs, take responsibility for their care, and advocate for them.

5.3.8. Recommendations

Recommendations for better governance of GR regulation at all levels:

- **Information asymmetry** needs to be addressed, transparency should be ensured, and users should have choice on the basis of information.
- **Information** on the GR regulation should be updated and shared among all relevant actors.
    - Incentives for sharing information should be introduced by the MOH, instead of deducting hospital marks for high numbers of GR cases.
    - Information should be made available in the report cards in the hospital, and through websites and open consultations.
    - The interest of patients and the Patients' Council in the GR regulation should be raised through various channels: the mass media, regular meetings in the hospital to inform patients about their responsibilities and benefits, and through CSO's involvement.
    - Regular M&E and reporting systems should be improved, including for private practices.
    - The capacity of technical committees, lawyers, local state inspectors should be strengthened to get them more involved in GR

implementation and evaluation in the health system.

Standards of GR regulation should be reinforced. A mandatory factor in the implementation of GR regulation in the health sector should be introduced. This will help to avoid discretionary actions in favour of health providers and ensure equity of citizens. In addition to this, the possibility of creating external an independent mechanism to mediate patient-provider interaction for GR processes should be an option.

Incentives for all actors who are doing GR work should be ensured. The government should invest more for GR work at all level because of its importance in ensuring equity and quality health services. At local health facilities, leaders should recognise the importance of GR work and invest sufficiently.

- Sufficient resources should be provided for GR officers/work in hospitals (such as a permanent assigned person with an allowance, and training and other resources).
- Feedback channels should be improved, including through the People's Council, direct feedback, and in solving anonymous cases if possible.
- The balance between actors' priorities should be addressed, without too much focus on income generating.
- Emphasis should be given to the opportunity for learning and improving health services from GR.

Accountability: The MOH, government and leaders at all levels should have tools to reward and penalise both good and violating performance. These should be sufficient to educate staff and enforce quality improvement, rather than simply have symbolic value. The MOH should consider equity as a wider goal of society as a citizens' right. A balance between actors' priorities should be established, rather than focusing on

income generating only.

- Experiences of GR cases should be shared, especially in recommending use of the non-mandatory regulation from the MOH.
- Chief health inspectors, the media, the DHO and courts should collaborate in solving GR cases.
- Funds for compensation of medical errors should be provided in cases of unintended consequences.

CHAPTER 6. COMPARISON OF THE THREE CASE STUDIES

6.1. The regulation framework

The three case studies investigated three different regulations concerning maternal health and health in general: EMOC, ANC and GR. Findings from the studies suggest that these regulations are potentially political tools/ mechanisms to achieve goals on reducing MMR, stabilising the sex ratio and ensuring citizens' rights. Implementation of the regulations is influenced by the extent of political will, consequent administrative interest, resource allocation and, most critically, the power of different actors in the regulation process.

6.1.1. Content

The EMOC regulation deals specifically with maternal health services in that it specifies the delivery of both comprehensive and basic EMOC services in different health care facilities according to their technical functions. The ANC regulation deals with maternal health in prohibiting ultrasound for sex determination purposes in health facilities, both public and private. The GR regulation deals with the issue of how to ensure citizens' equity in making and solving complaints concerning medical examination and treatment at health facilities.

Thus two of the three regulations directly relate to maternal health services. The GR regulation does not specifically deal with maternal health, although many complaints concerning medical examination and treatment are related to this area.

The EMOC and ANC regulations are both related to clinical areas, but the EMOC regulation has much more complexity in addressing eight services for basic and

comprehensive functions, while the ANC regulation is only concerned with ultrasound diagnosis of foetal sex during antenatal care visits. In contrast, the GR regulation has no specific relation to clinical services.

The EMOC and GR regulations were technically guidelines, providing enabling conditions for the implementation of services. In contrast, the ANC regulation specifies restrictions / prohibitions in the context of service implementation.
Furthermore, both the EMOC and GR regulations were mainly designed for the public health sector. The private health sector is guided by the Ordinance on Private Practice Medicine for similar services.

There was no specific binding mandate for the implementation of either the EMOC or the GR regulations. In contrast, the ANC regulation was technically a legal decree and therefore implementation was mandatory in all health facilities, including private practices, at all levels of the Vietnamese health system.

The difference in mandate among the regulations is related to their objectives. The EMOC regulation was part of a technical assignment by the MOH (Regulation 385/2001 BYT or 23/2005), which provided standards for all health facilities to strive for, with the assumption that all conditions are enabling for effective implementation. Given that these conditions are not always met in practice, these were to be considered as desirable standards and no mandate was set.

The MOH regulation on solving complaints (GR) was an initiative of the MOH to provide recommendations of activities to be considered in the process of solving complaints in the areas of drug/vaccine quality, food safety, and medical examination and treatment, and also made the assumption that conditions for effective implementation were available. Since these are recommendations, no binding mandate was set.

In contrast, it is compulsory for all health facilities to implement the ANC regulation. The additional regulation on administrative penalties for violating behaviour/facilities further reinforced this mandate. This also showed the strong commitment of the government to achieving a balanced sex ratio in the country, regardless of the existence of favourable conditions for effective implementation.

Since the content of the three regulations differs, the actors responsible for the regulation process are also different. For the EMOC regulation, the main actors are maternal health providers at different levels, such as the MCH department at the MOH, the department of PMM at the PHD and the OBGYN department at hospitals. Although the ANC regulation is dealing purely with maternal health services in the form of ANC visits, the imbalance of the SRB is the responsibility of the GOPFP, and therefore the main implementing agencies are the population and family planning network. Solving complaints under GR is the responsibility of the inspection network.

