Health Policy 98 (2010) 178–185

Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol

Health policy processes in Vietnam: A comparison of three maternal health case studies

Bui Thi Thu Ha[a,*], Andrew Green[b], Nancy Gerein[b], Katrine Danielsen[c,1]

[a] Hanoi School of Public Health, 138 Giang Vo, Ba Dinh, Hanoi, Viet Nam
[b] The Nuffield Centre for International Health & Development, Leeds Institute of Health Sciences, University of Leeds, Charles Thackrah Building, 101 Clarendon Road, Leeds LS2 9LJ, UK
[c] Royal Tropical Institute, Mauritskade 63, 1092 AD Amsterdam, The Netherlands

ARTICLE INFO

Keywords:
Health policy
Reproductive health
Maternal health
Adolescent reproductive health
Domestic violence

ABSTRACT

Objectives: To describe and analyse the policy processes related to maternal health in Vietnam.
Methods: A multi-method, retrospective comparative study of three case studies of maternal health policy processes-skilled birth attendance, adolescent reproductive health and domestic violence. It drew on primary qualitative data and secondary data. The underpinning conceptual framework of the study with key elements of policy processes is described.
Results: The study identified significant differences between the policy processes related to the different case studies. Various factors affect these processes. Critical amongst these are the nature of the policy, the involvement of different actors and the wider context both nationally and internationally. The changing national context is opening up increasing opportunities for civil society to interact with policy processes.
Conclusions: Understanding the nature of policy processes is critical to strengthen them, particularly in a changing environment. There is potential for a review of government policy processes which were developed in the period prior to Doi Moi to reflect the changing composition of civil society.

1. Introduction

In the area of reproductive health, the Vietnam government has developed nationwide strategies and implemented activities to strengthen reproductive health. In particular the Ministry of Health (MOH) has developed the Reproductive Health Strategy (2001–2010), which addressed for the first time the issue of adolescent reproductive health and gender equality. It led to a *National Safe Motherhood Plan for period 2003–2010* to address the continuing high rates of maternal mortality, as well as a National Master Plan of Action (2006–2010) and Vision (to 2020) for Adolescents and Youth to address the issue of adolescent reproductive health. The government has also, with the active involvement of the MOH, developed a law in 2008 on Domestic Violence prevention and control.

Such policy is important for guiding activities in the health system, yet the processes which develop and implement such policies are not well-researched particularly in a changing society and economy such as Vietnam. Health policy processes are generally accepted as being led by government though increasingly there is recognition of the reality and importance of the involvement of actors outside both the government sector and the health system. In recent years, under the influence of factors such as globalization, health sector reform, decentralisation and the development of public-private partnerships, health policy

* Corresponding author. Tel.: +84 4 266 2344; fax: +84 4 266 2385.
E-mail addresses: bth@hsph.edu.vn (B.T.T. Ha), A.T.Green@leeds.ac.uk (A. Green), N.Gerein@leeds.ac.uk (N. Gerein), k.danielsen@kit.nl (K. Danielsen).
[1] Tel.: +20 5688711.

0168-8510/$ – see front matter © 2010 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2010.06.015

