Health Policy Analysis Institutes: Landscaping and Learning from Experiences: The case of Health Strategy and Policy Institute of Vietnam

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Executive Summary

This is the first external evaluation of the Health Strategy and Policy Institute (HSPI) since its inception in 1998. Vietnam HSPI is one of the eight multi-country assessments of similar Health Policy Analysis Institutes, in particular when HSPI is a research institute under the jurisdiction of and reporting to the Ministry of Health (MOH). The study applied document reviews and in-depth interviews of key informants from HSPI, policy makers, research users and partners in and outside MOH.

The context environment in the last twenty years since the inception of Centre for Human Resources for Health, the predecessor of HSPI were in favour of HSPI in terms of increased demand for evidence, and limited research community, HSPI is operating in an oligopoly environment where MOH is the main users though gradually extend its audiences to outside MOH, such as the National Assembly and relevant departments in the Politburo.

HSPI is a research agency belongs to MOH and the director is appointed by Health Minister. HSPI has comparative advantage of being close to policy circle; it has several opportunities and many mechanisms to directly and indirectly influencing policies, though criticisms from outsiders of not independent to conduct policy research in particular when results and recommendations are not in line with the MOH or the government policy directions. However, HSPI maintained to some extent its scientific integrity. There is a fine line to strike a balance not too close to lose independent and not too distant to be irrelevant, an arm-length relationship with MOH.

Staff profile reflects a young and female dominant (71% of total 42) research organization with high commitment, morale and job satisfaction and high demographic dividends. The median age of senior staffs was 39 years, junior staffs 32 years, and administrative staffs 33 years. The limited number of administrative staffs (5) results in researcher shouldering administrative and coordination works. MOH allocates annual budget to HSPI to cover all salary bills, overhead and some research budget. Remuneration from government budget alone does not match living standards which results in additional payments based on numbers of projects. Turnover rate of staff is low – internal brain drain of only 2 PhD in the past six years, no international brain drain. Assessment found adequate number and skill-mix required for effective health systems and policy researches, though increasing health systems complexities require new skills and continued waves of capacity development.

Long term capacity, notably from SIDA SAREC Vietnam collaboration, in the 1990s bears fruits today when a number of Master and PhD came back from abroad with zero international brain drain and significantly contributed to researches or high level management of MOH. At this juncture, HSPI secures medium term grants for fellowship but more number of grants and even longer term e.g. PhD studies are required.

Between 2004 and Aug 2009, domestic financial resources have played a significant proportion of total revenue (58%) and, in addition, HSPI are successful in mobilizing international resources for researches, through short and medium term collaborations.

Research portfolio between 2005 to Aug 2009, of the total 64 projects, 70% were short life projects of less than one year, 25% were medium term project of 1-2 years, and 5% were longer term of more than 2 years project life. This results in many small unlinked projects which require high administrative efforts to manage. HSPI faces a daunting challenge of publication as evidence indicates efforts were given to influence policy and

lose sight on publications, especially international peer review journals. Research network is limited and mostly on an ad hoc basis.

The most outstanding contributions of HSPI are the capacity and proven track records in influencing policies via different channels. Many enabling factors of success in getting evidence into policies are, for example, sitting in “policy ring side” which ensures policy relevant research, good relationship between HSPI director and the current Health Minister, research institute in public health sector and enabling environment from outside MOH such as National Assembly requiring social impact assessment of any prospective law to be submitted prior to its promulgation; and inside MOH when health systems in Vietnam is in rapid transition, in particular the emerging role of private health sector, changing the role of the State, social protection extension and health insurance development.

The evaluation team felt not appropriate to assess HSPI without providing recommendations. Various recommendations to address current and emerging challenges were discussed in a debriefing session with leaders of HSPI on the last day of the mission, HSPI found useful for their further reflections and internal reviews.

I. Introduction

1. Background

Health Strategy and Policy Institute (HSPI) was gradually evolved from the former Centre for Human Resources for Health (CHRH), which was established in 1987, and later renamed as the Centre for Social Science and Health in 1996. Finally HSPI was founded on 11th November 1998 by the Decision of the Prime Minister No 230/1998/QD-Ttg; to meet the societal goal of equity and effectiveness in health systems and meet the trend of global integration.

Recently, as stated in the Decree No 188/2007/ND-CP on function, task, authority and structure of Ministry of Health that HSPI is a research institution under the Ministry of Health and has financial autonomy to conduct its mandates. This external institutional assessment is the first in the ten year history of HSPI.

2. Country context

It is essential to understand the country contextual environment for which HSPI charges its mandates.

Political and socio-economic context: Vietnam is a socialist republic and one-party state governed by the Communist Party of Viet Nam [1]. The National Assembly is designated the highest representative body of the people and is the only organ with constitutional and legislative power. Beyond central government, the People's Committees at different levels are responsible for daily administration at the local level. Mass organizations, such as the Women's Union, the Farmers' Union and the Youth Union, exist to serve the interests of the population and to act as a link between the people and the Party.

Although the political system is stable, many concerns on a number of occasions about lack of transparency, administrative inefficiency and corruption have been raised. Steps have been taken to strengthen open public debate and effective rule of law from the central to local level.

Vietnam has adopted a free-market economy with socialist orientation, to modernize the economy and to produce more competitive, export-driven economy. This has led to a strong gross domestic product growth rate. Major economic achievements in the period 2001-2005 included, among others, a high level of economic growth, averaging 7.2% per year; comprehensive development; the solution of many social problems, especially hunger eradication and poverty reduction; and the improvement of people's living standards.

In 2000, the GDP per capita was US$ 400; it increased to US$ 562 in 2004, higher than the mean for the lower-income-country group (US$ 530 per capita). By 2006, it stood at US$ 722, representing an 80% significant increase in comparison with 2000. It is expected that, by 2010, GDP will be 2.1 times higher, equivalent to US$ 1050-1100 in real terms.

Using the national poverty definition, average expenditure per capita per month produced by the General Statistics Office (GSO), the poverty rate significantly fell from 37.4% in 1998 to 16% in 2006. However, poverty was concentrated in rural areas for which the government demonstrated high political commitment to the deprived areas.

Health systems context [1]: Total health expenditure (THE) in 2006 was 6.6% of GDP, with government expenditure accounting for only 32.4% of THE. Most health finance is used for curative and preventive care (98%): 84%-86% for curative care and 14%-16% for preventive care. There is little expenditure on scientific research and training (less than 2%). By 2006, about 36 million people (43.81% of the population) were enrolled in the public health insurance system, which includes compulsory insurance, voluntary insurance and fully subsidized insurance for the poor.

In the review of primary healthcare achievement in the past 30 years, despite the limited health resources, Vietnam demonstrates the second highest level of annual reduction in child mortality between 1990 to 2006 and on track to reach all MDG [2]. Vietnam has achieved the comprehensive primary health-care level with a GNI per person of less than $1,000.

II. Methodology

As this is one of the eight multi-country case studies conducted by Alliance for Health Systems and Policy Research, a common protocol including approaches for literature reviews, guides for semi-structured interview were developed and applied to this study, See **annex 1**. Two main approaches were applied, in depth interviews of a number of relevant key informants and document reviews.

The total seventeen key informants were interviewed during 10-15 August 2009 by two researchers [VT and WP]. **Table 1** provides detail information on the profile of key informants; the number and profile of key informants for in-depth interviews are jointly decided by HSPI administers and the researchers. HSPI facilitates the invitation and appointment for interviews.

Table 1 List and profile of key informants interviewed

Category	Number
A. HSPI staff [ID01-11]	**11**
• Director	1
• Vice director	1
• Former Director, now retired	1
• Former Vice Director, now retired	1
• Senior-level researchers / Head of department	3
• Researchers	3
• Financial officer	1
B. Outsiders [ID12-17]	
B1. MOH (user)	**4**
• Former Head of Department in MOH	1
• Head or Deputy of Departments, MOH	2
• Senior staff of MOH	1
B2. International collaborations	**2**
• Policy advisor to MOH	1
• WHO Vietnam	1
Total key informants	**17**

Written informed consent was sought prior to the in-depth interview; interviewees were fully informed of the objective of the study for which frank assessment and opinion are required, all their information would be treated with confidentiality. Interviews were not tape recorded as culturally, interviewee felt uneasy when conversations were taped. Note taking either in paper (for which in a later phase transcribed into word document) or directly typed in word file was done by interviewers during the interview session. A total of sixteen interview sessions were conducted for seventeen KIs (two KIs were interviewed together in one session). One interview session consumed an average of 1.5 hours (maximum 5 hours for one KI). Eleven sessions were jointly conducted by VT and WP, while three sessions were conducted by WP and two sessions by VT. Interviews were mostly conducted in English, less than 10% of interviews/discussions (or only one interviewee) require interpretation.

The report observes the anonymity of opinions expressed by key informants; accordingly, interviews are referenced in the text using a code where appropriate.

The interviewers were familiar with the work of HSPI during the last 3-8 years for which this facilitates rapid understanding of the institute, where more time were given in the in-depth probe and assessment.

In a short time period of fieldwork [12 person-days], HSPI was able to make appointment with all relevant partners for interviews and furnish documents for reviews. On the last day of the mission (Sunday 16 August 2009; 0900-1130 am), a debriefing workshop with senior staffs of HSPI on the preliminary findings was convened to discuss the results and verify the accuracy of some key facts.

III. Historical evolution and mission of HSPI

1. Historical evolution of HSPI

In 1987, when the country rapidly moved from subsidized command to market economy, it was foreseen by some intellectuals, that there would be huge changes and impact on the social sector that the Government requested MOH to establish Centre for Human Resources for Health (CHRH), the predecessor of the current HSPI. The set-up of this Centre was initiated and led by intellectual in Hanoi Medical University and the close circle of the Health Minister and vice Minister of Health in that period. Initial research portfolio is on reforms of medical education hoping it would contribute health sector reforms and maintain health equity and efficiency. It is hoped that research would contribute to "influence" but not involve in the "policy development", which is the political decision.

In 1996, CHRH was changed to Centre for Social Sciences and Health (CSSH), the Minister of Health appointed the Vice Minister to head CSSH, thinking that medical sector should have social science components to guide policies but later the ideas were moved beyond social science to cover strategy and policy that HSPI was founded in 1998 as an MOH research institution to provide objective information for reform.

The socio-economic and political context of moving from centrally planned to market economy, various policy questions were raised for which evidences were required for decision. For example, government has limited fiscal capacity to keep the free public health service goes or else quality if poor due to lack of infrastructure and maintenance, then should government introduce user charge? Who should and should not pay for health services? How to exempt the poor from health payment? Should the government liberalize and allow private practices by government doctors? In addition, the opening up and increasing role of international development partners in health systems, demanded health sector review and other evidence to plan their health programs. These enabling contexts help nurturing the establishment and evolution of HSPI since 1987.