Improving EMOC is an important strategy for reducing the MMR in Vietnam, an issue that has received much attention from different actors, including donors, resulting in two revisions of the regulation document. In contrast, the topics of the other regulations are not priorities and no official evaluation has been conducted (see Section 6.1.2 below).

The design of each of the three regulations shows some deficiencies, which constrain their effectiveness. For all three, a lack of attention to feasibility, especially resource availability, can be seen, creating a clear mismatch between policy intent and resource allocation. The GR regulation is especially under-resourced, in both financial and human terms. The design of the regulations does not take sufficient cognisance of the appropriateness of and capacity of the health bureaucrats interpreting and implementing it at lower levels of the health system. For example, the ANC regulation does not take into account the tension between the well-established small family policy and the prevalent strong desire

to have a son in the family. In the process of implementation, the population inspectors do not have sufficient power to make inspections or to sanction non-compliant behaviour. In the case of GR, the regulation design originated outside the health sector and thus implementation was challenging within this sector because it has its own specificities: usually, for example, people make complaints only when extreme problems have occurred such as severe complications or death. Human resources are reportedly inadequate in all three regulations, both in terms of quantity and motivation to work in implementing positions. These design deficiencies have constrained the effectiveness of the regulations.

6.1.2. Regulation processes

The three regulations have gone through different processes. While evaluations of the GR and ANC processes are yet to commence, the EMOC regulation has already been twice amended and revised. These differences in processes are very much related to the nature of the issues addressed by the regulation. EMOC coverage is important for the achievement of the MDG targets on reducing MMR in Vietnam. Therefore, this has received a lot of attention, and various projects aimed at reducing MMR have been conducted with support from different donors, including the UNFPA. Evaluations of these projects brought to light the need to update the EMOC regulation.

GR is an important topic prioritised by the Party and central government. Ensuring citizens' rights in making and solving complaints is linked to the political commitment to combat corruption in Vietnam. However, anti-corruption strategies have not been very successful in recent years. Moreover, in the health system development plan, GR is yet to receive attention from the higher levels. More urgent topics such as health financing; health insurance; health service delivery and human resources are higher priorities. Therefore little effort and resources have been committed for evaluation of the regulation (106).

The sex ratio imbalance is becoming an increasingly important issue in Vietnam, especially after the results of the 2009 census were released (50). It attracted the attention of the National Strategy for Population and Reproductive Health 2011-2020, which set an objective to reduce the sex ratio imbalance to 115 by 2020 (107), although in 2009 it already stood at 110.6. This issue has been earmarked for policy evaluation with support from UN agencies in the future (50). Up to now, maternal health policy and HIV/AIDS prevention are issues which have received much more interest from donors than the other areas (50).

Differences in the processes can therefore be partly explained by the level of importance of the issue to those actors who are able to provide resources for regulation processes. Given the scarce resource allocations from the government, the level of priority given to the issue by donors and UN agencies is important in Vietnam. It can be speculated that the sex ratio imbalance and EMOC will be more likely than GR to attract support from UN agencies and other donors in the coming years. Improvements in policy analysis and evaluation are therefore likely in these areas.

Due to differences in the content and processes of the three regulations, there is also variation in information management and transparency; the level of mandate / legal strength; incentives; and accountability and participation of different actors across the three processes (see Section 6.2).

The findings from the three case studies also indicate weaknesses in available M&E and learning processes. In the case of the ANC and GR regulations, although feedback loops exist, they are not effectively used. Very few violation cases have been identified under the ANC regulation, although a high proportion of pregnant women know the sex of the foetus before birth. Very few GR cases are reported up to higher levels in the health system due to the desire to protect the reputation of the hospital involved. Other feedback channels also exist, such

as the mass media and lawyers, but these are not strongly utilised to strengthen the regulations.

In the GR case, although learning opportunities exist for improving the quality of health care services, the hospitals do not utilise these, but rather try to cover up the number of GR cases. The different purposes of various M&E and learning processes should be clarified: sanctions should aim at control, whereas supervision should aim to provide support and incentives in order to improve the system.

In the implementation process, approaches to the private and public health sectors are also different. Challenges are evident for the effective management of the private sector, including in how to monitor and collect valid data.

6.1.3. Actors

Implementation of the regulations appears to include significant levels of interpretation by different actors. These actors can be classified into different groups: health actors (both administrators and implementers), other public sector actors, private actors and civil society organisations. Their participation is categorised in Table 25. Health actors are divided into four levels: the MOH, provincial, district and commune levels. The table provides information on the power and potential of different actors in the formulation, implementation and evaluation processes of the regulations.

An actor's power is understood as the extent to which he/she is able to persuade or coerce others into making decisions, or follow certain courses of action. Power may derive from the organisation or from the person's position within it (100). The potential to act or to be affected by a regulation or institution resides in the actor's specific context and location, including his/her knowledge or rights. Actors have very different degrees of power to control decisions that have effects on regulations and institutions, and they have different degrees of 'potential' to

contribute to, or ‘importance’ in achieving, a particular objective. Four levels of power and potential are indicated in the table, as follows:

++++: high power and potential; referring to full involvement and responsibility;
+++: high power, low potential; referring to partial involvement and responsibility;
++: low power, high potential, referring to limited involvement and responsibility;
+: low power and potential, referring to almost no involvement or responsibility.