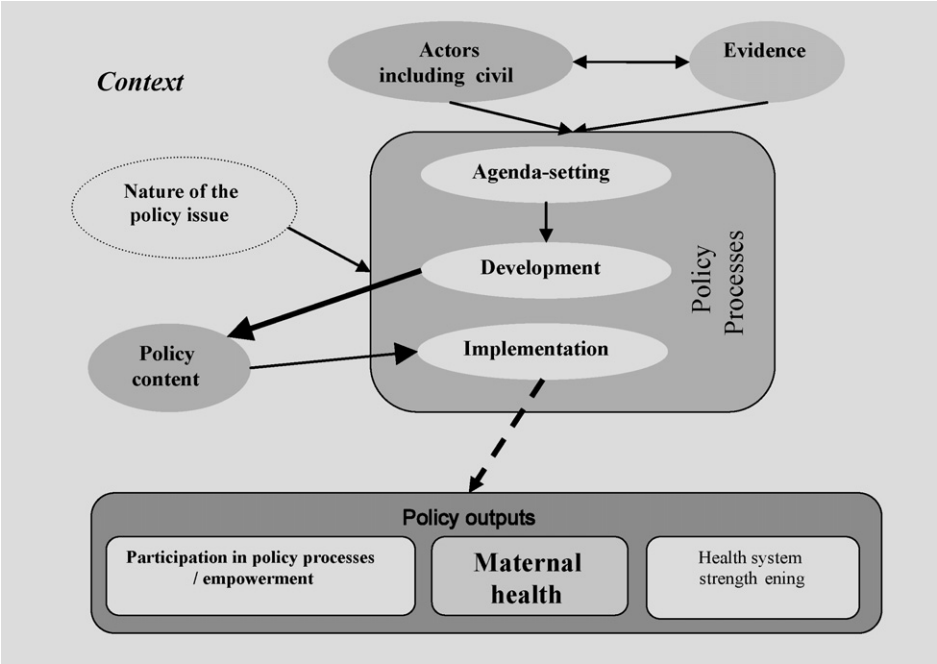

Fig. 1. HEPVIC conceptual framework.

processes have become less top down and more consultative, involving more actors and networks, and taking into account people's understanding, values and beliefs [1,2]. Understanding *how* policies are developed and implemented is critical if the appropriateness and robustness of such policies is to be enhanced.

This paper reports on research conducted in Vietnam on such policy processes. The research was part of a wider project,[2] which aimed to enhance health policy-making processes through a comparative study of three Asian countries – Vietnam, India and China – using a case-study approach in the field of maternal health (HEPVIC). In Vietnam the policies studied related to safe birth attendance (SBA), adolescent reproductive health (ARH) and domestic violence (DV). A conceptual framework which focuses on policy processes and their relationships with key elements—the policy content, the overall context and the actors involved (Fig. 1) is used [3]. This framework draws on a well-known way of describing the public policy process, the *stages heuristic* [4,5], which analyses policy processes as a series of different stages. Whilst in practice policy processes are messy and iterative, and such stages are not clearly delineated, this approach is often seen as a helpful way of analyzing the different elements [6] and in this research we focused on three key stages, agenda-setting, development and implementation.

The paper describes and analyses the policy processes related to maternal health in Vietnam focusing on the differences and similarities between the three cases and possible explanations for these, taking into account the relationships between the actors, context, content and processes.

Such policy processes occur against a changing context in Vietnam. In 1986 it instituted a major political reform (*Doi Moi*) with greater orientation to a market economy. However, despite a recent high annual economic growth rate [7], the health sector has suffered from low public funding and high out-of-pocket payments by households [8], with negative equity implications. The private health sector is playing an increasing role in providing outpatient services (32% of total visits), but still has only a very modest share of inpatient services (1.7% of visits) [9].

The numbers of qualified health staff, and their level of qualifications have increased significantly in recent years. However, the ratio of health worker/population in mountainous and remote areas remains low. The shift of health workers from the public to the private sector and from poor provinces to big cities has exacerbated the maldistribution of human resources. There is a reported a lack of doctors specialized in obstetrics and gynaecology [10]. The MOH is seeking to introduce a policy to redistribute health workers more equitably and improve the standards of service delivery. In the rest of this paper we outline the methods deployed in the research and then the key findings followed by a discussion of their significance.

2. Materials and methods

In this study, maternal health is used as a case study of the wider policy processes. Within the field of maternal health, three cases and the processes related to specific policy documents were selected:

- The *skilled birth attendance (SBA) policy*—a 'non-controversial' case study, focusing on the National Plan

[2] An overview of HEPVIC and the findings of the comparative research undertaken can be found in Green et al. (submitted for publication).

Case studies

- Skilled birth attendance (SBA)
- Adolescent reproductive health (ARH)
- Domestic violence (DV)

Data collection period

- December 2006 – July 2008

Data collection methods	SBA	ARH	DV
In-depth interviews with key respondents (policy-makers, managers/planners, researchers, civil societies, international development partners/donors, politicians)	11	11	12
Documents reviewed	37	50	53
Participatory stakeholder workshop			1
Focus group discussion	1	2	

Fig. 2. Summary of research methods.

of Safe Motherhood 2003–2010 (NPSM). This related to a clearly defined and widely accepted international policy, which needs implementation at a country level.

- *Adolescent reproductive health (ARH) policy*—a 'controversial' case study where there was a mixture of support and opposition to the policy. This case study focused on the National Master Plan for Adolescents and Youth 2006–2010 (NMPAY).
- *Domestic violence (DV) policy*—a case study of an issue which cuts across a number of sectors, focusing on the Law on Domestic Violence prevention and control.