The contextual environment was in favour of evidence based decision making. There were positive enabling environment and demand for evidence and researches--a good ground for HSPI growth. For example, in a rapid emerging country, key health sector reforms such as hospital user fees policy, health insurance and protection of the poor and hospital autonomy stimulate demand for evidence both upstream policy design and formulation and down stream policy evaluations.

The current research community for health system is limited, for which HSPI is the strongest among these oligopoly partners in terms of number of qualified researchers, policy link with MOH leaders, and institutional legitimacy as one of MOH institutes with annual budget allocation to cover the staff salary and operating cost of the office.

Institutional mission is moulded by the context, the founders of the institute and subsequent leaderships. **Table 2** provides detail information of the leadership and evolution from CHRH to HSPI.

Table 2 Phases of HSPI evolution; leadership and focus

Phase	Banner of institute	Leadership of Institute	Minister of Health
1st 1988 - 1996	Centre for Human Resources for Health	• Director: Pham Dung (check name), former Health Minister (check)?, 1988-1996 • Vice: Pham Huy Dung 1988-1996	• Prof. Dr. Do Nguyen Phuong Oct 1995 – Aug 2002 • Ass. Prof. Tran Thi Trung Chien Aug 2002-Aug 2007 • Dr. Nguyen Quoc Trieu 2007 until now
2nd 1996-1998	Centre for Social Sciences and Health	• Director: Pham Dung, former Minister?, 1996-1998 (check) • Vice: Pham Huy Dung, 1996-1998	
		•	
3rd 1998 to date	Health Strategy and Policy Institutes	• 1st director: Prof. Nguyen Van Thuong*, 1998-2004 • Vice: Pham Huy Dung, 1998-2004	
		• 2nd director: Dr Dam Viet Cuong, 2004-2007 until retired • Vice: Pham Huy Dung until retired in 2004-2005	
		• 3rd and current director: Ass. Prof. Le Quang Cuong. 2007- • Vice: Drs Vu Thi Minh Hanh and Tran Thi Mai Oanh	

* Serves three positions at one time for six years, Vice Minister of Health, Director General of Military Health Department and HSPI.

Understandably, CHRH is headed by the Minister of Health, the institute must belong to MOH, as the highest leadership heads CHRH, and responsive to MOH research needs and policy interests.

HSPI as successor of CHRH inevitably belongs to MOH. The vice director who served CHRH since the beginning, also served vice director of CSSH and vice director of HSPI (until 2005) had the longest historical memory of how HSPI was evolved. The first director of HSPI had many role and responsibility, and little efforts given to HSPI.

> *"He (the 1st HSPI director) worked as a part-time for HSPI as he had three tasks in his hands at one time. He did not have much time for HSPI; most of the work was handled by the deputy director"* [ID09]

Compared to the previous experience, the current director since 2007 had the best work relationship with the current Minister of Health; HSPI contribution to policy formulation is very significant.

Therefore the mission of today HSPI is to serve the interest of national policy formulation for which the MOH is the definitive stakeholder [3]. As definitive stakeholder, MOH has strong capacity to successfully develop policies, implementation and adjustment of policies because MOH has power, legal authority, interest and is legitimate to do so. When HSPI works with definitive stakeholders, it tends to be successful.

2. Mission of HSPI

HSPI did not produce clear vision and mission statements, however, these are the key functions and tasks of HSPI for which is reflects the missions.

1. Conducting research in the area of health policies and strategies to provide evidence for policy making.

- Conducting assessment of the implemented health strategies and policies.
- Conducting health system research and forecasting studies concerning with health strategy and policy.
- Synthesizing scientific evidence and practical experiences nationally and internationally for health policy and strategy development.

2. Providing consultations on the issues of health policies and strategies to Ministry of Health.

- Providing consultations and recommendations on health strategy and policy.
- Conducting appraisal and opponent for health strategy and policy which are proposed for approval.
- Participating and/or coordinating projects on developing health strategy and policy following assignment given by MOH.

3. Conducting continuous training on development of health policies and strategies.

- Participating and organizing continuous training on topics related to health strategy and policy

4. Collaborating with international partners in the research areas concerning with health policies and strategies.

IV. Organization structure and systems

1. Organizational form and autonomy

There are six research departments: Department of Public Health, Social Medicine, Medical Service, Health Economics and financing, Human Resources for Health and Pharmaceutical and Medical Devices. However, the number of researchers in each department is small and spreads too thin, some 3-5 staffs per department.

> *"Six departments, but with only 3-5 staffs in a department, actually work together and need support from other departments, e.g. go to field trip together, comments work, due to limited staff."* [ID04]

Also there are four functional divisions to serve and support the function of the institute. These divisions are Administrative Division, Organization and personnel Division, Financing and accounting Division and Division of Scientific management, training and international collaboration.

2. Governance, Leadership and Strategy

Dr Le Quang Cuong was a neurologist and deputy director of department of medical services of MOH before appointed by the Health Minister to head HSPI in 2007. Two vice Directors are also appointed by the Health Minister, Drs Vu Thi Minh Hanh and Tran Thi Mai Oanh, both female. Imaged by a leading neurologist, Dr Cuong had good relationship with many stakeholders in and outside MOH e.g. with the National Assembly and Politburo to generate demand for evidence among these key stakeholders. Official relationship with the current Health Minister is very good for which evidence from HSPI was listened to and applied by the top leader of the MOH.

Governance is the most crucial issue being discussed at great length and detail verifications, triangulation with key informants inside and outside HSPI. Legally, as one of the MOH agencies, HSPI charges its duties and reports directly to the MOH. It is not surprising that, outside communities may views of lack of independent in conducting scientific research in particular related to policies, in particular when research findings and recommendations do not in line with the MOH policies. There are both strengths and weaknesses, although researches are very policy-driven and heavily used by decision makers in particular in the MOH. Research results and recommendations can be, in theory, manipulated to serve political interests, for which there is a fine line how to strike this balance. So far, from our quick assessment, HSPI faces a difficulty to produce independent recommendations which are scientifically sound but not in line with the current political environment.

HSPI is drafting some operational management details for internal management of resources such as allowance for staffs in line with Item 3, Article 4 of Decree 115/2005/NDD-CP.

There is a committees oversee the quality of researches, the Scientific Committee, committee members are directors or deputy directors of research departments and other related experts from MOH and other institutions. The Advisory committee provide advices on the broad direction of the HSPI. Members are leading experts in different related areas and policy makers from MOH and the Government, See **Annex 2** for detail profile.

As HSPI belongs to MOH, understandably it is often criticized by outsiders for not able to provide independent evidence in particular if it challenges the MOH policy directions. The independent evaluation team felt there HSPI needs "immunity" through the increasing roles of the Scientific Committee and the application of external peer review processes to ensure scientific soundness of research findings. Also there is a need to "buffer" HSPI from undue political manipulations, for example, the independent priority setting processes and peer-review processes involving more non-government stakeholders. However, in the view of the evaluation team, the Scientific and Advisory Committees are too much dominated by government officials and may not be able to play independent roles. In such case, there is a need to consider increasing non-government representations in the Committee. HSPI need to self-monitor the extent the MOH officials' dominance in the function of these Committees.

Following direction of the Minister of Health, HSPI is the focal point together with other senior experts (those who are working or ever worked at Central agencies/organizations of Communist party and Government, related sectors and ministries, research institutes, free lance, and international experts) to mobilize expertises in developing health strategies and policies. Currently, HSPI is developing a project "Development of senior expert network for the health sector" that will be submitted to the Minister of Health for the approval in the coming time.

On micro-management of HSPI, decision is not made only by HSPI Director or two vice directors. It is a collective decision on consensus by key senior staffs such as use of fund or research proposals development. However, it is more on ad hoc nature, as there is neither executive committee nor senior management committee. The independent evaluation team felt that "ad hoc" process works well in the context of trusted leader and participatory environment, but one may foresee problem when there is change in the leadership.

Consistently, interviews of key informants in HSPI reflect a "warm family" environment in HSPI. Morale and commitment are high in such an environment. At least, as we know, three current staffs have been worked in HSPI since day one of the institute establishment. Some key factors influenced staff to work in HSPI are also specified. For example; staffs are well recognized by high level people, proud of their work, contribution to society, good working environment, and adequate income for staff.

> *"HSPI is the first working place for me. I continue working until today and will be for the future. … Working environment here is very good. It seems that we live and work within a family. … I can talk to everyone here, including the director and vice director. When I need consultation, I can ask from everybody. No, there is no hierarchy here. Everyone is friendly."* [ID05]

> *"We have good people in good working place to produce good things for society. We work together and live together like brother and sister."* [ID01]

> *"Compared to many past years, now we are extremely busy but we feel good. We have more workloads but we still would love to work. This institute is very flexible. Sometimes, we can work at home when we request.* [ID08]

3. Human resources

The institute has a multi-disciplinary research capacity with a total of 42 staff members. There are 30 researchers (22 senior and 8 junior), see table 3. Their professionals include medical doctors, public health experts, sociologists, economists, lawyers, anthropologists, mathematicians and statisticians. There are 1 Associate Professor who is

PhD, 6 PhD staffs, 14 Masters and 9 Bachelors. In addition, the institute has a network of functional collaborators at central and local levels who can involve directly in studies conducted by the Institute.

It is clear that qualified researchers in HSPI are critical foundation and main drivers of successful HSPI mission. Fortunately in 1990s, there were a consistent capacity development of young professionals at Master and Doctoral level from university abroad through, in particular Swedish SIDA SAREC collaborative research including capacity development and the involvement of Karolinska Institute. We wish to pay tributes to the far sight of Professors Goran Sterky of Karolinska and Professor Pham Huy Dung vice director of CHRH (since the inception in 1987), CHHS (in 1997) and HSPI (until 2005) as these qualified staffs bear the fruit of conducting policy relevant researches and significantly influence the policies. A table of full account of the current HSPI staff profiles is shown in **Annex 3**.

Table 3 Staff profile, as of August 2009

	Senior researchers	Junior researchers	All researchers	Administrative staffs	Other staff*	Total
Number	22	8	30	5	7	42
Median age	40	32	37	33	na	36
Gender						
• Male	9	2	11	1	na	
• Female	13	6	19	4	na	
Education						
• PhD	7	-	7	Na	na	
• MSc	14	-	14	Na	na	
• BSc	1	8	9	Na	na	

Note: * 3 drivers, 3 door keepers and 1 odd job

4. Funding and Sustainability

As a government research institute, HSPI is currently funded by government budget. In 2007, total government budget allocated for HSPI was about VND 8 billion. This budget is used to cover current expenditures and to conduct research assigned by MOH. Total revenues of HSPI were increased significantly every year (see Table 4). Main source of finance was from government annual budget through MOH (average 58% for the past six years, 2004-2009). International sources were from multilateral, bilateral agencies and private foundation which all accounted for 42% of total revenue (Figure 1).