Table 25: Actor analysis

Actors	Involvement in EMOC			Involvement in ANC			Involvement in GR		
	Formulation	Implementation	Evaluation	Formulation	Implementation	Evaluation	Formulation	Implementation	Evaluation
MOH actors									
AMS	**++++**	**++++**							
MCH Dept	**++++**	**++++**	**++++**	**++**	**++**				
GOPFP				**++++**	**++++**				
Inspectorate							**++++**	**++++**	
Provincial health actors									
Dept of professional medical management		**++++**							
Dept of Private practice management		**++**			**+++**			**+++**	
Inspectorate					**+++**			**++++**	
Provincial RH centre		**++**							
Provincial IEC centre					**++**				
POPFP					**++++**				
Provincial		**++++**			**++++**			**++++**	

hospital									
District health actors									
District health centre		**++**							
District health office		**++**			**++**			**++++**	
District hospital		**++**			**++++**			**++++**	
DOPFP					**+++**				
Commune health actors									
CHCs		**++**			**++**			**+++**	
Other public actors									
Social Insurance		**+++**							
Ministry of Culture, Sport and Tourism					**+++**				
Local authority		**+++**			**+++**			**+++**	
Private health actors									
Private health facilities		**++++**			**++++**			**++++**	
CSOs and development partners									
++++	**++++**	**++++**	**++++**	**++++**	**++++**	**++++**	**++++**	**++++**	

It should be noted that one actor with high power and an influential position in the implementation of one regulation could be in a different position for the implementation of a different regulation. For example, the MCH department was positioned with high potential and power for the implementation of EMOC because it was assigned by the MOH to be the lead agency in EMOC regulation. This meant MOH actors had the full right and expertise to be involved as leaders in the processes of formulation and implementation, and were therefore assigned 4 dots (++++). However, in the ANC regulation, the department was only partly involved, because the MOH assigned this regulation to the GOPFP for leadership. Despite the MCH's expertise in ANC delivery, they did not exercise full involvement or expertise with regard to this regulation, therefore they were categorised in the chart as having low power but high potential, with 2 dots (++).
In this context, the concepts of power and potential were strongly related to the position of actors in the regulation processes, in particular to the tasks of actors assigned by the MOH. In the EMOC regulation, the MCH was the lead agency in formulation and implementation, while GOPFP was lead agency for the ANC regulation.

Both the GOPFP and the MCH department are under the administration of the MOH, and during our study it was reported that there was quite good co-ordination between the MCH and the population network. However, several other reports have identified weak co-ordination among agencies as a problem in the governance of the health system (4, 27, 106). The passive participation of the MCH network in the ANC regulation appears to support this observation. The question of how to improve co-ordination among agencies in the implementation of the regulation remains, therefore, and of identifying incentives that are the driving force for its effective implementation. These issues deserve further study.

In the table, it can be seen that health service facilities (hospitals and CHCs) at all levels, including private and public, are responsible for implementation of all three regulations. Both provincial and district hospitals are in positions of high power and potential, except in the case of the EMOC regulation, for which district hospitals are in a low position. Although all district hospitals are responsible and authorised to implement the regulations, only 68.2% of district hospitals were in fact able to provide C-section. Those unable to provide comprehensive EMOC had been unable to mobilise resources (HRH and facilities) from different sources to deliver services. On the other hand, there may have been insufficient incentive for hospital leaders to strive for improved EMOC services, given the context of underutilisation of district health services.

By contrast, in the implementation of all three regulations, women/patients as beneficiaries were in a position of low power and potential (++). They were not invited to participate in the formulation phase. Although there has been improvement in the policy making process with the participation of a range of actors, there was still very limited participation by civil society organisations, including service users (4). The design of the ANC and EMOC regulations remained mainly in the hands of health providers, and users did not have much opportunity for comment or participation. In the implementation of GR, the voices of patients in the Patient's Councils in hospitals were still quite limited, especially when they were still in hospital and could not speak out about their complaints. Overall we found that users were not in a position to persuade or coerce others into making services available. They have little knowledge or rights to contribute to decisions on how to make EMOC and GR services available or how to improve them. In the ANC regulation, on the other hand, they are able to demand to know the sex of the foetus, as suggested by the evidence that more than two thirds of women in a 2006 study knew foetal sex before delivery.

In contrast to EMOC and GR, the ANC regulation process also involved the Ministry of Culture, Sport and Tourism, which was involved in the development

process as well as in controlling publications related to prenatal sex determination and sex selection. Their involvement may have been related to the recognition that the sex ratio imbalance is a social topic, and therefore not limited to the expertise of the health sector.

In all three case studies, variation in the behaviour of actors involved with the implementation of different regulations is evident. For example, in the ANC regulation, the Southern provinces were not implementing activities due to a perception that there was no imbalance of the SRB in these areas, while many activities were being implemented in BG due to evidence of an alarming SRB imbalance. In the case of GR, different tactics were applied by different provinces, due to differences in users' behaviour. For example, BG was more likely to classify GR cases as denunciations in order to protect health providers, as well as to cope with potential abuse of the compensation system by users. In DT, the PHD took the decision to proceed with anonymous GR cases and publish results on their website because Southern people are generally direct and straightforward and only used the anonymous mechanism when necessary. Variations in interpretation of the regulations are also evident on the part of 'street level bureaucrats' in regulation implementation. So variations in the behaviour of actors were strongly context related. These variations and the reasons for them need to be made explicit in order to identify entry points to intervene when interpretation works to the detriment of policy intent.

6.1.4. Effects

The three cases studies show that the regulations have achieved their intended effects to a limited extent. The EMOC regulation has contributed to a limited increase in EMOC services across the country in recent years (2007-2010) as well as in BG and DT provinces. The ANC regulation has contributed to increasing awareness of both providers and users on the necessity of not revealing the sex of a foetus to patients, although the number of women knowing foetal sex remains very high. The GR regulation has had some modest effects in

ensuring citizens' rights in making complaints. However, effects on improving the quality of services remain limited.

Different unintended effects for the GR and ANC cases were revealed by the studies. For example, due to poverty, some GR regulation users aimed to get compensation to cover their health care expenses, and some have used the regulation to complain against or denunciate colleagues with whom they are in conflict. For the ANC regulation, a consequence of the failure to implement it widely could be an increasing number of sex selective abortions, as well as other consequences.