The study was a multi-method, retrospective comparative study of three case studies of maternal health policy processes. Fig. 2 summarizes the research methods.

The Vietnam research team, supported by European partners, carried out the analysis. The data was analysed using a framework approach with text analysis (NVivo 7.0) software. Quality assurance checks were used to ensure the reliability and validity of findings, including discussions with, and validation by, all project partners.

3. Results

3.1. Policy processes

Table 1 summarizes the key features of the policy processes for each case study.

The characteristics of the policy processes related to each policy case are quite different. Firstly, the three cases are at different stages. The SBA case has completed agenda-setting and development and is now at the level of nationwide implementation; the ARH case has only just commenced initial implementation of activities; and implementation of the DV law has not yet commenced, with the implementation guidelines still being drafted.

The speed of the policy processes was affected by various factors including policy leadership, existence of evidence, international policies and cultural acceptability of the policy.

The locus of policy-making and the actors involved are affected by the nature of the policy issue. The development of the NPSM and NMPAY policies were seen as clearly the responsibility of the health sector and as such co-coordinated by the reproductive health (RH) department of the MOH with the final policy approved within the MOH. In contrast the DV law development involved actors from a variety of different ministries and was coordinated by the Social Affairs Committee of the National Assembly.

The evidence of extremely high maternal mortality ratios (MMR), particularly in mountainous areas, from the 2001 Maternal Mortality Survey [11] provided strong justification for the NPSM. Furthermore, global concepts and movements had an important impact on policy development [12]. The existence of a clearly defined and widely accepted international policy on SBA facilitated the NPSM process, resulting in a relatively short agenda-setting and development period. In comparison, although the ARH movement was influenced by the Western Pacific Region Office/WHO guidelines on youth and adolescent development [13], the cultural sensitivity of adolescent reproductive health issues in Vietnam led to greater reluctance to act and resulted in a lengthy agenda-setting stage of the policy process, followed by a further 4 years for development.

International movements also influenced the DV policy, especially the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and ICPD. However the cultural perception of domestic violence as a private household problem was seen as the most critical barrier to acceptance by policymakers and the wider community of the need for the law. This, together with its multi-sectoral nature which required complex inter-ministry coordination, resulted in a long agenda-setting period of almost 20 years.

3.2. Policy content

The policy content for the SBA and ARH policies focused on health service delivery. In the former, there are clear objectives on improvement of existing services, focusing on institutional delivery in most of the country and home delivery with the assistance of trained health workers in less accessible mountainous areas. In the latter, a new 'friendly service for adolescents and youths' was introduced into the health service. By comparison, the DV law

Table 1
Summary of policy processes of three cases.

Processes and policy content	Skilled birth attendance (NPSM)	Adolescent reproductive health (NMPAY)	Domestic violence (DV)
Policy content	The plan sets out strategies for improved service delivery on safe motherhood by 2010 related to availability, accessibility and quality of obstetric and neonatal care at commune health centres and district hospitals	The National Master Plan focuses on delivery of different reproductive and sexual health care services for youth and adolescents through different channels such as health education and training, advocacy and counselling services	The DV law defines types of domestic violence, the rights and reporting obligations of domestic violence victims as well as the responsibilities of the State, organizations and communities to prevent domestic violence and to protect the victims
Level of approval	Ministry of Health	Ministry of Health	Government (National Assembly)
Agenda setting period	2001–2002	1996–2002	Since 1980s
Policy development period	2002–2003	2003–2006	2005–2007
Source of external funding for policy development	Royal Netherlands Embassy (RNE)	Swedish International Development Agency (SIDA) and WHO	Royal Danish embassy, Swiss Embassy, Asian Development Bank, UNFPA and UNICEF
Policy implementation period	2003–2010	2006–2010	Implementation is required by the law by July 2008, however the guideline for implementation is still being drafted
First implementation phase	2003–2006: piloting of intervention plan in 6 districts of 3 provinces	2007–2008: 20 provinces developed the plan of action following the NMPAY	
Source of external funding for 1st phase implementation	RNE	SIDA and WHO	
Second phase	2006–2010: implementation in only 14 highland provinces with high maternal mortality due to lack of funding	2008–2010: provinces with action plans received limited funding from national target programme to conduct training for health workers due to lack of funding	
Funding source for 2nd phase implementation	RNE as the official donor for implementation of NPSM Small fund from national target health programme		

Table 2
Actor involvement in the policy processes.