Table 4 Increasing rate of financial sources compared to the previous year

% growth	2004-2005	2005-2006	2006-2007	2007-2008	2008-Aug 2009
A. Domestic resources	**53.59%**	**69.57%**	**10.72%**	**32.48%**	**4.92%**
A1. Government (national and provincial)	53.59%	69.57%	10.72%	32.48%	4.92%
B. International resources	**-27.90%**	**177.17%**	**60.30%**	**59.26%**	**-23.41%**
B1. Multilateral agencies (EU, WHO...)	-55.13%	445.71%	-9.35%	70.66%	-75.12%
B2. Bilateral agencies (SIDA, IDRC, DFID, Ausaid)	398.48%	32.63%	-57.09%	560.46%	44.53%
B3. Private foundation	-66.62%	-100.00%		-10.60%	3.10%
Total	**19.14%**	**97.10%**	**28.56%**	**44.49%**	**-9.09%**

Note: There were only 8 months (Jan – Aug) in 2009.

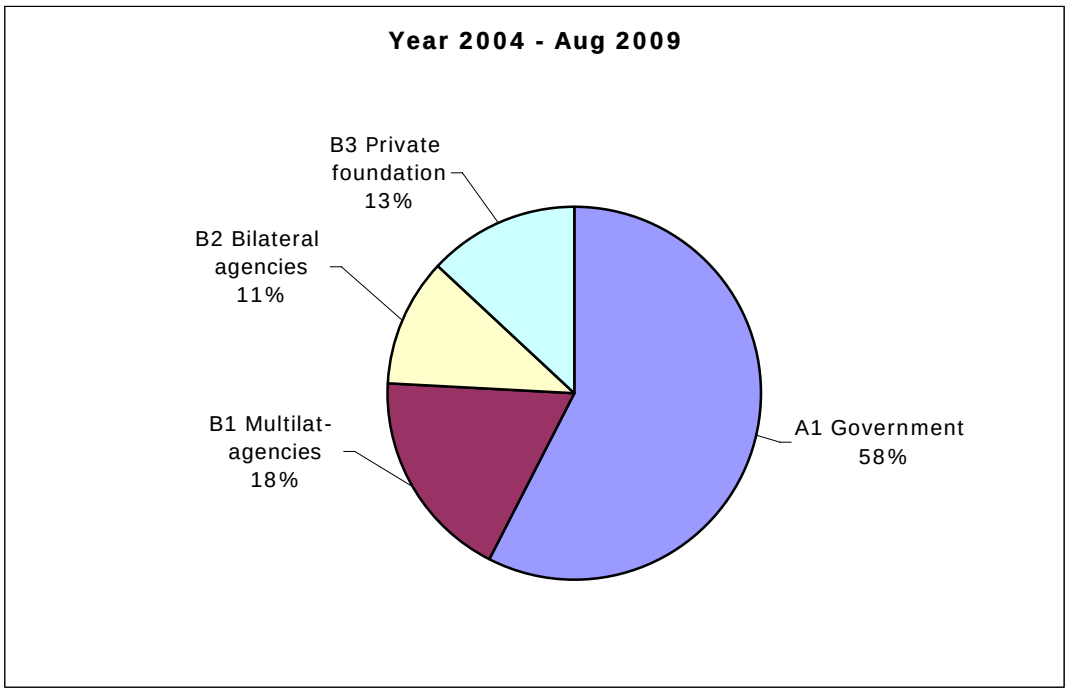

Figure 1 the profile of financing sources of HSPI; accumulated revenues between 2004 and 2009 (Jan-Aug)

V. Functions

1. Scope

According to HSPI mandates, four scope of its mandates were (1) conducts research in the area of health policies and strategies to provide evidence for policy making, (2) provides consultations and advices to the MOH on the issues of health policies and strategies, (3) provides continuous training on development of health policies and strategies and finally (4) collaborates with international partners in the research areas concerning with health policies and strategies.

On conducting researches, scope is wide including upstream research providing evidences for policy formulation, downstream evaluation researches and Knowledge management, such as synthesis scientific evidence and experiences nationally and internationally.

On advices to the MOH, HSPI also provides consultations and recommendations on health strategy and policy upon requests, conducts appraisal for prospective policies for approval as required by the government or the National Assembly, such as social impact of health policies prior to its approval and participates in projects assigned by MOH.

On training, focus is given to capacity building for in-house staffs, e.g. short course given by experienced local and international experts, supporting HSPI researchers to attend advanced training including post-graduate in country and abroad. Some training also focuses on capacity building for MOH health managers on planning, implementation, monitoring and evaluating local program. It is planned to develop post-graduate training on health policy from 2011 onward offered by HSPI.

2. Services provided

Over the past years, HSPI has carried out a range of scientific researches based on assigned tasks and functions and in accordance with the orientations and priorities of health sector. The Institute has conducted a series of scientific researches to provide evidences for policy development as well as to evaluate the implementation of health policies at local level in order to provide suggestions of appropriate adjustment in the new socio-economic context. It should be noted that MOH is almost the sole audiences of HSPI for which is should expand and diversify audiences to broader constituencies.

HSPI has carried out a range of studies to provide evidences for the development of some laws and draft laws such as:

- Law on the organ donation and transplantation: study on the awareness, attitudes and acceptance of community towards the donation of tissues, viscera especially cornea (2006–2007). This study contributes to the formulation of related Law on organ transplantation.

- Law on HIV/AIDS prevention issued on 29/6/2006: analysis of main findings from evaluation of 8 year implementation of the Ordinance on HIV/AIDS prevention conducted in 5 provinces/cities (2006). This is an evaluation research on HIV/AIDS policy and implementation, and very useful for program reorientations.

- Draft law on Health insurance: Evaluation of implementation of health insurance policies (2006 – 2007). This significantly contributes to the appropriate design of insurance schemes in different perspective.

HSPI also carried out a series of studies in providing evidences for the amendment of legal documents such as:

- Adjustment of Decision No 139 on free healthcare for the poor. Both studies contribute to the better organization of free care for the poor.
    - Impacts of Healthcare Fund for the poor on poor households in Hai Duong and Bac Giang provinces (2005)
    - Evaluation of healthcare for the poor in five northern mountainous and highland poor provinces (2006)
- Change of the management model of health sector at district level: Study on the management model of health sector at grass-root level after the implementation of Decree No 171, 172 in some localities (2006 – 2007)

Other contributions are for example, HSPI involved in the writing Vietnam Health Report 2006, in writing a Joint Annual Health Report 2007 (JAHR). The joint report is a annual review jointly collaborate by MOH and all relevant international development partners. It looked into the key situation of achievement and challenges in the past year and recommends future actions, including researches. It helps harmonizing donors' research in line with the MOH and government health priorities.

Research requested by the MOH leaders in particular the Health Minister worth mentioning. This ensures the immediate use of evidences from HSPI. One key example is the Evaluation of the implementation of Decree No 46-NQ/TW issued by Politburo and Instruction No 06 – CT/TW issued by Central Committee in some localities (collaboration with Central committee for education and science, MoH Office), See **Box 1**

HSPI in collaboration with Department of Curative Medicine conducted a study to assess the joint ventures and business collaborations in upgrading medical equipment and developing elective services in large public hospitals serving the better off areas. Study demonstrates various forms of elective health services across hospitals. It ranges from special patient rooms and elective surgery to after-hours examinations. With regard to user fees for elective services, HSPI survey in 14 provincial and district hospitals revealed that there are usually two different user fee schedules, one for normal services and one for elective services. Fees for elective services vary substantially across hospitals. This reflects the highly diversified forms of elective health service delivery in public hospitals in the absence of specific provisions for more uniform implementation [4]. This study contributes to fine tuning the policies on public private partnership, which is one of the most critical policy issues.

Box 1 Decree 43, the Government Flagship. [5]

HSPI had fully involved and contributed to the design of the scheme. The major content of the Decree are the development of a universal HI system, strengthening the socialization of health services in line with the increased State investment to support health care for the poor and vulnerable targets.

A series of financial policy revisions in healthcare has been introduced to achieve objectives set out in the Decree, including: swiftly increase the ratio of public finance sources; gradually decrease direct payments from patients; upgrade healthcare facilities; give priority to local health networks; ensure financial support from the Government for health service to the those awarded merit in the national revolution, the poor, children under six years old and targets of social policy priority; develop and implement a road map for universal HI early in 2010; and develop a policy for hospital fee collection on the basis of accurate and sufficient calculation of direct costs for patient services, with transparent information to the public on collection of and cost items from hospital fees.

For international collaborative research, HSPI secured several grants for example:

- Bringing healthcare to the vulnerable-developing equitable and sustainable rural health insurance in China and Vietnam. This is an EC funded in collaboration with Liverpool School of Tropical Medicine, Karolinska Institute, AOK, and MOH of China.
- Providing scientific evidence on mortality and morbidity for health policy making process in Vietnam, this is a AP funded in collaboration with University of Queensland.
- Pilot instrument for health system assessment, collaborative work with USAID.
- Assessment of initial impacts of hospital autonomy on provision of and payment for health services, supported by Ford Foundation.
- Medium term capacity building for HSPI staffs funded by Ausaid in collaboration with University of New South Wales.

Table 5 provides a full account of research conducted in 2006 to 2009. There were 9 projects in 2006, 6 in 2007, 7 in 2008 and exponential growth to 21 in 2009 (not shown here). All projects produces research report, for which abstracts were compile in the HSPI publications [6, 7]. We read all the abstracts published [7] in order to assess the subject area, nature of study (e.g. evaluation research or policy formulation), methods applied and policy relevance*. We found that almost all projects applied survey methodologies, either quantitative or qualitative tools. Subject areas varied year by year and there is no trend, except in 2007 that health financing and insurance was peaked. Most of projects were program evaluation with a few contributed to policy formulation.

In 2006-2008, the deliverables of all projects were research reports. There was neither publication, nor book chapter nor policy briefs.

HSPI staffs are working hard and facing problems of burn out. However, number of researches in Table 2 is not large compared to the number of professional staffs. We do not have time to investigate in greater depth what explain this. It should be note that there is very little number of research assistants and coordinators. The situation may result in professional researchers may have to absorb the coordination and logistics management.

* The evaluation team makes its judgment whether each research is policy relevance based on the current Vietnamese policy contexts. Some ad-hoc surveys demanded by donors without subsequent policy actions are counted as less relevant compared to policy questions requested by MOH for answers are more relevant. Published reports are mostly in Vietnamese with English abstracts.