For all three cases studies, there were methodological difficulties in assessing the effects of the regulation. The EMOC regulation is a small part of Decision 385/2001, and the ANC regulation is only one article (10) of Decree 104 guiding the implementation of the Population Ordinance. This made it challenging to attribute any effects to the single regulation, since they are a part of a family of regulations. The nature of the regulation – whether it is mandatory or provides guidelines; whether it is enabling or directs a prohibition – also made this assessment challenging because this nature has a strong influence on the effects of regulation. Additionally, the effects of the regulations are strongly influenced by providers' behaviour: how they interpret and operationalise the regulation.

In the GR regulation, unintended effects such as negotiation and settlement between providers and users were reported as common practice. This reflects deficiencies in the development stage when the contextual influences of marketisation and autonomisation were not sufficiently taken into account. For the ANC regulation, it can be seen that it is used as political tool to regulate the sex ratio imbalance and is more focused on organisational processes, using a control approach, rather that on producing outcomes at community level, where

strong son preference exists. These deficiencies have negatively affected implementation of the regulations.

6.2. Linkage between content – context – actors and effects

The three studies have also shown that there is sometimes inconsistency between the ideology and policy of different and pre-existing regulations. For example, the ANC regulation does not adequately address the tension between the small family policy and son preference. The GR regulation for the health system does not clearly reflect citizens' rights and equity in resolving health complaints, as compared to the general Law on GR. To understand why three regulations have achieved limited effects in increasing equitable access to quality maternal health, the issues of good governance, the influence of contextual factors, and actors' power and potential are worthy of further consideration.

6.2.1. Good governance

It can be seen that levels of awareness on the outputs and outcomes of all three regulations were poor at all levels. Their formulation also did not involve the women and other patient beneficiaries, despite the fact that beneficiaries' voices could be very important in considering the conditions for effective implementation. The feedback loops of all three regulations are poor: there is a lack of regular supervision, and a lack of reporting, especially from the private sector.

Constraints identified in the administration of regulations, such as a lack of guidelines for implementation, limited time, no reminders in the system, and a lack of resources for essential activities such as workshops and training, certainly contributed to poor awareness among actors at different levels. Many potential implementers could not even name the regulations.

Information and disclosure is a tool of all regulations. It can act both as a penalty for bad providers and a reward for good providers (108). However, this practice

was in limited use in each of the three cases, especially for the GR regulation. Most GR cases were solved at local health facilities and were not reported to higher levels. GR practice was not disclosed to a public audience and as a result, people could not identify good or not so good health providers. GR practice is predominantly an internal process and this affects how grievances are received, compensation negotiated, and whether the system learns from the particular case. The involvement of an external body in the mediation of GR cases could be helpful.

Thus, disclosure of information should be compulsory, and should be promoted and administered by the government. Regular reports on the regulation should be submitted to administrative agencies and annual information should be distributed to all related actors, including the media and the public. In addition to these, the ranking of hospitals is a further option which could clearly inform clients on the quality of services.

All three regulations are in some ways providing standards or benchmarks for implementation, especially the EMOC and GR regulations. However, only the ANC regulation – the only prohibition regulation – has a binding mandate for implementation. Mandatory regulations can be expected to gain greater levels of compliance than guidelines, assuming that sufficient conditions for effective implementation (HRH, facilities, finance etc) are in place. The lack of this mandate partly explains the limited effects of the EMOC and GR regulations. Hospitals at all levels can choose whether or not to provide comprehensive EMOC or whether to use the MOH regulation on GR, and this has resulted in low compliance – in the GR case, to non-use of the MOH regulation and in the EMOC case, to very modest EMOC coverage. In the case of the ANC regulation, the lack of conditions for effective implementation such as human resources, competencies and financial support contributed to low compliance. The issue of conditions for effective implementation should be considered before the formulation of regulations.

Incentives and accountability for actors to comply with regulations depend on different contextual factors. Actors responsible for the implementation of regulations will have greater incentives to implement a mandatory regulation than one that is not mandatory, and will also be more accountable to it. In the case of ANC, although the regulation is mandatory, the effect has been modest because the policy design did not take into account the conditions for effective implementation. For example, the tradition of son preference is so common and has been important for families and women for centuries, so a top down policy aiming to control only provider practice is unlikely to be successful. To change this tradition, more comprehensive measures will be needed, which take into account the voice of women, processes of women's empowerment, and marketisation mechanisms, within the specific context of Vietnam.

An important issue was the fact of limited rewards for good performance and very modest sanctions for non-compliance. In all three regulations, both carrots and sticks have had quite limited value for implementation. This also partly explains low compliance. Improving the success rate of a regulation requires ensuring that providers who fail to meet established standards will lose out. Although financial loss is not the only contributor to these 'costs' – professional integrity, community standing and personal satisfaction will all be important – they are perhaps the most easily wielded by both government and individuals. Experiences from different countries has shown that a contract between health insurance agencies and standard health service facilities is often the best solution (108). However, the contract should be kept small with a relatively simple payment system and with clear and observable conditions for success and failure.

All three regulations have a state command approach, with a strongly top down policy direction. Command and control forms the basis of many traditional approaches to government regulations, and may be the first approach considered by policy makers. This approach depends on the government's ability to formulate satisfactory laws or bureaucratic orders, monitor infringements and

enforce sanctions. The results from these three regulations show that this capacity is far from assured in the MOH. The government machinery alone might well be insufficient to govern regulations in Vietnam; the participation of civil society organisations could be very helpful.