Actor	Role and level of engagement in policy development and implementation		
	Skilled birth attendance	Adolescent reproductive health	Domestic violence prevention
Reproductive Health Dept./MOH	Coordinating	Coordinating	Participant
Legislation Dept./MOH			Participant
Social Affairs Committee of the National Assembly			Coordinating
Royal Netherlands Embassy	Donor and facilitator		
Royal Danish Embassy			Donor
Swedish International Development Agency		Donor and technical support	
Swiss Embassy, Switzerland Development Agency			Donor
WHO		Donor and technical support	
UNFPA	Technical support and co-executing the first phase		Advocacy partner consultation
Technical experts	Involved in development	Involved in development	Involved in development
Local provincial health departments	Involved in implementation	Involved in implementation	
NGOs	Involved in the first phase of implementation	Involved in agenda setting and development	Involved in agenda setting and development. Conducted research Formed a network of NGOs
Vietnam Women's Union	Involved in the second phase of implementation		Involved in development
Vietnam Youth Union		Involved in development	
Research institutions	Conducted research	Conducted research	Conducted research

emphasizes the responsibilities of wider organizations and agencies in the prevention of DV and protection of victims, alongside health service provision for victims. With the exception of SBA services where the details and responsibility for service provision are already well accepted, the specifics of service delivery for ARH and, even more so, for DV victims, are still far from clear.

3.3. Key actors

The research identified key actors with different roles within and between the case studies (Table 2). Two government bodies played a coordination role. They could make decisions on the scope of activities to be carried out during the processes: what types of evidence should be obtained, who should be consulted, and how to disseminate or utilize the evidence during policy processes.

In the SBA and ARH cases, the reproductive health (RH) Department of the MOH (an administrative government body) had a prominent role as a leading and coordinating agency in all three policy phases with a tendency towards a centralised and top-down approach. A key individual policymaker emerged in the RH Department for SBA, as a "policy entrepreneur" acting as a broker between different stakeholder groups (MOH policymakers and leaders, and the donor network) and as overall leader for the development and implementation of NPSM. This was a critical role; as one development partner put it:

> *Without the contribution of this policymaker... no safe motherhood program would have been done in Vietnam*

In the case of the DV law, the Social Affairs Committee of the National Assembly (a political body) was the leading and coordinating agency. This was stipulated in government regulations—when a legal area crosses sectors, the National Assembly should be the coordinating agency.

Besides these government actors, other actors were influential. Donors played an important role in the processes, with varied types of involvement. For example the Swiss Embassy and the Royal Danish Embassy provided the funding for the development of the DV law, but were not directly involved in the policy process. In contrast, the Royal Netherlands Embassy (RNE) played a role as a facilitator as well as a donor during the policy development process for the NPSM. The RNE also determined the executing mechanism for the first and second phases of implementation. Two UN agencies, WHO and the UNFPA, were actively involved in all three policy processes. These agencies followed their mandates, supporting policy development in fields where they have relevant expertise.

There were also groups of (mainly government) technical experts. They were invited by the MOH and the National Assembly to participate in the consultation processes and mainly contributed at the national level during the policy development phase. Many revisions of policy documents resulted from their comments. The contribution of experts was mixed; some made a significant contribution while others did not, depending on their level of technical expertise and the perception of the lead institution about their expertise. Local provincial departments were involved in processes through workshops and conferences, but their contributions were rather passive. Their main role was as implementers of set activities.

In Vietnam, the term 'civil society organization' (CSO) is understood to cover three different types of organizations: (1) mass organizations (such as the Vietnam Youth Union, and the Women's Union); (2) professional associations (such as Vietnam Public Health Association) and (3) Vietnamese and international NGOs [14,15]. In Vietnam there is no tradition of wholly independent organisations outside government; thus the first group which is 'quasi' independent with strong links to government, is still the

major CSO actor in policy processes. However there has been an emergence in recent years of more independent NGOs (the third category) and, though their role was not major, it is interesting to note the nascent development of this group in, and their occasional influence on, policy processes.