Table 5 Research portfolio, sorted by subject areas, 2006-2008

	Research Titles	Source of fund	Subject area	Nature of study	Methods	Policy relevance 1-5
2006						
1.	Management of free healthcare services for children under six years of age in the provinces of Ninh Binh, Da Nang and Tien Giang	UNICEF	Health financing /insurance	Program evaluation	Survey	5
2.	Evaluation of the network of nutrition improvement program collaborators in a northern lowland district and preliminary recommendations for sustainable development of the network to year 2010	State Budget	System-wide analysis	Program evaluation	Survey	4
3.	Improving awareness and strengthening roles of the Commission for Science and Education on reproductive healthcare and HIV/AIDS control	State Budget	Diseases specific	Program evaluation	Intervention study	5
4.	An assessment of healthcare for the elderly in Vietnam	SIDA	Service delivery	Program evaluation	Survey	4
5.	An assessment of alcohol abuse in Vietnam	State Budget	Diseases specific	Policy formulation	Survey	4
6.	Renovation of the health system governance towards equity, efficiency, and development	State Budget	Health system governance	Unclear	Unclear	2
7.	Awareness, attitude, and behavior on eye care, especially child eye care in Haiphong city and Thai Nguyen province	ORBIS International	Service delivery	Program evaluation	KAP survey	3
8.	Current practice of grass-root health management units in some selected areas	State Budget	Health system governance	Program evaluation	Survey	4
9.	Community's awareness, attitude, and acceptance towards the donation of tissue, viscera, and cornea	ORBIS International	System-wide analysis	Exploratory	KAP survey	4
2007						
1.	An evaluation of health insurance policy and its implementation in Vietnam	State Budget	Health financing /insurance	Program evaluation	Survey	5
2.	An assessment of hospital financing – Findings from a survey in some selected hospitals	State Budget	Service delivery	Feasibility study	Survey	3
3.	Healthcare for the poor in five mountainous provinces in the north and Tay Nguyen highland	EC	Service delivery	Program evaluation	Survey	5
4.	Development of equitable and sustainable health insurance	EC	Health	Program	Survey	5

	Research Titles	Source of fund	Subject area	Nature of study	Methods	Policy relevance 1-5
	in rural Vietnam (RHINCAV) – Findings from a qualitative research		financing /insurance	evaluation		
5.	Current situation of health insurance, healthcare utilization, and health expenditures in Hai Duong and Bac Giang provinces - Findings from a baseline survey	EC	Health financing /insurance	Policy formulation	Survey	5
6.	Feasibility of a pilot model of reproductive health care training for in-service personnel network	Pathfinder International	Health financing /insurance	Program evaluation	Survey	5
2008						
1.	An assessment of the implementation of the Political Bureau's Resolution 46-CT/TW on healthcare for and protection of people in face of the new era and the Party Central Committee's Directive 06-CT/TW	State Budget	Health system governance	Program evaluation	Survey	5
2.	Impacts of resources and socioeconomic factors on eye care and blindness prevention and control	Atlantic Philanthropies	Diseases specific	Program evaluation	Survey	5
3.	An evaluation of initial impacts of hospital financing autonomy policy on provision of and payment for healthcare services	Ford Foundation	Health financing /insurance	Program evaluation	Experimental study	5
4.	Hospital overload in Hanoi and Ho Chi Minh City – An assessment and recommendations	WHO	Service delivery	Program evaluation	Survey	5
5.	Indicators based survey serving the National Target Programs to 2010 and vision to 2020	State Budget	Health system governance	General	Survey	3
6.	People's knowledge, attitude, and practice on avian influenza in some selected ethnic minority areas	State Budget	Diseases specific	General	KAP survey	3
7.	Awareness and responses to avian influenza among health workforce	State Budget	Diseases specific	Program evaluation	KAP survey	3

3. Influencing policy

HSPI has physical proximity and regular policy dialogues with the MOH in particular the Health Minister and Director of various departments. Undeniably, the MOH is the definitive stakeholder, therefore linkage between HSPI and MOH has major policy influences.

Two major contextual and enabling factors worth mentioning; outside factors were increasingly important to build up the image of HSPI to be a national research agency, not only responsive to the MOH but expand to broader policy stakeholders outside MOH such as the National Assembly requirement of social impact assessment of prospective law and regulation prior to its endorsement stimulate demand for evidence from HSPI. Inside MOH enabling factors are critical in ensuring evidence policy decision; through formal and informal communication. Also refer to the other contextual environment of increased demand for evidence.

> *"Nowadays this is an era of evidence-based decision making. Policy makers need more information or evidence to support their decisions, not just from their thought. It is a new environment which happens not only in health sector but also other sectors or in other words it is for all, through out Vietnam."* [ID12, ID13]

> *"….HSPI can do a lot because the current Minister of Health use its results, mandate them to do this and that, and very supportive. HSPI director was invited to weekly Friday afternoon meeting with all directors of MOH Departments…"* [ID14]

> *"Unlike the 2nd director of HSPI, he is not pleased by the Health Minister and invited not to sit in the weekly Friday afternoon meeting".* [ID10]

Major contributions of HSPI were discussed during many interview sessions [ID01, 02, 04, 12-15 and 17], HSPI participated in policy development process, such as: national policy on injury prevention (2002), national strategy on preventive medicine up to 2010 and the orientation up to 2020 (2006), draft law on Health Insurance (2007), Project No 59/TW on "complete the institutions of socialist-oriented market economy in the conditions of international economic integration" (2007 – 2008) and development of health sector master plan of some provinces/cities.

> *"We trust HSPI as HSPI is a part of MOH. They are very keen in research, especially health system and health policy research. In addition, HSPI will be responsible on whatever the impacts of their recommendations are."* [ID17]

In the HSPI context, the director plays a policy entrepreneur role, and a major success factor on influencing policies. Strategy of making conversation between the HSPI director and policy makers are also key successful factors. For formal channel, HSPI director applies weekly Friday afternoon meeting as a major platform, for informal channel, personal dialogues with members of National Assembly, or relevant partners in the Politburo, or in long haul flights travelling in country or abroad, booking seat beside the Minister of Health provides ample opportunities for face to face dialogues and briefings.

> *"This director has clear vision to influence policies. He is also very close to the Health Minister. He regularly participates in a meeting of all MOH departments every Friday. Frequently, the Minister officially and directly requests him to do some works for MOH. He also has many strategies to meet and talk to the Minister."* [ID15]

> *"This director applies many channels to push evidences into policy arena. Sometimes if there is no appropriate opportunity to talk, just keep silence – don't say at that time, but look for other opportunity or try other channels for example talk in a small group first or sending personal message to colleagues or even try to book a seat next to the Health Minister during travelling in a plane and then they would have much more time to talk".* [ID02]

However, this poses both opportunity and threat; capacity to influence policies on the one hand, on the other hand, what should be the longer term arrangement, in particular when the term of current HSPI director expires or reach retirement age. There is a need for HSPI institutional review how to move the policy influences from one individual policy champion to a collective institutional capacity to influence policy; for example, exposure to and delegation of policy influence responsibilities to other senior researchers. This is a delicate matter and we do not provide concrete recommendations.

It is interesting to hear from outside views, on what if HSPI is independent from MOH and which effective mechanisms translating evidence into policies? HSPI should gradually diversity its audiences to other Ministries, such as Labour, Finance, Social Welfare, Education and others including civil society, academia and research institutes responsible to address the social determinants of health outside health sector. Network with influential individual is vital.

> *"HSPI should prove themselves on how to make institute a real 'independent think tank of MOH', more transparency and make specific not general recommendations, high quality advices and make use of the results, not only researches and present in a workshop, 20 or more reports, but how to move this forwards into policies."* [ID16]

However, it is clear that officials in the MOH Department solely deal with day to day administration. It is responsible to manage, supervise some 50 central hospitals, managing budget, and managing daily advices on service provision, but grossly lack of capacity to see the broader national policies, e.g. financing direction. This is where the HSPI plays critical role.

> *"HSPI is one institute to provide policy advice to MOH. Scientific value of HSPI in terms of methodology design is highly appreciated – which is higher than others e.g. hospitals, department in MOH. This is because of expertise and experience of HSPI staffs in health system and public health policy. Unlike hospital staff, they are also very good but very keen in the scope of hospital management only, not beyond that. Departments in MOH are also busy to the routine work which is the prime mandates of them."* [ID14]

Various gaps were observed between policy and implementation; there is a lack of clear guidance how policy should be implemented at provincial, district and commune levels; there is also lack of enforcement. Gaps also observed between implementation and policy evaluation.

Box 2, 3 and 4 provides brief samples how HSPI contributed to key policy development in Vietnam.

Box 2 Devolution of Commune Health Station

Rational, objective and method

In 2004, Decree No 172 and Circular 11/2004/TTLB-BYT-BNV were launched. In effect, local Governments directly commanded all Commune Health Stations (CHS). While Provincial Health Bureau directly command District Center for Preventive Medicine and district hospitals. This Decree had major impact on district health systems.

HSPI conducted a qualitative assessment in three provinces representing three geographical regions in October 2006 to assess the results of implementing Decree 172.

Main findings

Evaluation identified a few strengths such as increased responsiveness and participation of local government, platform for intersectoral actions and opportunities to mobilize local resources, and a number of weaknesses such as fragmentation and mis-alignment between primary care services provided by CHC and preventive and curative services provided by District Centre for Preventive Medicines and district hospitals. In reality, there is lack of technical capacity, financial and human resources in a number of local governments to operate the CHC as required. Also, the guidelines were confusing and overlapping across the three agencies.

Policy actions

In addition to assessment in three provinces, HSPI reviewed strengths and weakness of two models of District Health Systems during the period of 1975–1997 and 1988- 2003.

Various expert meetings and a national workshop (participated by the Minister of Health) were convened, to discuss and recommend policy adjustment. As a result, a new Decree 14/2008/ND-CP and other related circulars replaces Decree 172, CHC is now under the direct management of District Health Center, the former District Center for Preventive Medicine.

Box 3 Economic evaluation of tobacco control interventions

Rationale, objectives and methods

In order to provide evidence for a regulatory impact assessment (RIA) report for the National Committee for preparation of Tobacco Control Bill, this study examines the cost-effectiveness of a number of tobacco control interventions. These evidences inform policy makers on more investment in cost effective interventions in the light of scarce resources to reduce smoke prevalence.

Four tobacco control interventions were examined in this analysis: increase in excise tax; graphic health warning on cigarette packs; mass media campaign and smoking ban in public and work places. A multi-state life-table model in Microsoft Excel was developed to examine the cost-effectiveness of the tobacco control interventions. CostIt, developed by WHO was used to develop a context-specific cost analytic framework for collecting and estimating economic costs related to these four interventions.

Findings

Results suggest that all interventions are very cost-effective and should be considered as priorities in the context of Vietnam. Graphic warning label was the most cost-effective option among the four interventions (VND 558 per DALY gain). Tax increase was the second most cost-effective intervention even with a relatively small level of increase. The incremental cost-effectiveness ratios for mass media campaign (VND 88,628 per DALY gain) and smoking ban (VND 122,060 and 376,277 per DALY in public and work places respectively) were significantly higher than the previous two interventions.