6.2.2. Actors' power and potential

The three case studies also showed that different actors have different levels of power and potential in regulation processes. This very much depends on the position of actors regarding the respective regulation. Administrative actors are often in a position of high power and potential, while beneficiaries/patients have low power and potential. Actor analysis is important to understand the different situations, and could help to improve service delivery by identifying different possible coalitions, support mechanisms, or actions for change to policies or institutions. Strategies for supporting actors in positions of low power and potential can include monitoring their interest (100). Women/patients should be invited to all the processes of regulation. They should speak for themselves and express their needs and demands. A patient-centred health care approach would be most desirable for improving the situation.

For those with high power and potential, one strategy could be greater collaboration with administrative agencies and health providers; likewise, for those with low power but high potential, such as CHCs and district health facilities/agencies, a strategy of involvement and capacity building could result in harnessing that potential.

The role of street level bureaucrats is a profound one in all three case studies, but especially in the GR case (42). Here, the provincial chief health inspector invented a coping strategy to avoid the unintended effect of abuse of the compensation system, which involved directing lower levels to classify GR cases as denunciations or accusations instead of complaints. Lipsky (1980) argued that the practices of street level bureaucrats ultimately become public policy, rather than the intended objectives of the policy at central level (42). This was further

illustrated in the provinces in that the Law on GR for solving grievance cases is widely used, rather than the MOH regulation on solving complaints.

Our findings emphasise the need to understand implementation systems and the actors responsible for implementation, in order to clarify why policies do not achieve their expected outcomes. The key implementer is the person that should provide closest attention to the regulation's processes. In the GR case, the chief health inspector is the most critical key informant. In the ANC case, the head of GOPFP/POPFP/DOPFP is the focal person. In EMOC, the hospital director is the most important person. Those individuals should be provided with sufficient information about the regulation process and its intended objectives. In order to strengthen the implementation of regulation, personal competence and inter-personal trust between central, provincial and lower levels in the health system is necessary. Trust should be built up at all levels, both vertically and horizontally. Coaching and supervision can be good tools for building trust across levels. Therefore, strengthening coaching and supervision should receive more attention in the future from policy makers and managers.

The findings from the three case studies are also evidence of poor governance of the regulations by government bodies. In order to widen enforcement, an increasing role of civil society organisation (CSOs) to help enforce standards can help to ensure that regulation is effective. Empowering individuals, community, groups and the media to enforce standards may help to reduce the burden on the state, minimise the risk of capture and ensure that choices better reflect local needs (108). In all our three cases, the role of CSOs remains limited. The Women's Union, for example, had almost no voice in the regulations. However, the development of CSOs is still in its infancy and their voice was barely considered by the government in the formulation of the regulations. To ensure effective implementation, women's voices should be taken into account in the development and implementation process to find feasible solutions to combat sex selection.

In Vietnam, the national mass media (TV, radio, printed press) are actively involved in addressing poor performance and low responsiveness in the health system, including taking up issues of bribery, poor ethics of health providers, and the overload of central hospitals (109). Feedback via national TV is an effective channel for addressing non-compliance to regulations. A World Bank report of 2010, for example, highlighted a promising role for the media in many countries for monitoring non-compliance of taxi drivers to regulations, and helping the government to address those violations accordingly (99).

6.2.3. Contextual influences

In all three case studies, the influence of various contextual factors is highlighted, such as the context of district health reform; the autonomisation and marketisation of hospitals; and region-specific culture and behaviour. These three regulations are not well aligned with, and have been slow to respond to changes related to social, political, economic and technological development.

Comparison of the three cases suggests that health system factors have a general influence in the performance of regulations. On the other hand, cultural factors have had greater influence on the ANC case; while health-seeking behaviour has had more influence on the EMOC and GR cases.

All three case studies have the state command approach in common as the main driver of the regulations. This approach assumes that all regulations will in fact be implemented in the existing health system. However, in practice, the lack of resources for implementation in all three case studies showed the failure of this top-down approach.

The influence of marketisation in the three case studies suggests that in a market economy, the government should try to regulate the market and/or provide opportunities to patients/clients to have a say in health decisions affecting them,

factors that have become increasingly important because of economic transition and the growing awareness of citizens' rights.

The lack of HRH, poor co-ordination, lack of resources and poor service delivery for all district health agencies were all consequences of district health reforms, which took place in all provinces since 2005. This was reported consistently in interviews. The majority of key informants would like to go back to the old model of a unique district health centre, with a hospital and a unit of preventive medicine, but without a separate district health office. In this model, the district health centre is responsible for both curative and preventive medicine activities, and CHCs are under its administration. This model would help to save HRH as well as other resources, and would improve co-ordination among actors in health care service delivery.

Globalisation and the development of a market economy has had a profound influence on the performance of regulations. 'Doi Moi' introduced the market economy to Vietnam in 1986 (110), and the marketisation of health provision has been progressing rapidly. At the time of our research, the private medical sector accounted for about 3.6% of hospital beds throughout the country (4) and 60% of health expenditure was out-of-pocket expenditure (111). Financial incentives for public health facilities undergoing hospital autonomisation have resulted in evidence of the overuse of drugs, investigations, and other procedures generating revenues (112). Profit is an important objective of health care delivery in both public and private practices in Vietnam, and has been identified as an important determinant of clinical decision making in private health practices. The private health practitioners' income is directly related to patient's ability and willingness to pay. Willingness to pay in turn is directly related to provider's ability to meet patients' expectations and demands (113). Therefore, for example, the compliance of private practices with refusing to disclose the sex of a foetus to the client is low. In order to receive payment and secure their private practice, they are more likely to respond to clients' demands. Therefore, a systematic

discussion and dissemination of medical ethics, including to address the need for a balanced sex ratio, should be introduced in the health system, including for undergraduate students.