Some CSOs voiced their views substantially during the development of the DV law and the NMPAY. In the case of the DV law, a network of Vietnamese NGOs emerged to advocate for the law. This network arose from already existing CSOs working in a broad field of related topics such as gender, health and research. They were successful in providing evidence of high rates of domestic violence that helped to persuade policymakers of the need for a DV law. In the case of the NMPAY, the Vietnamese Youth Union (VYU), with the support of Care International (an international NGO), was an influential advocate for the inclusion of an additional objective in the policy related to disadvantaged youths and adolescents. The power they gained from these prior experiences with ARH project gave them a stronger voice in this process.

> *European Union/UNFPA adolescent health project (RHIYA) provided evidence on a participatory approach and it drew quite a lot of attention, at least at that time [2003–2006]. It also showed that when integrating three areas, policy advocacy, behaviour change communication and youth friendly services, it was possible to obtain good outcomes toward improving adolescent reproductive health. . . .Only after RHIYA was our group able to provide documents to guide policy advocacy for adolescent reproductive health. I think the RHIYA program had a very important role. It showed the importance of advocacy to make government officials, other stakeholders and policy makers understand and to help create a favourable environment for adolescent reproductive health policy and programs." (Vietnam Youth Union)*

In all three cases however, there were various actors who were 'missing'. For example, in the SBA case the voice of traditional birth attendants was not heard. And in none of the three policy processes did women have a direct voice. Representatives from the growing private sector in health care were also absent. In both SBA and ARH cases, there was minimal involvement of certain departments within the MOH, such as the Departments of Personnel, Science and Training, and Finance and Planning. Those actors could have provided important inputs in the areas of human resources, finance, health systems, and the role of the private sector. By not including these actors, these perspectives were incompletely reflected in the final policy documents.

3.4. Effect of context on policy processes

Policy processes are affected also by the wider context, including key national and international events. These are summarized in Table 3. The crosses in the table refer to our analysis of the influence of key events on agenda-setting and development of the policies. The number of crosses represents the level of contextual influence on the policy processes. More crosses means more influence.

The international context had considerable influence. The ICPD 1994 served as a platform that changed the attitudes of policymakers and health managers, and redirected the reproductive health programme towards a more holistic approach. This event was cited as the key event by respondents in all cases.

The commitment to meeting the MDGs was also a strong political factor that shaped the agenda for SBA and DV in the local context. The WPRO/WHO policy on adolescents and youth had a direct influence on ARH in Vietnam, and the National Master Plan on Adolescents and Youth was very much in line with WPRO/WHO policy. At the national level, the National Strategy on Reproductive Health Care (RHC) was the background policy document guiding the development of all three policies.

In addition to these key events and overarching policies, there are also specific issues that contributed to the development of the policies. In SBA, the global movement promoting skilled birth attendance had a direct influence on Vietnam's safe motherhood policy, reflected in part by the addition of the term "trained health worker" into the official health indicators in the year 2000. In DV, the Vietnamese definition of domestic violence differs from that of other countries; internationally, DV usually refers only to women, but the Law in Vietnam specifically included other family members, both male and female. As an *international development partner put it:*

Table 3
Effect of the wider context on the policy processes.

Key events	Skilled attendance at birth	Adolescent reproductive health	Domestic violence law
International			
CEDAW 1979			+
ICPD 1994	+++	+++	+++
Millennium Summit (MDGs)	++		+
Skilled attendance at birth global concept	+++		
WPRO/WHO policy on adolescents and youth		++	
National			
National Strategy on Reproductive Health Care (RHC) for the period 2001–2010	+++	+++	+++
National standards and guidelines for reproductive health care services	++	++	++
National guidelines on monitoring and evaluation for reproductive health care services	+	+	

One success of our efforts in advising the National Assembly was to shift the target of the Domestic Violence Law from exclusively family members based on blood or marriage relations to include also those cases of divorce or living together as husband and wife without marriage registration. This is in line with other revised laws such as the Law on Marriage and Family and it will be practical in real life.

In practice, however, many respondents noted that the DV law is intended to be applied only to women victims, and the updated guidelines for RH services include screening of only female victims who visit reproductive health services.

4. Discussion

It can be seen that the three cases have different policy processes, influenced by the nature of the issue, its 'sectoral home' and type of policy. These processes involved different actors and were influenced by contextual factors, both international and national.