Policy actions

Results of this study were included in the RIA report and submitted to the National Assembly and will help the members of the National Assembly reviewing the tobacco control draft Bill. HSPI has already received invitation to present evidence of the control intervention effects in a workshops organized by the National Assembly.

Box 4 Assessment of Social Health Insurance Policies

Rationale, objectives and methods

Social health insurance has been introduced in Vietnam since 1992 as one of major health reforms. Despite many efforts, the coverage was limited and health insurance fund incurred large deficit. HSPI has been assigned by MOH to assess the policy and implementation to provide evidence for the drafting a health insurance law.

This study analyzes current health insurance scheme design, assess the results of its implementation and propose policy for achieving universal coverage

A cross-sectional descriptive study, using quantitative and qualitative methods has been applied. Secondary statistical data from General Statistics Office, Ministry of Health, Ministry of Labor and Social Affairs, health insurance agency and from seven selected provinces were collected and analyzed. In depth interview and group discussion were conducted with stake holder representatives at central and provincial level.

Findings

Good coverage in formal sector employee, though their dependants were not covered by Law. Low compliance found among private enterprises; health insurance agencies were not empowered to supervise compliance to enroll in Social Health Insurance. Enforcement measures were not adequate. There was low coverage of informal sector workers, but adverse selection was very frequent among members of voluntary social health insurance schemes for informal sector. Most rural households cannot afford to pay insurance premium. Fee for service payment is the only provider payment method for their medical services, results in significant health care cost escalation.

Main policy actions

Several dissemination workshops have been organized, with participation of policy makers. Report was sent to all members of committee for health insurance Bill preparation. HSPI has been invited by the National Assembly Committee for Social Affairs (designated to review health insurance draft bill) to present the assessment results and policy proposals. Key proposals by HSPI were accepted and a major content of the draft Law, for instance coverage of dependants, universal coverage by compulsory schemes (instead of voluntary approach), and introduction of capitation and/or diagnostic related group (DRG). The new health insurance law is effective by October 1, 2009.

HSPI is quite successful in providing evidence for policy; **Table 6** provide a full account of five key health policies for which HSPI is one of the key contributors in supporting evidence, until related Decrees and regulation were promulgated.

Table 6 Five policies for which HSPI is one of key players in supporting evidence until legislations

Area of reform	Legal document	Contents	Year
Hospital user fees policy	Decision No 45-HDBT by Ministerial Council	Partial collection of user fees in all public hospitals	1989
	Decree 95/1994/ND-CP and then modified by Decree 33/1995/ND-CP(1994-now)	Partial collection of user fees in all public hospitals	
Health insurance	Decree No 299- HDBT by Ministerial Council (1992-1998)	Regulation on Health Insurance	1992
	Decree No 58/1998/ND-CP by Prime Minister (1998-2005)	Regulation on Health Insurance	1998
	Decree No 63/2005/ND-CP by Prime Minister (2006-2009)	Regulation on Health Insurance	2005
	Decree 62/2009/ND-CP by Prime Minister (since 2009)	Regulation on Health Insurance	2009
Private practice	Resolution on Private practice No 26/1993/PL-UBTVQH 9 by National Assembly IX	Regulation on private practice	1993
	Resolution on Private practice No 07/2003/PL-UBTVQH 11 by National Assembly XI	Regulation on private practice	2003
Health care for the poor	Decision 139/2002/QD-CP	Establish Health care Fund for the poor at provincial level with financial subsidy from central budget	2002
Hospital autonomy	Decree 10/2002/ND-CP by Prime Minister	Granting autonomous financial mechanism applicable to revenue-generating public entities	2002
	Decree 43/2006/ND-CP by Prime Minister	Granting autonomous authority to public entities in terms of operation, organization, personnel and financing	2006

VI. Capacity development and external support

It should be noted that the capacity of HSPI in terms of infrastructure is quite adequate, for example, the current office space is adequate, though a bit crowded, a new building will commence in 2011 with an ample floor space. Information technology, computers and printers are well equipped, financial systems were adequate.

Critical number of qualify researchers is the cutting edge of the strengths of research institute and health systems development. Since the 1990s, there were significant investments of human resource in general and in particular for health and researches notably through the continued longer term financial support from SIDA SAREC [8] and institutional relationship with the Swedish Karolinska Institute on collaborative research works. It is recognized that the institutional relationship between CHRH and Karolinska on collaborative research, capacity strengthen are beneficial for long term capacity building of MOH at large and for HSPI in specific. A cadre of doctoral graduated from KI serves key position in the MOH and in HSPI and contributed significantly to evidence based health systems development.

The selection process of staffs in CHRH for long term fellowship at Master and Doctoral level was based on merit [ID01, 02, 04 and 10], with the following criteria such as good at heart to talk the truth, good brain good at hands, good work on researches, not only the scientific knowledge but also good feeling of the community advocating equity [ID11]. There is zero rate of international brain drain of well trained qualified Masters and Doctoral, all returned back and served the homeland.

HSPI has developed a close collaboration with different local partners including: Departments of MOH, National Assembly, Government Cabinet, relevant Government agencies, other academic institutions such as Medical Universities, Hanoi School of Public Health, Social Institutes, Institute of Economics and Provincial Health Bureaus. In addition, HSPI has collaboration with various international partners including bilateral and multilateral ones as well as NGOs, such as WHO, EC, ADB, Ausaid, USAID, AP and Pathfinder. International collaborative researches and partnership not only support relevant researches but also capacity building through on the job training and also some long term fellowship locally and abroad. Nevertheless, these collaborations based on individual relationship or with project based without clear vision of long term plan or official mechanism.

> *"…. There should be official way of collaboration, maintain and sustain such collaborations, wider partners and more official arrangement. Now HSPI invites them on a project based, no continuity and not sustainable. HSPI need more hands, and spend time for thinking and policy interface."* [ID14]

VII. Summary of findings

To facilitate easy reference to the main findings, **Table 7** summarizes key findings of all six components [1. contextual environment, 2. organization structure and governance, 3. human resources, 4. financial resources, 5. research portfolios and 6. influencing policies]. The table is self-explanatory with substantial short details. Having understood the situations from literature review and interview of key informants; the recommendations in table 7 were generated based on our independent views.

To prevent factual misunderstanding, contents in Table 7 was already discussed with and cleared by the senior staffs/leadership of HSPI in a debriefing session on Sunday 16 August 2009. We reserved our independent assessment on strengths and weaknesses and recommendations as an independent evaluation team, for which HSPI senior staffs and leaders agreed and recognized.

Table 7 Summary matrix of key findings

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
1. Contextual environment				
1.1 Key health sector reform initiatives	Five key initiatives: (1) Hospital user fees policy, (2) Health insurance, (3) Private practice, (4) healthcare for the poor, (5) hospital autonomy had major impetus on demand for evidence to inform policy decisions	Stimulate demand for research and evidence for policy decision [upstream policy formulation, midstream implementation design and downstream policy evaluation]	No	
1.2 Vietnamese health systems in huge rapid transition, due to opening up to market economy and globalization	Increased role of international development partners in health sector	Increased international resources in addition to domestic resources for researches	Increasing challenges posed by globalization: intellectual property and trade in health services Private health sector growth challenges the public health sector in light of weak regulatory and governance capacity of government	Expand human capacity and research portfolio to cope with globalization, intellectual property, trade and health services It is suggested to maintain the negotiating skills and capacity with international partners in such a way that research and program are in line with national priorities
1.3 Enabling environments for evidence based decision making - culture among policy makers	Increasingly policy makers apply evidences for their decisions HSPI is one among six research institutes to advice health policy (Agriculture, Science, Education, etc.) The whole range of policy development requires evidence, three streams policy development observed in Vietnam: (a) the Communist Party provides broad policy	Strong platform for demand driven research agenda and use of research findings These furnishes strong ground for HSPI to generate evidence and support policy decision, Increasing domestic resources for researches	Huge increase in demand for research in relation to the exiting institutional capacity to respond	Maintain the culture of and continued stimulate the importance of evidence based policy decisions Increase institutional capacity, broad base research networks, strengthen the collaborative work, synergy and avoid duplication environment in the network

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
	direction, (b) line Ministry (MOH) provides evidence for policy formulation, systems design, and evaluation of policies (c) the National Assembly requires social impact assessment prior to the endorsement of Laws			
1.4 International collaboration	Previous collaboration: Vietnam-Sweden research cooperation program [†] in particular training and education for health professionals since 1990s, significant contribution on capacity building of health staffs, a cadre of MPH and PhD serves key function in health research [HSPI, universities], high level managements in MOH. The Vietnam-Swedish long term sustained collaboration is felt as very critical in terms of successful capacity building. Ongoing collaboration: e.g. Ausaid program, WHO, U of Queensland, EC also contribute to human capacity building through policy relevant researches	Collaboration focuses not only research programmes but on human resources development	Vietnam becomes lower middle income country soon – tendency of reducing donor resources	Need to increase local resources and diversify other international sources on capacity development for both research capacity and human capacity development
2. Organization structure and governance				
2.1 Nature of current health research community	Limited number of qualified research institutes which results in oligopoly environment. Key	HSPI is the strongest among these oligopoly partners in terms of (1)	Little competition over quality of research and scientific debates, deliberation or	Extend research communities, involvement by the public in research agenda setting, more

[†] http://www.sarec.gov.vn/english/index.php?option=com_frontpage&Itemid=53&lang=english

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
	players are very limited, a few government research institutes e.g. HSPI, Health Policy Unit of MOH Dept of Planning and Financing-HPU supported by SIDA, Hanoi Medical University, Hanoi School of Public Health and some non-government research institutes	number and qualified researchers, (2) policy link and (3) institutional legitimacy as one of MOH institutes	producing different results, may result in research institute driven agenda	collaborations and networking among research institutes
2.2 HSPI governance structure – critical issue, highly pro and con.	Legally, HSPI functions and charges its mandate and reporting directly to MOH	Policy-driven and relevant research portfolio, policy maker ownership and use of research findings their decisions	Theoretically, research results and recommendations can be manipulated to serve political interests. As MOH staffs, it is difficult to produce independent recommendations which are scientifically sound but not in line with the current political environment. Research requested by MOH requires MOH Scientific Committee to approve the proposal, methodology and outputs; for which some outputs and recommendations having political sensitivity, the researchers have to take great care in crafting and presenting recommendations, either directly or indirectly. Sometime, further researches are recommended by the Committee, when the committee requires more information, or larger studies.	Increase engagement and broaden ownership and participatory research agenda setting by public and other research institutes, external peer reviews of research findings and recommendations. Stride to maintain an arm-length relationship with MOH by not being too close to be dominated and losing HSPI scientific integrity and independence to produce results and recommend things that policy makers like/dislike, and not being too distant to be policy irrelevant and lose opportunities to influence policies

<table>
<tr><th></th><th>A. Current status</th><th>B. Strengths</th><th>C. Challenges</th><th>D. Recommendations</th></tr>
<tr><td>3. Human resources</td><td></td><td></td><td></td><td></td></tr>
<tr><td>3.1 Demographic profile</td><td>A total of 42 staff (as of Aug2009):

<u>Researchers</u>
22 senior and 8 junior researches, median age 37, 7 PhD out of 30 researchers

<table>
<tr><th></th><th>Senior R</th><th>Junior R</th><th>All R</th></tr>
<tr><td>Total</td><td>22</td><td>8</td><td>30</td></tr>
<tr><td>Median age</td><td>40</td><td>32</td><td>37</td></tr>
<tr><td>Male</td><td>9</td><td>2</td><td>11</td></tr>
<tr><td>Female</td><td>13</td><td>6</td><td>19</td></tr>
<tr><td>PhD.</td><td>7</td><td>-</td><td>7</td></tr>
<tr><td>MSc.</td><td>14</td><td>-</td><td>14</td></tr>
<tr><td>BSc.</td><td>1</td><td>8</td><td>9</td></tr>
</table>

<u>Admin staff</u>
5 admin staffs, median age 33 and other 7 supporting staffs e.g. drivers, door keepers.