The growing economy and marketisation in health care has also allowed people to have more choice in services; for example, whether to give birth at local health facilities (CHC or district hospitals) or bypass these for the central level. Demand for comprehensive EMOC in district hospitals, therefore, was low. A needs-based approach to provision of services should be considered, instead of a one-size-fits-all policy.

Despite the rapid growth of the private health sector, the governance of this sector is rather weak. The main activities have been the control of standards through the granting of licenses, and collecting taxes, but there has been a failure to meet the need for general oversight of the sector. Moreover, the health management agencies are not supplied with updated information from the private sector, as private facilities fall outside the scope of mandatory provision of statistics (106). Improving the governance of the private health sector should be urgently addressed in the near future.

Hospital autonomisation has a strong influence on the EMOC and GR regulation implementation. The government aims to reduce the burden on the central budget and has encouraged hospitals to develop new sources of incomes, in the interest of upgrading the quality and range of services as well as for covering staff pay (3). Pressures for income generation are pushing hospitals to find different ways to deliver new services and protect the hospital's reputation in order to attract patients/clients. This leads, for example, to an increasing number of GR cases being solved at local levels. If the actual number of GR cases appeared publicly, this would diminish the hospital's image, and could be associated with poor quality services. Similarly, hospital leaders will try to provide comprehensive EMOC services to attract clients to come for services. They will

strive for this if the conditions, including the possible number of patients coming for EMOC services, and sufficient human resources and facilities, can be met. The incentives that hospital autonomisation introduces into hospitals threaten to undermine principles of equity, transforming 'public' health services into private profit centres (3). The MOH is currently undertaking evaluation of implementation of Decree 43 on hospital autonomisation; hopefully this process will encourage the MOH to devise a strategy for improving equity for patients in the context of autonomisation. In the future, it will be important to assess how the government makes use of the findings of this evaluation.

Markets are always imperfect since they do not themselves deliver on equity, affordability and quality (54). Health care markets in Vietnam are no exception. The growth of pluralistic and unregulated markets means that there are multiple actors in the health field who all have to make a living and not necessarily in ways that ensure the client is not harmed or that prices are affordable.

In the health sector, the relationship between state actors and markets has changed with growing marketisation, and state actors have been unprepared and unable to control market transactions in most situations. This has direct implications for regulating what have become unorganised markets. There remain a number of questions regarding how to develop the private health sector, as part of the general development framework of the health system, and how and to what extent the state should control and inspect the quality and prices of services in the private health sector (114). With dual employment a very common practice in Vietnam, the regulation of market transaction seems to face particular challenges. The organisation of managerial duties so as to scrutinise the role of the private sector in is an urgent issue for Vietnam (114).

For the ANC regulation, the context of son preference is strongly influential in the regulation's failure. Particularly in Northern Vietnam, where son preference is very prevalent (10), people will try many different ways to have a son to keep the

family line. This geographical variation partly explains variation in the SRB, but there is also a need to examine variation by social classes. In other countries with an imbalanced SRB, such as India, it has been shown that class specific variation in sex ratios at birth are not only related to a (lack of) capacity to pay for ultrasound tests etc., but also to other factors such as the situation that in many rural areas even young girls are productive, whereas in towns they become a consumption unit during their study years. There is a need to explore these hypotheses and examine SRBs in Vietnam disaggregated by social group.

For the ANC regulation, our study suggests that the top-down policy approach has not been effective. In order to balance the sex ratio, a broader social policy approach together with more effective detection of frauds (as in Korea) would be more appropriate.

6.3. Comparison of processes, actors and contextual factors for maternal health regulation with general health regulation

The study revealed that there is not much variation between the administration, implementation and evaluation of regulations on general and on maternal health. The common mode of administration is document receipt, classification, dissemination to the appropriate department, and taking subsequent action such as developing a plan for implementation, and disseminating to other related actors. The speed of the response depends on the emergency status of the topic. Maternal health regulations are often administrated within the MCH network, from the MCH department of the MOH to the provincial reproductive health centres and to lower levels through conferences or meetings and the M&E mechanism. The service delivery network for maternal health often consists of OBGYN departments in general hospitals or OBGYN hospitals at different levels. The general health regulations deal with broader network of curative or preventive medicine, not limited to the above-mentioned actors of MCH network.

Actors of the MCH network often play the key roles for maternal health regulations, such as the EMOC regulation, while in implementation of general health regulation, such as GR, other health facilities play important roles (such as inspectorate units).

The study, however, revealed a difference in administration, implementation and evaluation between the public and private sectors. There is a lack of attention by the administrative agencies to the private sector due to a lack of resources (human, financial) in administration, implementation and M&E activities (106). Few private health facilities are invited to attend the administration of key regulations; there is poor compliance of this sector on reporting and ensuring quality of services; and no sanctions are applied to this poor compliance. As suggested, the dual roles of many actors in both public and private sectors means that civil servants are not motivated to control the private sector because of many types of conflicts of interest.

6.4. Recommendations

In health care, good governance implies that health care systems function effectively and with some level of efficiency. The findings of the three case studies provide insights for generating recommendations to improve the governance of health system regulations in Vietnam at different levels, including regulation development, administration and implementation.

Development (policy designers)

Information

- Clear information is needed on outputs and outcomes of all regulations. Accurate data on regulation performance should be regularly collected and shared at all levels.
- Information on the resources needed for implementation should be considered during development process.

- Regular feedback loops including reporting, coaching, and supervision should be implemented. Information generated by feedback loops should be shared at all levels and disclosed to the public.
- Information on rewards and sanctions should be shared with relevant actors at all levels.
- Information on facilities' services, including type of services and their prices should be announced publicly in the frontline desks

Standards

- Regulation standards, benchmarks and criteria, should be used at all levels by relevant actors to assess and inform policy, provision and performance.
- The criteria, benchmarks and mandate of regulations should not allow too much flexibility for implementation, as this produces variation in compliance with the regulation.