Kingdon identified three streams critical for policy change – the problem, politics and policy streams – whose confluence would provide an opportunity for action [16]. In the case of SBA, they emerged almost simultaneously: the problem stream (high MMR in Vietnam); the politics stream (compatibility of interests between MOH and development partners) and the policy stream (development of a policy to reduce MMR to meet the MDGs). For ARH, the problem stream appeared in the 90s: a young population with many reproductive health problems including abortion and HIV/AIDS/STDs. However, this stream preceded those of politics and a potential policy response. Politicians were initially sceptical about the importance of ARH issues, therefore, agenda-setting took a long time. Policy development began in 2003 when the politicians accepted ARH as a problem, influenced by international pressures, and the three streams finally merged. The DV case was different again. While the politics stream surfaced with the signing of the CEDAW in the 1980s, the problem stream only emerged in 2005 when evidence about domestic violence was publicised. Policy development began effectively in 2005 when the three streams came together.

The difference between the cases in the agenda-setting stage, particularly in terms of the length of time of the process, was also strongly influenced by the nature of the policy issue and the perception of the effectiveness of possible responses. This was seen clearly in the SBA case, where the intervention was non-controversial (institutional delivery with assistance by skilled birth attendants), with modified application in the Vietnamese context (institutional delivery in mainland areas, and home delivery by trained health workers in mountainous areas). In comparison, the idea of an ARH policy was not always clear and consistent, due to its sensitive nature in the Vietnam context. In addition, the solution to ARH problems, such as sexual and reproductive health education, was not uniformly accepted, being described as an "unproven intervention" by some parents and policymakers. The ARH policy introduced a new concept and service (youth-friendly service) into the MOH, requiring additional investment in terms of organisational structure, human resources and facilities. Similarly, as we have seen, the DV concept was initially not well supported by policymakers since this was considered as an 'internal household issue'; furthermore the DV law introduced a very new and unclear concept with ill-defined service delivery requirements. This made it difficult to develop an implementation strategy.

The clearer global agenda in the SBA case made it easier to bring the topic to the policy table, increased the likelihood of getting support from politicians, policymakers and donors, and consequently reduced the time for agenda-setting. Domestic violence and adolescent reproductive health were not traditionally part of global or national health policies or service delivery, therefore, when the global agenda was not aligned specifically to the country context, and the policy issue required debate, the agenda-setting stage took longer. The lack of specificity and clarity of the policy idea (the causes of the problem, effective interventions, technical issues) contributed to the delayed agenda-setting, development and implementation, and led to challenges in monitoring the implementation of ARH and DV policy.

None of the policies could be implemented as planned, either in scope or timeline. This raises questions of accountability and responsibility of related stakeholders in ensuring policy implementation. The MOH does not have standard procedures or guidelines for the involvement of actors in policy processes. One of the consequences is that each of the policy processes studied shows different involvement of different actors. In the case of the DV law, involvement of external actors in the process was not defined by standard procedures or guidelines and this created difficulties in coordinating activities and may have delayed the implementation process. Clear institutional leadership, and the involvement of fewer agencies, would make the implementation process easier.

The cases show that although no official policy and procedures for civil society involvement exist, the possibility of influence of civil society on policy processes is increasing. Both cases, DV and ARH have strong involvement of the civil society groups in the agenda-setting stage. The international development partners have had an important influence in this respect (provide funding and technical support). Besides, the growing freedom of the press and media and especially, in DV case, the role of the Assembly allowed the emergence of an open debate around the contested policy issue of DV. The current legal framework does not give the civil society full independence, and this issue still remains politically sensitive [17], Nevertheless, from DV and ARH cases, it can be seen that there is much scope for facilitating the movement of CSOs from the margins to the mainstream of development action and increasing their impact on the policy-making process. However, in order to make the policy processes more democratic and accountable, and serve the needs and rights of people, more transparent procedures for policy-making are needed which set out who should be involved and how.

The role of "policy entrepreneur" appeared clearly in the NPSM while this was not so clear in the ARH and DV cases. In the case of NPSM, this helped to accelerate the

agenda-setting and development stages. However, the discussion above shows that the policy issue and the global agenda are very much influential in this process. The ARH and DV cases show how bureaucrats still have much power in deciding to support the policy and this explained why the agenda-setting of those two policies took so long. Nevertheless, under pressure of international partners and local civil society, they had to compromise by explicitly including 'sexuality' and 'sexual health' in the definition of ARH, and also included consideration of vulnerable youth in the policy in the case of ARH and also to accept the development of DV law in response to DV issues.