Female dominant research institute, 30 (71%) of total, 12 male (29%)</td><td>High demographic dividend: young researcher organization with high productivity and return of investment</td><td>Too few administrative supporting staffs, therefore senior and junior researchers have to absorb some of the administrative and coordination in addition to scientific works</td><td>Need to review the management efficiency, time spent by senior / junior researchers in coordination and management works. Consider a need for improvement of supporting capacities</td></tr>
<tr><td>3.2 Remuneration profiles</td><td>All researchers are government officials (few contract staffs), lower salary compared to living standard – resulted in additional work related payments from project</td><td>Decent additional income to staffs to keep retention

Additional financial and non-financial incentives were in place</td><td>Continued heavy workload results in “burn out”

Limited contribution of female researchers with young children</td><td>Review remuneration policy in conjunction with the upcoming Decree 115 to determine the appropriate level of allowance for HSPI staffs</td></tr>
<tr><td>3.3 Skill-mix profiles</td><td>Currently, adequate skill mix-</td><td>Inter disciplinary research</td><td>Still lacking in policy</td><td>Review to identify emerging</td></tr>
</table>

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
	inter disciplinary team members	works	researches and capacity to intercept policy. Not adequate to meet increasing complexity and health systems challenges, and demand for evidences from policy makers	skill-mix required in response to complex health systems in medium to long term; and long term plan for capacity development
3.4 Morale profiles	High commitment and good work ethics		Increasing heavy workload and family obligations offsets work morale in the long term	Review in conjunction with item 3.2 on remuneration profiles
3.5 Political and social ideology	Most researchers and scientists had public mind and stand firm on public interests in the light of socialization policies		In some critical research concerning the role of private sector in service provision, there were divide opinion, in favour and not favour public sector role; therefore it is unavoidable that critiques from outside HSPI charges the potential bias of HSPI researchers, of in favour of public health sector and also a number of outsiders support HSPI positions	Methodological rigour, transparency, objectivity and peer review help ensure scientific sound research and immunity against criticisms
3.6 Retention profiles	Small magnitude of brain drain, only 2 PhD in the past six years and only internal drainage. There is no external brain drain	High retention, decent additional income from project related works	Tendency of increase workload put serious constraint and staff "burn out" Potential future challenges to maintain retention rates from "push and pull" factors	Financial, non financial incentives are vital, social recognition. Review in conjunction with item 3.2 on remuneration profiles
3.7 Career advancement for current staffs	HSPI management level is aware of the importance of staff development. However, there is no clear plan yet.	Awareness to build up capacity in modelling and forecasting expertise	Can secure a limited program (Ausaid) for medium staff development, in country short courses and long term master	Government and MOH should invest and mobilize resources for long term capacity development at Master and PhD levels

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
			courses.	Diversify funding sources for staff development in various neglected fields e.g. intellectual property and trade in health services, chronic diseases. Improve the quality and use more of the in-country and regional training courses for Master and PhD, affiliation in thesis supervision of local universities
3.8 Recruitment of new staffs	Increasingly, difficulty to recruit high calibre new researchers to HSPI. There are competitions from international development agencies and private job opportunities.	Mobilize human resources from Provincial Health Department in various field works and surveys	Increasing competition to secure high calibre researchers in the light of economic growth	
4. Financial resources				
4.1 MOH funding profiles	HSPI prepares annual work plan and budget request to MOH and get approval. Budget covers staff salaries, office running cost and some research grants. Annual MOH budget allocation to HSPI, 8 billion VND per annum in 2007, increased about 87% from the year 2004	Annual recurrent budget allocation from MOH is adequate to cover staff salary and administrative cost Regular research budget from MOH for research works is adequate There are increasing proportion of non-regular budget for projects requested by MOH which is higher than regular research budget	Staff remuneration is inadequate for decent quality of life	Justify increase budget allocation, Review in conjunction with item 3.2 on remuneration profiles and make good use of the implementation of Decree 115

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
		Some unfunded mandates for researches requested by MOH was subsidized by regular research budget		
4.2 Sources profiles	Ratio domestic to international resources was 58 to 42 (average of 2004 to Aug 2009)	High capacity to mobilize international resources, High proportion of local research resources reflects political commitments towards evidence generation Donor projects provide decent pay to staff, in addition to basic salary	Future international competitive bidding requires high quality of proposal whereby staff have limited skill and experience of proposal writing	Annual joint health review between MOH and international partners is a useful platform to harmonize donor funding on research in line with government priority
4.3 Resource security	Analysis of HSPI five year projects profiles [2005 until 21 Aug 2009]: we found that 3 projects were longer term more than 2 year project life, 16 were medium term projects (1-2 years) and 45 were small short term projects (less than 1 year). Government mostly funds short term projects to respond to immediate policy questions. Long 3 5% Medium 16 25% Short 45 70% Total 64 100%		Limited number of long horizon program [only UQ, Aus Aids, EC], High proportion of small-short term projects results in financial non-sustainability and efforts to mobilize more projects in light of staff constraint	Institutional review financial security in conjunction with research portfolios
5. Research portfolios				
5.1 Research	Six research departments,	Clear line of demarcation	Spread too thin current	Review if there is need for

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
departments	approved by Decree 115 MOH, with the application of WHO health systems building blocks and small number of staffs in each department	of research works Inter-departmental collaboration is strong for managing cross cutting researches	capacities, number of team member in each department is small range from 4-5	functional combination of departments to address a common cross cutting issues Regular review of the relevance of research departments
5.2 Research portfolios	Highly policy relevant researches in many areas e.g. tobacco, health financing and health insurance, socialization of public health sector, private health sector roles	Demand driven research questions enables the uses of research results in policy making	Diverse research project with short life and smaller grants, see section 4.3 above	Gradually move from research projects to larger research programs to meet increasing health system challenges
5.3 Research diversity	Covers a whole range of upstream policy formulation, mid-stream policy and systems design and down-stream policy evaluation researches	High resilience and institutional capacity and contingencies to accommodate policy questions in short period	Many small projects which dissociated among each other and quite diverse may quickly deplete the current capacity	Development of research projects into Program with longer term horizon and continued in-depth investigation of difficult issues for longer term, including building up specific research expertise.
5.4 Research agenda prioritization	Internal MOH process of prioritization within HSPI; Scientific Committee plus comments by MOH departments	Agenda is implicitly generated from policy demands e.g. annual policy development of MOH in October and from the Friday afternoon meeting with all MOH Departments chaired by Minister of Health	Internal process of prioritization within HSPI may not accommodate wish of other partners and tend to be researcher driven agenda	Expand to broad base consultation and ownership to broader stakeholders e.g. the politburo[‡], the National Assembly
5.5 Objectivity	Refer to section 2.2			
5.6 Publication profiles	Still no structural mechanism and incentive to publish papers, the deliverable of almost all projects are research report, there is no policy briefs, a few	Mostly are research reports, and some domestic journal publication,	Limited track records in publishing in international peer reviewed journals. The evaluation team does not have chance to review HSPI	Review needs for, and if yes, motivate publications in addition to influencing policies

[‡] the main government group in a Communist country, which makes all the important decisions

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
	book chapter [5]	Researches findings were significantly taken up by policy decision without publishing	publications but Table 5 provides detail research portfolio	
5.7 Research collaboration with networks	Limited role of other research institutes but involve individual person on a personal capacity, not representing institute, as co-investigators in some projects, ad hoc basis, no systematic networking with other research communities	Capacity to recruit research expertise outside HSPI where needed	Involvement but not participatory ownership and systematic institutional network building	Review and take balance between in-house and commission research, research collaboration and network strengthening
6. Influencing policies				
6.1 Enabling environment inside MOH	Formal and informal policy communication using all possible channels including personal meeting and briefings. Policy briefs seems not as effective as face to face briefing and two ways dialogues with policy makers Examples: Decree 43, National Health Insurance Law, Traffic accident law, etc, for which HSPI had contributed significantly on these evidence policy decisions.	Weekly Friday afternoon meeting with Minister and MOH departments ensures policy relevant researches Participating as observer in group for policy M&E with MOH, HSPI plays as "ring side observer" ensure policy relevant researches and capacity to guess for future policy questions and plan for future research portfolios MOH requests HSPI to provide advices on policy documents in its development process, before submission to the Government		Strike a balance and keep "arm-length" relationship with MOH, See section 2.2

	A. Current status	B. Strengths	C. Challenges	D. Recommendations
6.2 Enabling environment outside MOH	Demand from National Assembly for social impact assessment prior to the endorsement of a Law	Formal and informal communication by HSPI leaders with key influential policy actors	HSPI has no connection with civil society organizations.	Fostering enabling environment from outside MOH to strengthen image of HSPI of not only serving MOH interests, but a broader public interests, also solicit financial support from outside MOH, to create ownership of outside agencies of HSPI works.

VIII. Discussion, conclusion and recommendations

1. Governance: pro and con of being MOH research agency

HSPI is MOH research institute, HSPI director is appointed by the Minister of Health. HSPI directly reports to the Minister of Health, and formally has strong and regular link with policy stakeholders in the MOH [in particular for the current HSPI director, the second director had bitter relationship with and ignored by the Minister of Health] and in the last few years gradually expanded its linkage with policy stakeholders outside the MOH such as the Health Department of the National Assembly, and the Politburo of the Communist Party.

Being research institution of MOH has both strengths and weaknesses. The Minister of health and MOH department directors increasingly requested for urgent evidence from HSPI and increased substantial constraints to the limited staffs engaging in the ongoing and pipeline researches.