Incentives

- Incentives associated with a regulation motivating specific types of compliance behaviour should be developed in the light of analysis of actors and their roles at the formulation stage.
- The government should invest sufficiently in implementation, including financial and human resources.
- A comprehensive approach, with a more socially oriented perspective, would be more effective in addressing the issue of sex ratio imbalance.
- A patient-oriented approach could be appropriate to consider in regulation design.
- Contracts between health insurance agencies and good health facilities should be considered, and these should be amended regularly based on performance assessments with the participation of users.

Accountability

- Improving the governance and scrutiny of the private health sector with

regular reporting and quality services will be essential. There should also be appropriate guidance in the context of hospital autonomisation to protect patients' interests and equity.

Implementation (Implementers)

- Ranking hospitals based on regular assessments from different sources is a good solution for transparency of information to ensure quality of services.
- Routine audits should be conducted in all health facilities and report cards should be published in the media.
- Sufficient training for health providers to ensure all competencies is important, as is a mechanism for sufficient payment to all health providers.
- Accountability mechanisms for holding public officials/providers answerable for processes and outcomes, and imposing sanctions if specific outputs and outcomes are not delivered, should be improved. The leaders of institutions should be able to reward for good performance, and discipline, transfer and terminate employees who engage in abuses. They should also be answerable to actors (local People's Councils) on the performance of public services.

Users

- The involvement of local people such as representative of mass organization like Women Union, Fatherland Front, Farmer Union in decisions and oversight of health care provision is important. Regular annual meetings with local citizens, communication with the media and feedback to local councils are also good mechanisms for ensuring accountability. The involvement of CSOs, including the media, should be encouraged to maximise compliance with regulations in the health sector.

CHAPTER 7. CONCLUSIONS

The findings from the three cases studies on EMOC, GR and ANC in Vietnam have shown that these regulations achieved limited desirable effects on increasing access to EMOC services, ensuring patient's equity in solving complaints, and prohibiting sex determination. Several contextual factors mediated the effects of these regulation, such as the health system, cultural and behavioural factors, and marketisation and autonomisation. Limited governance of the regulations including poor information management, lack of mandate, poor incentives and limited accountability have hindered the possibilities for equitable access to quality maternal health care in Vietnam. Specific findings in relation to the five research questions in the context of Vietnam are set out below.

RQ 1. Approaches and processes

Objectives

The three regulations were intended to achieve different objectives. The EMOC regulation intended to increase comprehensive and basic EMOC provision according to the technical functioning levels at different facilities. The ANC regulation aimed to rectify imbalance in the SRB by prohibiting health providers from diagnosing foetal sex. The GR regulation aimed to ensure citizens' rights to make complaints when they have a grievance concerning health care services.

Approaches

The two main approaches identified in the three regulations are state command and enabling/prohibitive approaches. The state command approach is the most common one for health regulations in Vietnam, including in maternal health. In this approach, the government expects that the regulation will be implemented by the administrative and public agencies, while the private sector follows the

Ordinance of Private Practice Medicine. However, conditions for effective implementation of most regulations are insufficient in practice.

Under the influence of the marketisation of health care, a consumer-oriented approach is gaining ground and is also threatening the equity of patients. This situation requires state intervention to regulate markets as well as to provide opportunities for patients/clients to have a say in health decisions affecting them. These factors have become increasingly important due to economic transition and increasing awareness of citizens' rights.

Processes

The three regulations were formulated at the central level by experts, but this process had some deficiencies, such as the lack of resource allocation and planning, and not taking into account the influence of contextual factors such as decentralisation, marketisation, health system reform and health technology development. Regulation design also did not take into account capacity to interpret and implement the regulations at lower levels of the health bureaucracy.
The regulations were well administrated at the central level, whereas MOH officers delivered information on the regulations to provincial health departments. However, this information was interpreted differently among the provinces. In the case of GR, the MOH instruction on solving complaints was not well administered at the provincial level. BG and DT PHD reported using the Law on GR instead of the MOH regulation for solving complaints. The implementation of the ANC regulation was better in BG than in DT. There was no evidence on how the EMOC regulation was administrated at provincial levels.

Conditions for the effective implementation of the three regulations were insufficient in some respects, including human and financial resources. These are impediments to compliance with all three regulations.

Only the EMOC regulation has had two amendments as a result of evaluation processes. This difference in processes applied to the regulations is explained by the priority given to their content in relation to certain actors (in particular the UNFPA), who have an interest in, and the resources to promote, the EMOC regulation.

Governance

Except for users, there was quite good involvement of different actors in regulation processes. However, clear information on outputs and outcomes of all three regulations was not widely distributed at all levels. The formulation of the three regulations did not involve beneficiaries, and feedback loops were poor. There is a lack of regular supervision, and reporting from the private sector is missing. Information on rewards and sanctions was not publicly shared with relevant actors.

RQ2. Actor involvement in regulation processes

Different actors were involved in the regulation processes. At the MOH level, the MCH, GOPFP and Inspectorate are the main actors responsible for formulation, implementation and M&E of the EMOC, ANC and GR regulations. In the PHD, the Department of Professional Medical Practice is the main actor responsible for implementation of EMOC. The POPFP is the main actor responsible for implementation of ANC, and the Inspectorate for implementation of GR. Local hospitals, mainly public hospitals, are the implementers of the three regulations. Other actors involved in implementation are local People's Councils, service users, and communities. For specific regulations, there were also other actors, such as the Ministry of Culture, Sport and Tourism for the ANC regulation; the State Inspector for the GR regulation and health insurance agencies for the EMOC regulation. There has, however, been no involvement of CSOs in the formulation phases.