This study showed how international and national factors had a direct impact on agenda-setting. The Doi Moi reform with its market orientation and opening to global interchange brought the opportunity for the country to respond to international events. Since the Cairo conference, the national action plan and international agenda on reproductive health, along with the MDG targets, have created a more favourable environment for policy development in the three areas. However, the effect of the national context, such as cultural perceptions of ARH and DV issues, as well as the availability of appropriate leadership, is reflected in the differences in the policy processes in the three cases.

5. Conclusion

The paper describes and analyses the policy processes related to three Vietnam maternal health policy documents. The findings show that policy processes are different for three cases with a number of factors affecting these processes. Critical amongst these are the nature of the policy, the involvement of different actors and the wider context both nationally and internationally. Understanding such processes is important both for government policymakers to ensure that the policy responds to evidence and the variety of viewpoints on a particular issue and is timely in both development and implementation. It suggests the need also for a review of the government policy processes which were developed in the period prior to Doi Moi to reflect the changing composition of civil society. Understanding such processes is also important for the growing number of civil society organisations keen to have their voice heard in the policy arena.

Our research has not been able to answer a number of questions. Further research is needed to explore the policy outputs of these policies with regard to maternal health and wider effects on the health system. For example, what has been the contribution of NPSM to increasing the coverage and quality of services, and its effects on human resources, information systems, equipment and upgrading of facilities? Similar questions could be asked for the other two policies. Prospective research on processes that government could use to guide and coordinate different actors' involvement would be useful. Lastly, the research did not look in any depth at individual policy tools, such as regulatory or allocative mechanisms in the three policy documents; such research is needed to ensure that policy is implemented as designed.

Acknowledgements

The authors want to thank colleagues at the Hanoi School of Public Health and all HEPVIC partners for their contribution during the HEPVIC project. The research that this paper was based on was supported by the EC under FP6.

References

[1] Hajer MA, Wagenaar H, editors. Deliberative policy analysis. Cambrigde: Cambrigge University Press; 2003.
[2] Ministry of Health. Vietnam Health Report 2006. Hanoi; 2007.
[3] Walt G. Health policy: an introduction to process and power. Johannesburg/London: Zed Brooks, Witwatersrand University Press; 1994.
[4] Lasswell H. The decision process. College Park, MD: University of Maryland Press; 1956.
[5] Brewer G, deLeon P. The foundations of policy analysis. Monterey, CA: Brooks/Cole; 1983.
[6] Walt G, Shiffman G, Schneider H, Murrey F, Brugha R, Gilson L. "Doing" health policy analysis: methodological and conceptual reflections and challenges. Health Policy and Planning 2008;23:308–17.
[7] Central Institute for Economic Management. Vietnam Economic Report 2007. Central Institute for Economic Management; 2007, p. 90.
[8] Ministry of Health. Group HP. Joint annual health review 2007. Hanoi: Ministry of Health; 2008. p. 90.
[9] General Statistics Office. Vietnam Living Standard Survey 2006. Hanoi: Statistical Publishing House; 2008.
[10] Ministry of Health. Field assessment of safe motherhood services in Vietnam. Hanoi: Ministry of Health; 2003.
[11] Ministry of Health. Maternal mortality in Vietnam 2000–2001: an in-depth analysis of causes and determinant; 2002.
[12] Shiffman J, Smith S. Generation of political priority of global health initiatives: a framework and case study of maternal mortality. Lancet 2007;370:1370–9.
[13] WPRO/WHO. Policies on adolescent health and development: a guide for policy makers; 2002.
[14] Sinh BT. Civil society and NGOs in Vietnam: some initial thoughts on developments and obstacles. In: Meeting with the delegation of the Swedish Parliamentary Commission on Swedish policy for global development to Vietnam. 2002.
[15] Wischermann J. The Relationship between "Civic Organizations" and Governmental Organizations" in Viet Nam - Selected Findings of an Empirical Survey. Hanoi, http://www.politik.uni-freiburg.de/pdf/VietnamProj.pdf.
[16] Kingdon JW. Agendas, alternative, and public policies. New York: Harper Collins; 1995.
[17] Shanks E, Luttrell C, Conway T, Loi VM, Ladinsky J. Understanding pro-poor political change: the policy process. London: Overseas Development Institute; 2004.