There is a fine line between an independent research institute and high opportunity to influence policy. It is also not easy for HSPI leaders to strike an optimum balance, an "proper arm-length" position between "not-too-close" to the MOH to be dominated by Minister and lose scientific independence, and "not-too-distant" to be policy irrelevant and lack opportunity of influencing policy.

In the Vietnamese context, whereby policy formulation is more "MOH-level-influence", having considered carefully, we have the view that it is more advantage that HSPI stays as MOH research agency (rather than being independent institute) to gain the opportunity in influencing policies, in sitting at the "ring side" of policy stage, better understand the political context—both opportunities and limitation. However, this can be criticized by MOH outsiders as, theoretically and practically not independent in conducting policy researches. To overcome this criticism, HSPI may need various immunities for which currently, it has very little, for example, broaden its scope of partnership and networking with outside MOH institutions, application of external peer reviews in addition to the scientific committee of the MOH to maintain its scientific integrity, and maintain an "arm-length" relationship with the MOH.

Not only policy formulation, increasingly HSPI also contributes to supporting agenda setting through informal channels with the politburo and the National Assembly. As an MOH agency, our assessment found that "trust" between HSPI and policy stakeholders are strong ground for opportunities to influencing policies. In addition scientifically sound researches produced by HSPI foster the "institutional credibility" and societal acceptance.

Assessment from HSPI track records and in-depth interviews and triangulation with outside partners, it reflects that research results were straight forward based on evidence generated from scientific methods, and were not manipulated by politics in the MOH. However, policy recommendation, in case contradict with current policy direction, in theory can be toned down or use other indirect channel of presentation to policy makers, or conduct further studies. In addition, it should be noted that policy decisions do not lend itself totally on research evidence; there are many other justifications

Requirement for evidence on the social impact of any prospective health policies, mandated by the National Assembly to support its deliberation and endorsement of Resolution or Law is a key platform and entry point for which evidence and HSPI has a

clear role in public health policy making in Vietnam. However, it has yet to extend social impact assessment not only health policies, but to any public policies.

2. Research portfolio

HSPI, in the analyses of its research portfolio, contributions to policy formulation, policy evaluation in the context of broader health sector reform, however HSPI had limited outputs on national and international journal publications. This is explained by the fact that there were huge policy demands for evidence to feed into policy development in a very rapid changing economy and health systems evolution, private health sector growth and social health protection extension. Publications are therefore not HSPI priority in the first ten years; but HSPI had explicitly built up and sustained staff capacity and ensured seamless communication to, and influence on policy making processes. This is a success story of HSPI.

On research portfolio, there are huge workloads with many small short life unlinked projects for which is may not generate policy thrusts. In addition, most field surveys cover large number of provinces, districts and communes.

There is a need to move from various small short life projects to research program with longer term horizon for which various projects in the program address one inter-related critical issues, with partners in and outside MOH. The normative work such as National Health Account, financial resources tracking for specific diseases such as HIV/AIDS, burden of diseases, mortality and morbidity profiles, work with General Statistical Office in improving the national representative household survey questionnaire, to be able to capture health inequity such as wealth index, and ownership of durables in any social surveys including health. This kind of normative works needs to be reviewed of its relevant to HSPI.

The major deficiency of HSPI, consistently accepted by key informants inside and outside HSPI is publication records in particular in international peer reviewed journals[§], only research report are published both Vietnamese and English. In the past years, not only constrained by various pieces of project at one time by individual researcher, there is no motivation to publish and influencing policies had proven that it does not require publications. However, the management of HSPI agrees with the importance of publishing, not only for track records of the researchers and institutes, it is useful to share experiences to international audiences. The website serves as an outlet of its publicity, mostly are research reports.

3. Financial resources

Research requested by MOH are also supported by funding through the annual budget allocation for which it fully covers annual salary bills, administrative overhead and some primary research works. Increasingly, HSPI is successful in mobilizing research fund

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[§] Note that peer review publications are important as peer review process helps ensuring the quality of the work. However it may be too demanding for HSPI to publish in journals with high impact factor–because of the very nature of HSPI work may have limited international relevance, and also language barriers. There are some regional peer review journals which encourage regional relevant policy articles for which HSPI may consider to publish more.

from different non-state sources either short or medium term grants. The latter sources are important to on-top pay staff salary bills to a decent level. Medium term financial situation is quite secure from both sources.

4. Human resources

HSPI human resource capacity in term of qualification and their scientific contribution are well accepted by MOH and outsider constituencies, however, the number is still limited to meet increasing health systems development challenges, for which there are room for further capacity development. Staff morale is high, with good work ethics, commitments and enthusiasms; high retention was observed though strain on increasing workload was observed and can be long term threat for staff losses. In addition, the young staffs though very well educated there is a need to build up experiences and understanding of complex and emerging health systems and also understand the policy processes.

In house research capacity is good, but still focus on a limited number of senior researchers, not everyone in the institute. There is a need to train and strengthen the younger generations; otherwise there would be a big gap. To maintain continuation of staff capacity is vital for long term institutional development. In recruiting new staffs, there is a need to focus on both technical competency and good understanding of health systems which is not easy.

In medium term, there is a need to plan for sustainability of the HSPI beyond the current charismatic and influential director; though it is difficult to plan successors as appointment of HSPI director lies in the power of the Minister of Health.

5. Networking

Due to limited research communities; networking with other research institutes is not well defined. This was aware, since 2008, HSPI invited researchers, managers and PHB to join annual national forum. Ausaid supports establishment of health policy network with the participation by researchers, policy makers and managers at different level of health systems including provincial and district levels.

In view of increasing complexity of health systems and needs for a diverse expertise and skill-mix, HSPI needs to expand its research collaborators and network, as expertise is limited to accommodate every scientific fields. Increasingly HSPI may have to play a conductor role in managing different research projects to answer a large policy question, and contracting out some pieces to partner institutes and managing the translation of evidence into policy formulation rather than conduct all primary research works. Capacity and opportunity to influence policy is the most important comparative advantages, therefore in a context networking is an indispensable strategy to expand the role of HSPI in evidence based policy advice.

However, networking is easy to talk than to do, in particular, there are potential competitions across research units in MOH Departments or in Universities. The current approach applied by HSPI is research collaboration with individual not institution, on a project base without long term engagement.

However, international networks and institutional relationship between HSPI and other are its assets to keep abreast to international debates and relevant research contributes

to informing such debates, it also furnishes information and resources opportunities or collaborative research and capacity development.

6. Strategic recommendations

HSPI may conduct institutional self assessment to take a proper balance between several issues. For example one needs a balance between upstream for policy formulation and downstream policy evaluation research in particular in the light of capacity constraints. Evaluation research can be outsourced to other partners in the networks, if upstream policy formulation is more important and other partner agencies have less comparative advantages.

As project funding from international sources is higher in relation to projects sponsored by local resources, for which staffs tend to prefer higher funding. There is a need for the management of HSPI to respond appropriately to local need and international demands, and fair distribution of financial benefit to professional staffs between two types of project.

In view of increasing complexity of health systems and no research agencies looking into the future in a holistic and comprehensive manner; national research agenda for a big picture and knowledge managements are not less important than conducting primary research. HSPI has a comparative advantage to play this orchestrated function.

HSPI may wish to step forwards to look at potential development stemmed out from researches, for example, work strategically with General Statistical Office to fix the national household survey such as the Vietnam Living Standard Survey every five years and many other routine surveys conducted by GSO, so that these surveys capture health inequity on a routine basis.

Also there is a need to strike balance between normative and applied policy researches. Normative works are sometime boring such as maintaining National Health Account, and updating burden of diseases profile of mortality and morbidity, exposure to different risks in the population, routine health equity monitoring for which all required good national dataset. Therefore efforts should be given in fixing problems in these national dataset, in order to facilitate the updating of these normative works. Otherwise, HSPI will have to conduct special surveys of its own, which can be very exhaustive.

There is a need to reorient research portfolios from piece meal small projects to research program, for example obesity program, chronic diseases program, human resource for health program with tobacco as starting points for which a multi-disciplinary approach can be applied, tax and fiscal mechanism, supply and demand side interventions, health systems and behaviour science. As social determinants of health outside health sector and MOH is huge, for example, poverty, maternal education, ASEAN free trade agreement in favour of free import duties for tobacco and alcohol. Such research program, not only generate evidence for multi-sectoral action, specific capacity and expertise can be developed, and also provide opportunities to work with civil society sector to create social awareness.

One also has to take balance between many fighting battle fronts and building up new cadre of qualified professional researchers, with a skill-mix appropriate to the future complexity of health systems. It is felt that staff are over stretched with too many research projects, exhausted and may burn-out easily. Less important projects can be done by strategic partners in the network, and HSPI should concentrate on key strategic issues and challenges for which it has comparative advantages.

Acknowledgment

We wish to acknowledge the management of HSPI who facilitates the appointment of key informants for interviews and furnishes all necessary documents required for review. We thank all key informants for their frank assessment, productive and constructive discussions, Mr Dao Dinh Sang for his supports during the fieldwork and Nguyen Nam Lein of HSPI for her efficient support prior to and after the fieldwork.

The independent evaluation team wishes to declare that in conducting this study, it does not have conflict of interest and efforts were given to assess the institute objectively and independently.

Annex 1

Part I. Interview guide

1. History and mission

- When was HSPI originally established and why? How has the institute changed and evolved over time? What has been the main impetus for the changes described (issues linked to funding sources, internal strategic decisions, attempts to be more responsive to the policy environment)
- What is the current mission and goals of the institute? Have the mission and goals been updated? (please use this question both to clarify organizational mission, but also to assess how clear staff are about organizational direction of the Institute)
- Does the institute have an explicit political or social goal (such as to promote the rights of poor people, or promote the free market)? Is it perceived by stakeholders to have a particular ideological or political perspective (even if this is not clearly stated by the institute itself)?
- What are the key values and beliefs that drive staff? – Why do people choose to work here? What advantages/disadvantages does this environment offer over a regular university research environment?
- Which people/organizations are directly concerned with the institution and its performance eg. funders, target audience, partners – how diversified a group are they?

2. Organizational Structure and Systems

2.1 Organizational form and autonomy

- Is the institute public or private?
- Does it take the form of one single organization or a coalition of organizations?
- Is the Institute non-partisan and politically neutral?

2.2 Governance, Leadership and Strategy

- What are its governance arrangements? For example, is there a Board and if so what is Board membership? Is the Institute self governing? Does it report directly to a government official?
- If there is a Board or governing body, what is it's composition? How frequently does it meet? What role does it play in terms of (a) setting strategic direction (b) influencing which specific activities is pursued (c) ensuring quality of technical processes?
- Who started the institute and who is currently the head of the Institute? What is their background and professional standing? To what extent do respondents believe that a strong leader has been critical to the development and success of the institute (leadership issues)?
- Is there a senior management team for the Institute, who participates in this team?
- Does the institute have a strategic plan, how was this developed?
- Who sets the research and policy agenda for the Institute?