Different actors have different aims and priorities in relation to specific regulations that they are responsible for. However, all actors have broad aims to achieve coverage, quality, access and equity of health care services as stipulated in the health system development strategies. Typically, differences in priorities are reported between public and private providers. While it is true that the issue of profit is more profound for the private sector, the marketisation process is very influential in public health care also, and this is an impediment to the equity of patients/citizens.

Actors were involved in regulation approaches and processes differently because much depends on the type of responsibilities, rights and incentives they have for implementation. Most actors have responsibilities and a right to comply with regulations, but their incentives are varied. The administrative agencies are moving towards the health system objectives for equity, quality, access and coverage of health services, but health service providers have additional incentives for income generation under the influence of the hospital autonomisation process. Other actors, such as the local People's Council have high incentives to be accountable to the local citizens who voted for them.

Most of the administrative agencies and health service facilities have both high power and potential in regulation processes, since they are in the position of having both rights and responsibilities to provide services to users. They are also knowledgeable about health topics because this is related to their professional expertise. Users of services, on the other hand, had low power and potential in relation to all three regulations, because they have limited influence on health decision making as well as knowledge about the services.

Different contextual factors are influential for actor involvement in the three case studies. District health reform and autonomisation of hospitals, as well as more general factors like the increasing marketisation of the economy, globalisation, cultural and behavioural factors, and geographical variations all contribute to

influencing the governance of the regulations. The comparison of the three cases showed that health system factors have a general influence on regulation performance. In contrast, cultural factors have had more influence in the ANC case; while health-seeking behaviour has more influence in the EMOC and GR cases.

RQ3. Effects of the regulations

The three case studies show that the regulations had limited effects in achieving equitable access to quality maternal health care. The EMOC regulation is the most directly relevant, in aiming to increase EMOC services coverage and therefore equitable access at local levels. The other case studies, by the nature of the regulations, have had minor and indirect impacts on equitable access to maternal health care.

The EMOC regulation had a very modest effect on increasing coverage of comprehensive EMOC. The main obstacle was identified as low incentives for hospital leaders to strive for comprehensive EMOC. This was partly explained by the non-mandatory status of the regulation, allowing discretion to the hospitals to choose whether to comply. Secondly, low utilisation of local EMOC services by citizens has also discouraged leaders from striving for greater provision of services. Thirdly, the lack of HRH and facilities were important difficulties that prevented hospital leaders from moving forwards.

The effects of the GR regulation in ensuring equity and quality of services were also limited. Several factors contributed to obstacles, including the variation in interpretation among street level bureaucrats, an asymmetry of information between providers and users, the marketisation of health care and the poor accountability of actors. The GR regulation also had unintended effects, such as abuse of the compensation system by users in attempts to cover health expenses.

The ANC regulation is aimed at balancing the sex ratio by prohibiting the diagnosis of foetal sex, especially via ultrasound services during ANC visits. Administrative sanctions addressed non-compliance with this regulation. However, the case study showed its limited effects. Although most women knew the sex of the foetus before birth, a very small number of violating cases were detected or reported. This was analysed as a failure of implementation. Son preference remains the root cause of the sex ratio imbalance, and a command and control approach to regulation will not work in this instance. Rectifying the SRB will take time, and will need a much more comprehensive approach: by itself, the health sector has not been able to solve the problem.

However, the three case studies also faced methodological difficulties in assessing the effects of regulation because each is a part of a family of regulations, and is strongly influenced by the behaviour of providers and users in the regulation processes.

RQ4. Differences or similarities between regulation of maternal health care and health care in general

Two case studies represented maternal health (EMOC and ANC) and one represented general health. The study found little difference between these areas in terms of approaches, processes, actors and effects.

The majority of regulations enacted by the MOH use the state command and control approach. Other approaches may be prevalent in Vietnam, such as a customer oriented or market oriented approach. However, there is no clear evidence of these in the three case studies. There is yet to emerge a self-regulatory approach to health provision in Vietnam since there are no strong health professional associations which could apply ethical standards for medical practice.

The processes of the regulations are similar. Most of the regulations have passed through formulation, administration and implementation. An evaluation of two of the three regulations has not been conducted yet. Evaluation processes depend on the priority given to the issue by actors who have both an interest in the issue and the resources for evaluation. In the health sector, maternal health and HIV/AIDS attract more attention from donors, and as a result, regulations in these areas have been developed in a more comprehensive manner than in others.

The actors involved in the regulations are also similar across the cases: health professionals at central level are mainly responsible for formulation and M&E; administrative agencies are mainly responsible for implementation and M&E; and health facilities are mainly responsible for implementation. Maternal health regulations often have their own network, led and co-ordinated by the Maternal and Child Health Department at the MOH. At implementation levels, this network involves the provincial Reproductive Health Centre and different hospitals with OBGYN services and also CHCs which provide OBGYN services.

The private health sector is actively involved in providing maternal health services, but quality is of concern in this sector and the management of private services is weak.

Other sectors may also be involved in maternal and general health regulations, but this depends on the nature of the regulation. In general, the involvement of other actors is weak due to asymmetries of information and the professional monopoly of the health sector.

The findings from this HESVIC study on the limited effects on equitable access to quality health care can be explained by poor governance of regulations and the influence of different contextual factors, including the effects of street level bureaucrats and asymmetries of information between health providers and users.

This highlights the need for improving the governance of regulations, and generating different strategies for improving the power and potential of different actors in regulation processes.

RQ5. Recommendations to improve the effects of the regulations

Different strategies could be applied to enhance equitable access to quality maternal health care, which have all been outlined earlier. These should be included in strategies to improve the governance of information, standards, incentives and accountability that target different levels, including regulation designers, implementers and users. Advocating for strategies to enhance the power and potential of various actors in regulation processes will be an important contribution.

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