2.3 Human resources

- Does the institute have a clear HR policy with respect to hiring, firing, managing staff performance etc?
- Does the institute use HR policies of a parent organization (eg. Civil service HR policies, or university HR policies) – what are the strengths and weaknesses of this approach?
- How does the Institute typically go about recruiting it staff members, is there an open and competitive recruitment process or does the Institute typically seek to recruit more through networks of individuals it knows.

- How easy is it for the Institute to recruit and retain good staff? What factors has it found successful in attracting and retaining good staff?
- How many staff does the organization have, what are their qualifications, what is the turnover rate? Where have staff leaving the institute gone to?
- Does the institute have a network of researchers outside of the Institute whom it contracts with?

2.4 Funding and Sustainability

- What are the primary sources of funding for the institute?
    - Core funding (specify source)
    - Research grants
    - Consulting fees
    - Fees from training
- What mix of sources of revenues is there (I.e. breakdown by different specific donors and funders)?
- What overheads does the institute typically charge on research grants or commissioned work, and what do these overheads cover?
- Are Institute accounts published regularly, are they open or kept confidential?
- How dependent is it financially on any one source of funds?
- How has the funding profile changed over time?
- Is there a dedicated "business development" or "fundraising unit" within the institute?
- What role do Board members play in fund-raising?

3. Functions

3.1 Scope

- Does the institute focus on health policy only or also on policies in other sectors?
- Within the health sector, which topics does the institute focus on?

3.2 Services provided

- Which of the following functions does the organization carry out:-
    - Conduct policy-relevant research
    - Identify and synthesize policy relevant research
    - Conduct evaluations
    - Conduct systematic reviews
    - Commission systematic reviews
    - Commission independent research
    - Convene expert meetings
    - Organize conferences, seminars to stimulate debate
    - Provide policy advice (eg. Direct one-on-one discussions with policy makers, drafting of policy briefs)
    - training and capacity development for policy makers
    - data archiving and analysis
    - advocacy
    - other

- Which of the following products does the organization produce?
    - Research reports
    - Systematic reviews
    - Policy briefs
    - Monitoring reports
    - Health system profiles
    - Advocacy materials
    - Training materials

- When the Institute produces reports for policy makers or other decision maker audiences what formats are typically use:-
    - Full report with notes and references
    - Full report with executive summary
    - Summary of take home messages
    - Separate summaries versions for different users
    - Presentations
    - Tools for application

- How does the Institute maintain the quality of its products and services? What forms of technical review are used and at what points in the process?

3.3 Influencing policy

- How does the institute ensure the policy relevance of its work?
- What formal relationships does the Institute have with policy makers, representatives of donors and international organizations, and civil society organizations? How would you describe the informal relations between these different groups and the Institute?
- to what extent are policy makers directly involved in the work of the institute through for example collaborating on research design?
- Who is in charge of outreach and communication? IS there a separate communications unit, or are individual researchers responsible for undertaking research and policy outreach?
- What relations does the Institute have with the media? Does the institute send copies of its reports to the media? Is the media invited to conferences, seminars etc.
- Through which of the following channels does the Institute disseminate its products
    - mail or email to target users
    - Produce on CD and distribute to target users
    - Post on website
    - Submit to clearinghouse
    - Other (specify)

- How does the Institute assess the usefulness or impact of its products?

4. Capacity Development and External Support

- Has there ever been a capacity development plan for the institute? If so what did it encompass?
- What proportion of Institute spending goes to developing its own staff and capacity?
- Has the Institute received capacity development support from elsewhere? If so what form has this taken? Mentoring, external TA, international positions within the institute?
- Is the Institute part of any broader network within the country or internationally? (specify)
- Which aspects of capacity development have been most successful? Which have been least successful? What do you perceive to be the main capacity development needs for the Institute now?
- Has the institute helped in anyway to build the capacity of policy makers? Has the institute in any way undermined the development of government capacity?

5. General questions for the Institute

- What are the success stories of the Institute in terms of positive impact on policy (and what are the failures)?
- What advice would you give to others establishing a similar organization?

- Who are the strongest advocates of your organization and why?
- Who are the strongest critics of your organization and why?
- What do you think have been the key factors in contributing to the success of your Institute?
- How vulnerable do you think the Institute is to changes in the external environment such as a change of political regime, or the departure of one or two particular aid agencies?

Part 2 – Guide regarding data collection on the Context within which the Institute works

These questions are not designed to be asked as part of the semi-structured interviews (although it may be pertinent to pose the second question below to policy makers interviewed). However they should be primarily answered through review of available documentary evidence such as UN reports, published papers etc.

- How open (democratic) is the political system within which the institute functions?
- Are there strong pressures upon government to use evidence in policy, if so what is the source of these pressures?
- What is the state of development of civil society – are there many well established civil society organizations, many very new ones, or hardly any at all?
- Is the country a large aid recipient? Is there a big market for technical services among aid agencies. Where do aid agencies typically get their advice from?
- How (i) predictable and (ii) friendly/hostile is the external environment? Is the economy fairly mature and government budgets stable and predictable? How physically secure is the country

Part 3 – Published document review

A complete publications list for the past 5 years of the Institute should be collected. Please provide an analysis of ALL publications by type (eg. Policy brief, research report, evaluation report) and by subject area, as follows:-

- Health financing
- Health system governance
- Service delivery
- Disease specific analysis
- System-wide analysis (ie. Covering more than one aspect of the health system)
- Other

Depending upon the length of this list the researcher should then conduct a stratified sampling. Each strata should be based upon the type of publication (eg. Policy brief, research report, commentary). A sample of documents should be randomly selected from each strata.

A more detailed analysis should then be undertaken of this sample of documents including

- Types of methods employed
- Clarity of methods
- Clarity of referencing
- Presentation of executive summary
- Presentation of key messages
- Political and social orientation of publications and whether publications reflect any particular political or social bias.

Annex 2 scientific and advisory committee members

Scientific Committee:

1. Asso. Prof. PhD Le Quang Cuong, Director of HSPI – Chairman of the Committee
2. MPH Tran Thi Mai Oanh, Vice Director of HSPI
3. MPH Vu Thi Minh Hanh, Vice Director of HSPI
4. PhD Tran Van Tien, Head Division of Research, Training and International Cooperation Administration
5. PhD. Khuong Anh Tuan – Head Department of Health Service Management
6. MSc. Nguyen Khanh Phuong– Head Department of Health Economics and Financing
7. MPH Phan Hong Van – Deputy Head Division of Research, Training and International Cooperation Administration – Secretary of the Committee

Advisory Committee:

1. Mr. Nguyen Khanh – Former Vice Prime Minister
2. Prof. PhD. Pham Song – Former Minister of MOH
3. Prof. PhD. Pham Manh Hung, - Former Minister of MOH
4. Prof. PhD. Le Ngoc Trong - Former Minister of MOH
5. Mr. Dinh Quang An – Director – Institute for Central Economic Management
6. Mr. Le Minh Sat – Expert from the Ministry of Science and Technology
7. PhD. Mai Anh, Director – Hanoi Association of IT

In additions, depending on each specific situation, HSPI usually invites other experts from MOH/institutions, experts of HSPI who are retired for the consultation

Annex 3 HSPI staff profiles

No	Position	Degree	gender	age	Year start	Department / Division
1.	Director HSPI	MD, PhD in Medicine Associate Prof in Medicine	Male	51	2007	Director
2.	Deputy director HSPI, Head of Department	MD, Master in Public Health PhD in Public Health in 2009	Female	41	1998	Public Health Policy
3.	Deputy director HSPI and Head of Dept	MSc in Sociology	Female	45	1998	Medical Sociology
4.	Senior researcher - Head of Division	MD, PhD in Medicine	Male	56	2004	Research, Training and International Cooperation Administration (RTICA)
5.	Senior researcher, Head of Dept	MD, Master in Public Health, PhD in Public Health	Male	41	2000	Health Service Management
6.	Senior researcher, Head of Dept	Pharmacist, Master in Health Economics, PhD in Public Health in 2009	Female	37	1998	Health Economics and Financing
7.	Senior researcher, Deputy Head of Dept	MD, Master in Public Health PhD in Public Health in 2009	Male	33	2000	Public Health Policy
8.	Senior researcher, Deputy Head of Dept	Master in Sociology	Female	35	1998	Medical Sociology
9.	Senior researcher, Deputy Head of Division	MD and Master in Public Health	Female	40	1998	Research, Training and International Cooperation Administration
10.	Researcher Deputy Head of Dept	MD	Female	49	2000	Human Resource in Health
11.	Senior researcher	Master in Public Health	Female	32	2000	Medical Sociology
12.	Senior researcher	MD, Master in Public Health	Female	31	2002	Medical Sociology
13.	Senior researcher	MD, Master in Public Health	Male	38	2004	Medical Sociology
14.	Senior researcher	Bachelor in IT, Master in Public Health	Female	39	1998	Public Health Policy
15.	Senior researcher	MD, Master in Public Health	Male	45	2006	Public Health Policy
16.	Senior researcher	Master in Public Health, PhD in Public Health in 2009	Female	42	1998	Health Economics and Financing
17.	Senior researcher	Master in Public Health	Female	32	2001	Health Economics and Financing
18.	Senior researcher	Master in Public Health	Male	37	2004	Human Resource in Health
19.	Senior researcher	Master in Public Health	Male	48	2007	Human Resource in Health
20.	Senior researcher	Master in Public Health	Female	34	1998	Health Service Management
21.	Senior researcher	MD, Master in Public Health	Male	36	2007	Health Service
25.	Junior researcher	MD	Female	38	2005	Research, Training and International Cooperation Administration
26.	Junior researcher	MD	Female	30	2007	Public Health Policy
27.	Junior researcher	Bachelor in Public Health	Female	23	2007	Medical Sociology
28.	Junior researcher	Bachelor in Public Health	Male	23	2008	Health Service Financing

						Management
29.	Junior researcher	Bachelor in IT	Male	36	1998	Research, Training and International Cooperation Administration
30.	Junior researcher	Bachelor in Foreign Language	Female	31	2008	Research, Training and International Cooperation Administration
Administrative / supporting						
31.	Deputy Head of Division	Bachelor in Financing and Accountant, Master in Financing and Accountant	Female	32	2000	Financing and Accountant
32.	Staff	Bachelor in Financing and Accountant	Female	33	2000	Financing and Accountant
33.	Staff	Intermediate level in Financing and Accountant	Female	28	2004	Financing and Accountant
34.	Deputy Head of Division	Bachelor in Law, Master in Administration Management	Female	33	2000	Organization-Administration
35.	Staff	Bachelor in Economics	Male	49	2004	Organization-Administration

Besides, there are 3 drivers, 3 doorkeepers, 1 odd job

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